MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid Bulletin

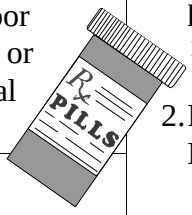
Program and Policy Information

Volume 4, Issue 4 October 1997

Pharmacy Participation Policy

Effective October 1, 1997, participation as a pharmacy provider in the Mississippi Medicaid program is limited to those pharmacies that hold a permit as a Retail Pharmacy, Closed-Door Pharmacy, or Institutional Pharmacy. These pharmacies must meet the following listed criteria for participation in the Mississippi Medicaid program.

Participation as a pharmacy provider in the Mississippi Medicaid program is limited to those pharmacies that hold a permit as a Retail Pharmacy, Closed-Door Pharmacy, or Institutional Pharmacy.



1. For pharmacies holding Retail Pharmacy Permits, participation in the Mississippi Medicaid program requires the Retail Pharmacy to be a fully-stocked community pharmacy, which is open during normal business hours. A pharmacist must be on premises to dispense drugs to the general public. Prospective drug utilization review of recipient records is required prior to dispensing prescriptions. An opportunity for face-to-face counseling must be provided to recipients or to their representatives (guardians, relatives, etc.) The Division of Medicaid will not reimburse a retail pharmacy provider for dispensing of prescriptions where a personal provider/patient relationship does not exist between the patient and pharmacy.

2. For pharmacies holding Closed-Door Pharmacy Permits, participation in the Mississippi Medicaid program is limited to pharmacies dispensing infusion therapy

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Pharmacy Policy Rx

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drugs or pharmacies dispensing drugs to recipients in an institutional setting, i.e., a nursing home or similar long term care facility. A pharmacist must be on premises to dispense drugs. Prospective drug utilization review of recipient records is required prior to dispensing prescriptions. Face-to-face counseling is not required if the recipient is a resident of a long term care facility or the dispensed drugs are administered by a physician, nurse, or similarly authorized health professional.

3. For pharmacies holding Institutional Pharmacy Permits, participation in the Mississippi Medicaid program is limited to the dispensing of drugs to recipients in an institutional setting, i.e., a nursing home or similar long term care facility. These pharmacies may be in-house or off premises, may have limited hours, and may dispense drugs to outpatient recipients. A pharmacist must be on the premises to dispense drugs. Prospective drug utilization review of recipient records is required prior to dispensing prescriptions. Face-to-face counseling is not required if the recipient is a resident of a long term care facility or the dispensed drugs are administered by a physician, nurse, or similarly authorized health professional.

   Permit holders who dispense drugs outside of the specified required criteria listed above are non-covered.

   Medicaid Pharmacy Provider Agreements will not be initiated or maintained with pharmacy wholesalers, holders of only a Drug Room Permit, Retail, Closed-Door, or Institutional Pharmacy physically located (more than) thirty miles from the state borders of Mississippi.

Medicaid reimburses pharmacy providers only for prescriptions that are received via hand delivery by a recipient or his/her representative, or received directly via phone, fax, or mail from a physician, dentist, nurse practitioner, or similarly authorized health professional, or an agent under the health professional's direct supervision, e.g., a nurse.

The Division of Medicaid does not reimburse for prescription claims when the prescription is transferred to the pharmacy from a third party, such as another pharmacy, a wholesaler, or a Drug Room permit holder.

This policy will be contained in Appendix M (Pharmacy Participation Policy) of the Pharmacy Manual. Please look for this policy in forthcoming manual revisions.

Independent Physiological Laboratories/Mobile Diagnostic Units

Effective January 1, 1998, the Division of Medicaid will no longer allow reimbursement to Independent Physiological Laboratories, or other independent mobile diagnostic units. Testing and diagnostic services provided by such units will be reimbursable only when ordered by the recipient's physician, and billed by an approved Medicaid provider, limited to physician, physician clinics, Federally Qualified Health Centers, Rural Health Clinics, and county health department clinics.

