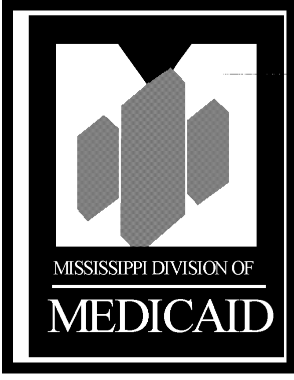



# Mississippi Medicaid Bulletin

## Program and Policy Information

Volume 3, Issue 10 April 1997


Reduction Mammoplasty Policy will be reflected in forthcoming revisions to the following manuals: Physician, Hospital, Rural Health, Ambulatory Surgical Center, Federally Qualified Health Centers (FQHC), and State Department of Health manuals.

EDS

### Reduction Mammoplasty Policy

Effective June 1, 1997, Mississippi Medicaid will require prior approval for all reduction mammoplasties.

The related CPT code utilized by physicians is 19318 with modifier 50 being applicable to bilateral procedures. The related ICD-9 procedure codes utilized by the facilities are 85.31 for unilateral and 85.32 for bilateral procedures.

The Mississippi Medicaid program will cover reduction mammoplasty only when there is medical documentation which proves the procedure is (1) medically necessary, AND (2) reconstructive, AND (3) performed as a last means of attempting to alleviate a patient's symptomatology **and** dysfunction due to the excessive breast size.

**All of the following criteria will be applied in determining the medical necessity for a specific case.**

1. The patient's history must include **all** of the following problems.

   a. Backache/Neck Pain/Postural Defects: must have history of conservative treatment by the referring physician and/or specialists (list name of treating physicians and explain treatment).

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b. Strap mark indentations: must be documented by photographs.

c. Restriction of normal activity: must explain how the activity is restricted.

A history of intertrigo (chronic irritation under or between breasts) will also be considered as documentation for medical necessity (list name of treating physicians and explain treatment).

2. A minimum of 1500 - 2000 grams of tissue must be removed from each breast.

3. The suprasternal notch to nipple measurement must be a minimum of 30 cm.

To request prior approval, the physician must submit the following information:

1. Full name and address of patient
2. Mississippi Medicaid ID #
3. Complete history of patient's breast condition
4. Complete explanation of patient's symptomatology associated with breast condition
5. History of all past treatment for breast condition with names of treating physicians
6. Patient's date of birth/height/weight
7. Suprasternal notch measurement
8. Frontal and lateral photographs of the breasts which also document any strap mark indentations (label with patient name and date)
9. Amount of breast tissue to be removed from each breast
10. Full name and address of physician requesting approval

Physicians who refer patients to surgeons for evaluations are encouraged to forward complete records with the patient which fully document the patient's history, symptomatology, and past treatment. Such records will be useful to the surgeon in the evaluation of the patient as well as for reviewing the case for coverage under Medicaid.

Physicians who refer patients to surgeons for evaluations are encouraged to forward complete records with the patient which fully document the patient's history, symptomatology, and past treatment.

The request for prior approval and the above information should be mailed to:

**EDS**
**Medical Review Department**
**P.O. Box 23061**
**Jackson, MS 39225-3061**

After review of the information, EDS Medical Review will inform the physician in writing of the benefit determination.

This policy will be reflected in forthcoming revisions to the following manuals: Physician, Hospital, Rural Health, Ambulatory Surgical Center, Federally Qualified Health Centers (FQHC), and State Department of Health manuals.

## Private Insurance and Medicaid Coverage

It is not uncommon for Medicaid recipients to have private insurance. Due to higher income allowances in the Aid to Families with Dependent Children (AFDC) program, intact family eligibility, and employed absent parents, some people with a third party resource can also be eligible for Medicaid benefits.

Federal law requires that providers participating in the Medicaid program protect Medicaid's interest when a third party resource is available. Federal law also protects the Medicaid recipient when he/she has private insurance. The provider participating in the Medicaid program cannot refuse service to a Medicaid recipient because he/she has a third party resource. The provider cannot pick and choose the services to be rendered to the recipient because of third party coverage. The recipient cannot be charged any more than the applicable Medicaid co-payment for the service. The provider must accept either the third party resource payment or the Medicaid payment as payment in full. The recipient cannot be charged the difference between either the third party payment or the Medicaid payment and the billed charges for Medicaid covered services. This is true regardless of the type of private coverage the recipient has.

