MISSISSIPPI DIVISION OF MEDICAID

Mississippi Medicaid Bulletin

Program and Policy Information

Volume 4, Issue 8 March 1998

Inpatient Certification for HMO Members

It is necessary that Medicaid eligibility be verified for each inpatient hospital stay to determine the appropriate agency to contact for inpatient certification. If the Medicaid recipient is in an HMO, the managed care information is provided at the time eligibility is verified. It is important that hospital utilization review (UR) staff know when a Medicaid recipient is an HMO member.

It is necessary that Medicaid eligibility be verified for each inpatient hospital stay to determine the appropriate agency to contact for inpatient certification.

Certification for Inpatient General Hospital Stays: HMOs are responsible for certifying services for those Medicaid recipients enrolled with an HMO. HealthSystems of Mississippi (HSM) is responsible for certifying services for Medicaid recipients who are not in an HMO.

Staff at HSM who are contacted by hospital UR staff will ask if the Medicaid recipient is in an HMO. If the UR staff does not have this information or advises HSM that the patient is not in an HMO and HSM provides certification, the certification will be invalid if it is determined that the patient was an HMO member at the time of certification. It will then be the responsibility of the hospital to address reimbursement with the HMO.

Certification for Inpatient Psychiatric Services: Senate Bill 2100 as passed by the Legislature during the 1997 Session requires a carve out of mental health services from the HMO program. Since mental health services are carved out of the HMO program, HSM is responsible for all certifications of Medicaid recipients enrolled with an HMO

(Continued on page 2)

Inside This Issue

EDS

(Continued from page 1)

whose primary diagnosis is a mental health diagnosis in the ICD-9 code range of 290-319.99. There will be some cases in which the primary diagnosis for admission purposes is a medical diagnosis and once the medical need is met, the patient continues the inpatient stay due to a mental health diagnosis. An example would be someone who is admitted for attempted suicide. Once the treatment for the injury is no longer primary, the mental health diagnosis to deal with issues causing the attempted suicide becomes the primary diagnosis. In this case, the HMO is responsible for certifying the stay necessary to address the medical diagnosis. When the primary diagnosis changes, the HMO is no longer responsible for certifying days and the hospital UR staff must contact HSM to certify these days. It is the responsibility of the HMO to notify the Division of Medicaid, Managed Care Division of any member who remains hospitalized and whose primary diagnosis becomes a mental health diagnosis in the range of 290-319.99. The hospital will also have to split bill the inpatient stay so that EDS can properly process the claims.

It is the responsibility of the HMO to notify the Division of Medicaid, Managed Care Division of any member who remains hospitalized and whose primary diagnosis becomes a mental health diagnosis in the range of 290-319.99.

HMOs and Telephone Numbers for Inpatient Certification:

AmeriCan Medical Plans	1-800-254-5184
Apex Healthcare	1-800-598-1668
Family Health Care Plus	1-800-323-1999
Mississippi Managed Care Network	1-800-410-3025

Questions about the process for inpatient certification should be directed to the HMO in which the Medicaid recipient is enrolled or to HSM.

Medicaid Charges for Fee Schedules and Provider Manuals

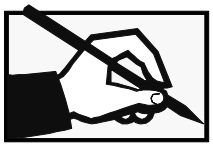
Medicaid Charges for Fee Schedules and Provider Manuals

Medicaid fee schedules are available in hard copy form and on diskette. The current fee schedule contains 158 pages. The charge for a hard copy of the fee schedule is $92. The fee schedule on diskette costs $45.78.

One provider manual is provided for each provider number. If providers request additional manuals, they must submit their request in writing to the Division of Medicaid. The charge for an additional manual is $25 per manual plus postage.

All requests for information should be sent to :

Rose Compere
Information Officer
Division of Medicaid
239 North Lamar Street, Suite 801
Jackson, MS 39201-1399



Billing Tip- When filing HCFA claim forms, claims should not be continued to a second page as stated in section 6.02 # 28 of the Mississippi Medicaid Physician Manual.

HealthMACS Referral Log

HealthMACS Primary Care Providers (PCP) are encouraged to use the HealthMACS referral log, which has been provided at HealthMACS workshops or to create their own tool/system to track all HealthMACS requests for authorization both approved and denied. The importance of this log is to track all authorizations to ensure that medical records documentation is returned to the PCP. The log is also used as a tool along with the PCP services rendered by non-PCP report to periodically monitor any misuse of the PCP's authorization number.

As of April 1, 1998, both emergent and urgent care situations will require **post authorization**. True non-urgent/non-emergent situations are to be redirected back to the PCP. This makes it even more important for PCPs to keep an accurate HealthMACS authorization log to document when authorization was approved or denied. When the PCP receives his/her services rendered by non-PCP report, it is to be matched with the PCP's referral log to ensure that the use of the PCP's HealthMACS authorization number was used as specified by the PCP.

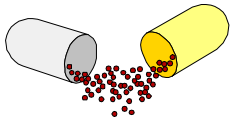
Hospital emergency rooms are required by federal law to complete medical screenings on each patient presenting to the emergency room (ER). If the medical screening determines that the patient has a true non-urgent/non-emergent situation, the ER is to redirect the patient back to the assigned PCP. It is expected that PCPs will provide post authorization for these medical screenings. Without HealthMACS authorization, the hospital will not be reimbursed for the medical screening. If the ER must provide treatment for stabilization, the PCP will be requested to provide post authorization for this treatment.

The PCP is to assist with educating enrollees who use the emergency room for problems that need to be treated by the PCP. The PCP can call the Managed Care Hotline at 1-800-627-8488 to request that a client field representative contact the enrollee to provide education about the appropriate use of health care services, when to go to the emergency room, when to contact the PCP, etc.

If you are a HealthMACS PCP and you identify or suspect that another provider is using your HealthMACS authorization number without your permission, please call the Managed Care Division at 1-800-421-2408 Ext. 6133. You will be asked to provide verification of the discrepancies noted on the PCP services rendered by non-PCP report as well as copies of your referral log. **As a reminder: Use of the PCP's HealthMACS authorization number without the PCP's permission is considered fraud.**

The PCP can call the Managed Care Hotline at 1-800-627-8488 to request that a client field representative contact the enrollee to provide education about the appropriate use of health care services, when to go to the emergency room, when to contact the PCP, etc.

Change in Prior Approval Requirement for NSAIDS



Beginning April 1, 1998 **ALL** innovator brand name non-steroidal anti-inflammatory drugs (NSAIDS) will require prior approval. Until that date, the present policy will continue, i.e., prior approval is required only for single source brand name NSAIDS.

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1	Checkwrite 2	3	4	5 ESC Cut-Off 5 pm	6	7
8	Checkwrite 9	10	11	12 ESC Cut-Off 5 pm	13	14
15	Checkwrite 16	Happy St. Patrick's Day 17	18	19 ESC Cut-Off 5 pm	20	21
22	Checkwrite 23	24	25	26 ESC Cut-Off 5 pm	27	28
29	Checkwrite 30	31	EDS Correspondence Unit 1-800-884-3222 or 601-960-2800			

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.