New Visit Frequency

The ClaimReview New Visit Frequency (Edit 447) prevents the inappropriate billing of a new patient Evaluation and Management Code. If the provider bills a new patient E & M code more than once in a three year period, ClaimReview replaces the new E & M code with the corresponding established E & M code if one is available.

The purpose of this notification is to clarify that new patient office visits are not allowed in situations where the physician sees the patient for the first time at a hospital and subsequently follows the patient in the office. New patient is defined as "one who has not received any professional services from the physician or another physician of the same specialty, who belongs to the same group practice, within the past three years." This definition is applicable when the patient is seen initially in the hospital (inpatient or outpatient) and then in the office and is uniformly applied to all specialties.

Providers are Reminded

New patient office visits are not allowed in situations where the physician sees the patient for the first time at a hospital and subsequently follows the patient in the office.

Diagnosis to Procedure Comparison (Edit 446) will be managed on a monitoring rather than a denial basis.

Diagnosis to Procedure Comparison

The Division of Medicaid recently directed that the ClaimReview Diagnosis to Procedure Comparison (Edit 446) be managed on a monitoring rather than a denial basis. The Division of Medicaid and our Physician Advisors will monitor all activity for several months and will reevaluate whether to continue on a monitoring basis or to return to denying the claims under Edit 446. Appropriate intervention, such as physician education or referral of the claims to the Program Integrity Unit, will be initiated when necessary. The Division of Medicaid supports the integrity of the ClaimReview product and expects cooperation from providers in being accountable for reporting appropriate diagnoses for medically necessary procedures.

Treatment for Children with "Special Needs"

Primary care physicians provide care for children with "special needs." Funding for special care (PT, OT, equipment, and supplies) for Medicaid eligible children is through the EPSDT program. The EPSDT Medical Review Team has always encouraged primary care physicians to seek consultation with orthopedists, physiatrists (Physical Medical and Rehabilitation specialists), the Children's Medical Program clinics (State Department of Health) or rehabilitation centers. A recent article, "The Role of the Primary Care Physician in Services for Children with Special Needs", by R.C. Sneed, M.D. in Health Baby Update (Volume 10, Number 4, June 1997) gives an excellent summary of problems primary care physicians face when caring for these children. Reprints of this article can be ordered from the Mississippi Chapter/American Academy of Pediatrics, P.O. Box 4725, Jackson, MS 39296-4725 or (601) 354-7558.

Reimbursement for a Surgical Tray

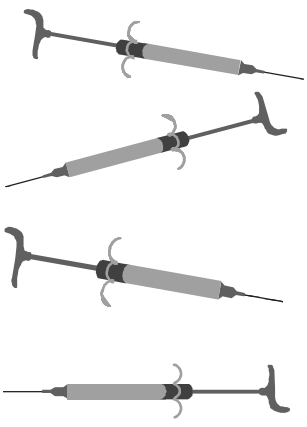
Physicians who perform the following procedures in their office (place of service 3) may also be reimbursed for a surgical tray under HCPCS code A4550. It is imperative that the surgical procedure be billed on the claim form BEFORE the surgical tray is billed. Failure to do so may result in an inappropriate denial of payment.

The surgical procedure **must** be billed on the claim form BEFORE the surgical tray is billed.

Surgical Tray (A4550) Codes

19101	28294	43234	45383	52250	52315
19120	28296	43235	45384	52260	57520
19125	28297	43239	45385	52270	57522
19126	28298	43245	49080	52275	58120
20200	28299	43247	49081	52276	62270
20205	32000	43249	52005	52277	68761
20220	36533	43250	52007	52283	85095
20225	37609	43251	52010	52290	85102
20240	38500	43458	52204	52300	95028
25111	43200	45378	52224	52301	96440
28290	43202	45379	52234	52305	96445
28292	43220	45380	52235	52310	96450
28293	43226	45382	52240		

Routine Venipuncture



Effective December 1, 1997, the Division of Medicaid will apply the following policy to routine venipunctures which are performed for the purpose of obtaining a blood sample for laboratory testing.

1. CPT Code 36415 will be closed and will not be accepted by Medicaid for dates of services on and after December 1, 1997.