A provider participating in the Medicaid program cannot refuse service to a Medicaid recipient because he/she has a third party resource.

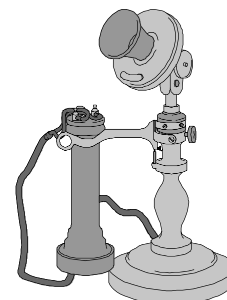
Third party coverage allows the provider to receive higher fees for service in most instances. Third party coverage also allows the Medicaid program to realize savings. In Fiscal Year 1996, the Mississippi Medicaid program recovered or cost avoided 35.5 million dollars due to private third party resources. Since Medicaid monies are taxpayer dollars, third party resources not only afford savings to the Medicaid program, but also to the taxpayer.

Any known violation of the above referenced laws and Medicaid program requirements will be referred to the DOM Fraud and Abuse Unit.

## Managed Care and Certification for Inpatient Stays

When requesting certification for Medicaid recipients who are in a managed care program, the following are to be contacted.

If the Medicaid recipient is in the HealthMACS program, inpatient certification is requested through the PRO at 1-800-884-3030. This is handled the same as for Medicaid recipients who are not in a managed care program, and is no different from what you are currently doing.



If the Medicaid recipient is in one of the health maintenance organizations (HMO) that has a contract with the Division of Medicaid, inpatient certification is handled by the HMO or its designee. Listed below are the HMOs and the telephone numbers to be used for certification of inpatient stays.

| | |
|---|---|
| AmeriCan Medical Plans | 1-800-552-7733 |
| Apex Healthcare | 1-800-598-1668 |
| Family Health Care Plus | 1-800-323-1999 |
| Mississippi Managed Care Network | 1-800-410-3035 |

Obtaining Referrals and Authorization for HMOs

## HMO Referrals and Authorization

Four HMOs (**H**ealth **M**aintenance **O**rganizations) began providing services to Medicaid recipients in Warren County on December 1, 1996, and in Hancock and Harrison Counties on February 1, 1997. Individual and group Medicaid providers have contracted with HMOs to form provider networks. Recipients enrolled in an HMO will receive all services through network providers, unless otherwise authorized by the HMO or for an emergency. For services provided by non-network providers, each HMO's referral/authorization process must be followed. **For HMO referrals to provide services, the HMO in which the recipient is enrolled must be contacted for authorization in order to be reimbursed for the services provided** Recipient HMO enrollment information and the toll-free telephone number for the HMO can be obtained by verifying the recipient's eligibility through one of the following methods:

1. Point of Service Eligibility Verification (swiping the Medicaid card)
2. Automated Voice Response System (AVRS) - 1-800-884-3222
3. Medicaid Telephone Representative - 1-800-884-3222

A brief description of the HMO referral/authorization process for each HMO and a toll-free telephone number is found below.

### Medicaid Providers Not in HMO Networks

If you provide non-emergency services to a Medicaid recipient who is in an HMO and you are not a contracted provider with that HMO, your payment for these services could be denied unless you have authorization from the HMO to provide the services. Providers need to call the HMO in which the Medicaid recipient is a member before non-emergency services are rendered. Before paying providers who are not contracted providers with the HMO, the HMO will need general information about the provider, such as address, type, tax ID number, etc.

### AmeriCan Medical Plans of Mississippi - 1-800-254-5184

As authorization for referrals, AmeriCan must have a referral form on file for the recipient. This form may be completed and faxed by the PCP to 1-800-525-8306 or initiated by telephone request by calling 1-800-552-7733. If you need to speak with an AmeriCan representative, please call 1-800-254-5184 and choose option 2.

### Apex Healthcare of Mississippi - 1-800-598-1668

An Apex Healthcare Referral form must be completed by the PCP to refer an Apex Healthcare member for specialized services. Hospital admission (unless an emergency) and outpatient surgical procedures require authorization prior to the services being performed. This prior authorization may be obtained by calling 1-800-598-1668. When using the Apex Health Referral form, the PCP should fax or mail the white page to Apex Healthcare. The PCP should give the yellow page to the patient to take to the

*(Continued on page 5)*

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specialist as notification to the specialist of the PCP's approval for the referred service. The pink page is placed in the patient's chart in the PCP's office. The fax number for referral forms is 1-800-491-2557. Referral forms should be completed by the PCP retrospectively for emergency care.

