MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid Provider Bulletin

Program and Policy Information

Volume 3, Issue 7 January 1997

Warren County HMO Enrollment Update

EDS

HMO Enrollment of Medicaid Eligibles in Warren County

The Division of Medicaid began enrollment of Medicaid recipients in Warren County with health maintenance organizations (HMO) on November 1, 1996. The monthly cutoff for HMO enrollment is the 27th of each month.

As of November 27, 1996, HMO enrollment for Warren County was as follows:

Apex Healthcare of Mississippi, Inc.	448
AmeriCan Medical Plans of Mississippi, Inc.	333
Mississippi Managed Care Network, Inc.	193
Family Health Care Plus	274

Enrollment packets containing information on each HMO were sent to approximately 7,000 Medicaid eligibles in Warren County during the last week of October and the first week of November. Of those enrolled, 61 percent, were enrolled by mail.

During November, members of the EDS outreach staff were available in social services offices, and 25 percent of the Medicaid recipients who enrolled with an HMO did so at one of the outreach sites.

On November 17 and 18, an enrollment fair was held at the Vicksburg City Auditorium. Each HMO had submitted a segment for a video which the recipients were able to watch to get an overview of each of the HMOs and their plans. The HMOs also had booths with representatives available to answer questions about their plans. Approximately 400 Medicaid recipients attended the enrollment fair and 54 percent of those who attended enrolled with an HMO. Of the total enrolled with HMOs, 14 percent was from the enrollment fair.

HMOs began providing services to Medicaid recipients enrolled with their plans on December 1, 1996.

Inside This Issue

Critical Care

Critical care codes 99291 and 99292 are allowed only in place of service 1 (inpatient) or place of service 2 (outpatient) when the patient is in **unstable, critical condition** and requires the **constant attendance** of the physician for one (1) hour or more. Having a physician in the area or on-call does not meet the criteria of "constant attendance".

Code 99291 is used to report the first hour of critical care on a given date. It is to be used only once per date. Code 99292 is used to report subsequent half hours beyond the first hour. Only full 30-minute increments are to be reported. Any time less than thirty minutes is NOT to be reported. The combination of codes 99291 and 99292 cannot exceed a total of eight (8) hours for any inpatient admission (place of service 1). If multiple providers submit claims for critical care, only a total of eight (8) hours will be paid per admission regardless of the number of providers. The combination of codes 99291 and 99292 cannot exceed a total of two (2) hours for any outpatient treatment (place of service 2) per date of service. If multiple providers submit claims for critical care in place of service 2, only a total of two (2) hours will be paid regardless of the number of providers.

The critical care codes are to be used to report the total duration of time spent by a physician providing constant attention to an unstable patient in critical condition, even if the time spent by the physician providing critical care services on that date is not continuous. These codes are NOT to be routinely reported simply because a patient is in an area designated for special care.

Critical care for less than one (1) hour per date of service IS NOT COVERED under the critical care code 99291. Care for less than one (1) hour and care that does not meet the criteria for critical care should be reported with the appropriate E&M code for either an initial service or a subsequent service.

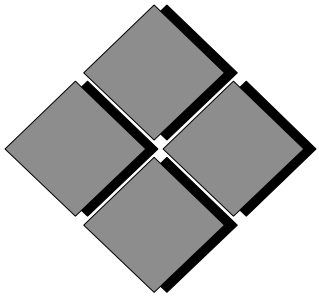
Codes 99291 and 99292 are inclusive of: the interpretation of cardiac output measurements, chest x-rays, blood gases, information data stored in computers (including the interpretation of ECGs), gastric intubation, temporary transcutaneous pacing, ventilator management and vascular access procedures.

The CPT E&M procedure codes 99295 - 99297 for neonatal intensive care are to be used to report services to a neonate. Procedure codes W9041 (intensive care of infants in an ICU/CCU) and W9042 (intensive care of children from 1 - 14 years of age in an ICU/CCU) are allowed only in place of service 1 (inpatient), ICU or CCU. These are inclusive codes that are covered at one (1) per day.

Either critical care codes 99291/99292 **OR** W9041/W9042 **OR** an E&M code may be reported. These codes should never be billed together. Also, codes for prolonged, face-to-face physician services are not to be reported with the critical care or intensive care codes.

Documentation of the services rendered, their medical necessity and the critical, unstable condition of the patient must be recorded in the medical record. Incomplete or inadequate documentation may result in a recoupment of payment.

Critical care for less than one (1) hour per date of service IS NOT COVERED under the critical care code 99291. Care for less than one (1) hour and care that does not meet the criteria for critical care should be reported with the appropriate E&M code for either an initial service or a subsequent service.