2. HCPCS Code G0001 will be opened and effective for dates of services on and after December 1, 1997. The allowance will be $2.10 to comply with state law, which requires Medicaid to pay physician services at 70% of Medicare's 1994 allowance.

3. Physicians or nurse practitioners may bill for the routine venipuncture only if the blood sample is drawn and all of it is referred to an outside lab. If all or part of the sample is retained for a test to be performed in the office, the provider may **not** bill for the venipuncture.

4. Finger/heel/ear sticks that are performed for the purpose of collecting blood specimens still are not covered under Mississippi Medicaid. Providers must not bill HCPCS Code G0001 when the blood samples are obtained by the "stick" procedure rather than actual venipuncture.

HMO and HealthMACS Update

Expansion of the Medicaid HMO program has been delayed at this time. Bolivar, Coahoma, Leflore and Sunflower Counties will not be implemented in November and December as previously scheduled.

Effective December 1, 1997, HealthMACS will be implemented in Clark, Jasper, Jones, Smith and Wayne Counties. Workshops will be conducted on October 8, 1997. See the HealthMACS Workshops article below.

HealthMACS Workshops

The Mississippi Division of Medicaid and EDS staff will be in your area to conduct workshops and recruit primary care providers (PCP) for the managed care program Health Through Medicaid Managed Access to Care and Services (HealthMACS). HealthMACS, a primary care case management program for AFDC/AFDC-related Medicaid eligibles, will be implemented in selected counties in your area on **December 1, 1997**. The selected counties are: **Clark, Jasper, Jones, Smith and Wayne.** HealthMACS links Medicaid eligibles with a PCP who is responsible for managing the health care needs of Medicaid eligibles assigned to him/her. HealthMACS offers better patient care by providing continuity of services and encouraging more appropriate use of the health care system.

The purpose of the 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. Some Medicaid services are excluded from HealthMACS and do not require authorization by the PCP. These services include: podiatry, dental, psychiatry, ophthalmology, eyeglass, hearing aids, emergency services, nursing home and ICF/MR, and emergency/non-emergency transportation.

Medicaid providers who can be PCPs for HealthMACS are: family practitioners, general practitioners, pediatricians, obstetricians (OB), gynecologists (GYN), internists, and nurse practitioners (pediatric, adult, family, OB-GYN, and certified nurse midwives).

If you are one of the provider types listed above and are interested in being a PCP for HealthMACS, you and/or your representative may want to attend one of the workshops scheduled below. Detailed information about the HealthMACS program will be given during the workshop. PCP requirements and responsibilities will also be addressed. PCP applications and provider agreements will be available. Completed applications for PCP participation in HealthMACS and pre-assignment of recipient enrollment must be received by the Division of Medicaid by October 10, 1997.	**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 HealthMACS workshops scheduled below.** If you are not sure if you need to attend a workshop, please call the Managed Care Hotline, 1-800-627-8488, or the Division of Medicaid Managed Care staff, 1-800-421-2408, for additional information about the program and the workshops.
October 8, 1997 - 9:00 a.m. **Sawmill Ramada Inn** **Laurel, Mississippi**	**October 8, 1997 - 1:00 p.m.** **Sawmill Ramada Inn** **Laurel, Mississippi**

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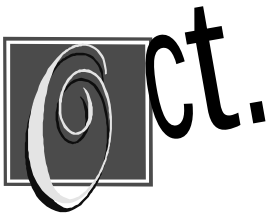

October 1997

S	*M*	*T*	*W*	*T*	*F*	*S*
EDS Correspondence Unit 1-800-884-3222 or 601-960-2800			1	2 ESC Cut-Off 5 pm	3	4
5	Checkwrite 6	7	8 Managed Care Workshop 9 am and 1 pm	9 ESC Cut-Off 5 pm	10	11
12	Checkwrite 13	14	15	16 ESC Cut-Off 5 pm	17	18
19	Checkwrite 20	21	22	23 ESC Cut-Off 5 pm	24	25
26	Checkwrite 27	28	29	30 ESC Cut-Off 5 pm	31	

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.