**Family Health Care Plus -1-800-323-1999**

Network providers are to be used whenever possible. Specialists are authorized to treat members through the Consultation Request Form (CRF). The upper portion of the CRF form must be completed by the PCP, otherwise payment may be delayed while additional information is being obtained. Check all boxes on the CRF that apply. Services beyond those specified on the original CRF form require a separate authorization. Subsequent referrals for specialty services require a separate authorization. Subsequent referrals by the specialist are prohibited. Elective admissions, outpatient surgery, outpatient diagnostic test procedure, or therapy require 72-hour prior approval. A CRF must be issued for such outpatient testing and therapy. Telephone requests for pre-admission certification will be answered and an authorization number issued within 24 hours or one working day. Written requests will be answered and an authorization number mailed within 24 hours from receipt. For more information regarding referrals and authorizations, please call 1-800-323-1999.

Recipients enrolled in an HMO will receive all services through network providers, unless otherwise authorized by the HMO or for an emergency.

**Mississippi Managed Care Network - 1-800-410-3072**

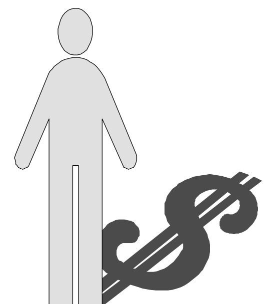
Mississippi Managed Care Network utilizes an electronic referral system that may be accessed via automated touch-tone to log or provide referral information. To learn more about specific services requiring referrals/authorizations, please contact a Mississippi Managed Care Network representative at 1-800-410-3072. For authorization of services, please call 1-800-410-3035.

If you have questions or need additional information about the HMO referral/ authorization process, please contact the HMO at the telephone numbers above.

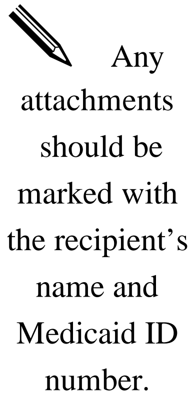
## Long-Term Care Facilities 1996 Owners' Salaries Limits

The limitations on owners' salaries are based on 150% of the average salaries for non-owner administrators in 1995. The maximum allowable salaries for 1996 are:

- Intermediate Care Facilities for the Mentally Retarded (ICF-MR) — $57,279
- Small Nursing Facilities (1-60 Beds) — $59,097
- Large Nursing Facilities (61+ Beds) — $76,455
- Psychiatric Residential Treatment Facilities (PRTF) — $58,181



## Billing Tips for Claims with Attachments



Any attachments should be marked with the recipient's name and Medicaid ID number.

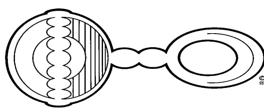
When submitting claims with attachments, please utilize the following terminology:

- Other Insurance Denial -TPL DENIAL, SEE ATTACHED
- Medicare Denial - MEDICARE DENIED, SEE ATTACHED
- Third party payments less than 20% of charges - LESS THAN 20%, PROOF ATTACHED
- Retroactive Medicaid eligibility - RETROACTIVE MEDICAID, SEE ATTACHED

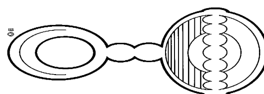
Any attachments should be marked with the recipient's name and Medicaid ID number. Do not staple attachments more than once as all attachments must be separated prior to filming and batching.

Providers that are submitting paper claims with TPL payments greater than 20% of the total charges may resume submitting those claims electronically. A copy of the Explanation of Benefits should be kept on file in case of future audits.

## Clarification of Billing for Critical Care



The initial neonatal intensive care code (99295) is reserved for the date of admission to the NICU and should not be billed again anytime during the admission.



The local W codes for critical care, W9042 (ICU care for children under 14) and W9410 (stepdown ICU for infants, per day) will be closed and will no longer be reimbursed by the Mississippi Medicaid program effective May 1, 1997. The closure date for W9041 (ICU/CCU care for infants) has been extended from March 1, 1997 to May 1, 1997.

Neonatal intensive care codes 99295-99297 are to be used to report services provided by a physician directing the care of a neonate or infant **in a neonatal intensive care unit (NICU)**. They represent care starting with the date of admission to the NICU. Codes 99296 and 99297 may be reported only once per day, per patient. The initial neonatal intensive care code (99295) is reserved for the date of admission to the NICU and should not be billed again anytime during the admission. Once the neonate is no longer considered to be critically ill or is moved from the NICU, the CPT codes for Subsequent Hospital Care (99231-99233) should be utilized.

