Part 202 Hospital Services

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.

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.

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.

CARDIAC REHABILITATION

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