State of Mississippi Division of Medicaid HMO Pilot Program

On behalf of the Mississippi Division of Medicaid, EDS invites you to attend a provider workshop focusing on the health maintenance organization (HMO) managed care pilot program in Harrison and Hancock Counties. Effective January 1, 1997, Mississippi Medicaid recipients in Harrison and Hancock Counties will have the option to choose a managed care program, an HMO, HealthMACS, or they may choose to remain in fee for service Medicaid. Following a 30-day initial enrollment period, recipients will begin receiving services from their respective HMOs on February 1, 1997. This workshop will provide you with a basis for understanding the HMO managed care program and billing for Medicaid recipients enrolled with an HMO. The Harrison and Hancock County workshops will be held on **Wednesday, January 15, 1997**, in Waveland and **Thursday, January 16, 1997,** in Biloxi at the following locations:

Holiday Inn Waveland
404 Highway 90
Waveland, Mississippi
Chandeleur Island Room
or
Holiday Inn Coliseum
2400 Beach Boulevard
Biloxi, Mississippi
Ballroom

There will be two sessions during the day that you may attend at your convenience.

9:00 a.m. Medicaid Managed Care Plans
or
1:00 p.m. Medicaid Managed Care Plans

There will also be representatives available from the various managed care plans to answer your questions and provide you with information about their plans. Representatives from the various managed care plans will be available to meet with you at your convenience.

Due to limited space, please respond as quickly as possible by calling the Managed Care Hotline at **1-800-627-8488.**

Billing of Laboratory/Radiology Procedures

Implementation of the claims evaluation software will be complete in mid January. At this time, it is imperative that laboratory and radiology procedures billed by doctors, clinics and CRNAs have a diagnosis specific to and appropriate for the lab/x-ray procedure performed. Independent labs and radiologists should leave the diagnosis field blank. If the lab/x-ray procedure billed is not specific to the diagnosis recorded on the claim, your claim will be denied.

With the implementation of the claims evaluation software, the following lab procedures are considered inclusive in automated, multichannel testing:

82040	82435	82554	84075	84295	84550
82250	82465	82565	84100	84450	
82251	82550	82947	84132	84460	
82310	82552	82977	84155	84478	
82374	82553	83615	84160	84520	

For any combination of tests listed above, bill with the appropriate multichannel code, 80002 - 80019.

Software

EPSDT Prior Authorizations and HMO Recipients

All Medicaid Providers servicing children via the EPSDT Prior Authorization System using active or open ended Plans of Care need to verify if a recipient is enrolled in an HMO. If the child is an HMO recipient the EPSDT Plan of Care is no longer valid.

If you have any questions, please call EPSDT at 359-6150 or the Managed Care Division at 359-6133.

Reimbursement for Nurse Aide Training and Testing

All nursing facilities must bill the Division of Medicaid for nurse aide training and testing expenses incurred during the period July 1, 1996 through December 31, 1996 by January 31, 1997. Since nurse aide training and testing expenses are reimbursed directly to nursing facilities, they are considered non-allowable costs for Medicaid cost reporting purposes. Nurse aide training and testing expenses billed (postmarked or hand delivered) after the January 31, 1997 deadline will not be reimbursed by the Division of Medicaid and will be excluded from allowable costs on the Medicaid cost report.

Testing fees that have been paid for by December 31, 1996, but for which pass/fail rosters have not been received by the nursing facility, should be billed to the Division of Medicaid no later than January 31, 1997. The pass/fail rosters should be forwarded to the Division of Medicaid as soon as they are received for the billed testing fees. Please note that this exception is for tests taken in the latter part of December 1996 only. The pass/fail rosters for all other test dates should be submitted with your bills.

Nurse aide training and testing expenses billed after the January 31, 1997 deadline will not be reimbursed by the Division of Medicaid and will be excluded from allowable costs on the Medicaid cost report.

Billing for Postpartum Care

Postpartum care (CPT Code 59430) may only be billed for services rendered in a physician's office within 60 days after delivery. This code does not count against the twelve (12) office visit limit. Reimbursement of inpatient postpartum care is considered inclusive in that of the delivery.

January 1997

S	*M*	*T*	*W*	*T*	*F*	*S*
			1 Closed	2 ESC Cut-Off	3	4
5	6 Checkwrite	7	8	9 ESC Cut-Off	10	11
12	13 Checkwrite	14	15	16 ESC Cut-Off	17	18
19	20 Checkwrite	21	22	23 ESC Cut-Off	24	25
26	27 Checkwrite	28	29	30 ESC Cut-Off	31 All nurse aid training and testing expenses must be billed to DOM	

Checkwrites and Remittance Advices are dated every Monday. However, funds are not transferred until the following Thursday and Remittance Advices usually arrive the following Friday.

Mississippi Medicaid Bulletin

EDS
111 East Capitol, Suite 400
Jackson, MS 39201-2121

Bulk Rate
U.S. Postage
PAID
Jackson, MS
Permit No. 584