For all patients except those critically ill neonates or infants being treated **in a neonatal intensive care unit**, the CPT codes for Subsequent Hospital Care (99231-99233) are to be billed after the allowed eight hours of inpatient critical care is exhausted.

**Please call the EDS Correspondence Unit at**
**1-800-884-3222 or 601-960-2800**
**if you have any questions regarding the information in this bulletin.**

## Prolonged Physician Services with Direct (Face-to-Face) Patient Contact

A recent review of the prolonged physician services CPT codes (99354, 99355, 99356, and 99357) has been completed. This review indicates that these codes are over-utilized, and in many instances, incorrectly and inappropriately billed. Because of this, each of these billed codes will be manually reviewed. Please submit a copy of the medical record(s) that supports the billing of a prolonged physician services code to EDS Medical Review. These copies must include the recipient ID number, provider number and date of service.

Please submit a copy of the medical record(s) that supports the billing of a prolonged physician services code to EDS Medical Review.

# HealthMACS Workshops

The Mississippi Division of Medicaid and EDS staff will be conducting workshops and recruiting primary care providers (PCP) for the Health Through Medicaid Managed Access to Care and Services program (HealthMACS). HealthMACS, a primary care case management program for AFDC/AFDC-related Medicaid eligibles, will be implemented in **DeSoto, Lafayette, Marshall, Panola** and **Tate Counties** on **July 1, 1997**.

The purpose of these workshops is to discuss the policies of the HealthMACS program, how it changes the way HealthMACS enrollees access care and services, and how medical care provided by health care specialists other than the PCP must be authorized by the PCP for Medicaid to reimburse for the services.

If you are interested in being a PCP for HealthMACS, you and/or your representative may want to attend one of the following scheduled workshops.

**April 22, 1997 - 9:00 a.m.**
**Holiday Inn Executive Conference Center**
**11200 East Goodman Road**
**Olive Branch, Mississippi**

**April 23, 1997 -9:00 am**
**Ole Miss Union**
**Room 405 A-B**
**University, Mississippi**

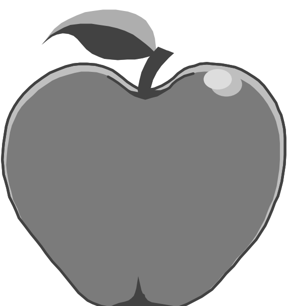
If you provide health care to AFDC/AFDC-related Medicaid eligibles in the counties listed above, you and/or representatives of your office/billing staff may benefit by attending one of the following scheduled HealthMACS workshops.

**April 22, 1997 - 1:00 p.m.**
**Holiday Inn Executive Conference Center**
**11200 East Goodman Road**
**Olive Branch, Mississippi**

**April 23, 1997 -1:00 p.m.**
**Ole Miss Union**
**Room 405 A-B**
**University, Mississippi**

If any additional information is needed, please contact the Managed Care Hotline at 1-800-627-8488.

If you are a provider in DeSoto, Lafayette, Marshall, Panola, or Tate Counties, you may wish to attend one of the upcoming workshops that will be held in your area.



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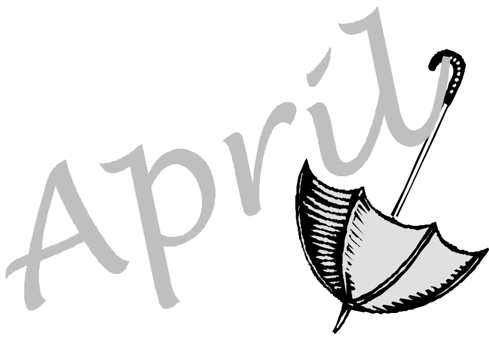


April 1997

| S | M | T | W | T | F | S |
|---|---|---|---|---|---|---|
| | | **1** | **2** | **3** ESC Cut-Off | **4** | **5** |
| **6** Daylight Saving Time begins | **7** Checkwrite | **8** | **9** | **10** ESC Cut-Off | **11** | **12** |
| **13** | **14** Checkwrite | **15** | **16** | **17** ESC Cut-Off | **18** | **19** |
| **20** | **21** Checkwrite | **22** Managed Care Workshops 9 a.m. and 1 p.m. | **23** Managed Care Workshops 9 a.m. and 1 p.m. | **24** ESC Cut-Off | **25** | **26** |
| **27** | **28** Checkwrite DOM **closed** for Confederate Memorial Day | **29** | **30** | | | |

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.