Mississippi Medicaid Bulletin

Volume 5, Issue 11

May 1999

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Prior Authorizations for Medicaid Beneficiaries

Providers are reminded that any prior authorizations (PA) issued by the Division of Medicaid or HealthSystems of Mississippi, are no longer valid for Medicaid beneficiaries enrolled in an HMO on the date services are provided. **This is especially important for services being provided in a different month than the PA was issued.** For HMO referrals to provide services, the HMO in which the beneficiary is enrolled must be contacted for authorization in order to be reimbursed for the services provided. HMO enrollment information and the toll-free telephone number for the HMO can be obtained by verifying the beneficiary's eligibility and managed care status through one of the following:

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

Please remember that a PA is not a guarantee of payment.

Prior Approval for Durable Medical Equipment (DME)

In accordance with Section 5.01 of the DME Manual, prior authorization must be obtained for all durable medical equipment, orthotics, prosthetics, and medical supplies. As of April 15, 1999, as mandated by the Division of Medicaid, HealthSystems of Mississippi discontinued processing retroactive DME Prior Authorization Request for items delivered prior to October 1, 1998.

MISSISSIPPI DIVISION OF MEDICAID

HealthMACS Achieving Goals

When the HealthMACS program was implemented in 1993, the following program goals were identified:

- Improve access to quality care
- Provide for more appropriate utilization of services
- Enhance the physician/patient relationship
- Achieve cost efficiency in health care

The Division of Medicaid is pleased to report evidence that suggests HealthMACS is achieving the established program goals. Ambulatory care sensitive (ACS) conditions were the focus of a recent study. ACS conditions are inpatient admissions that could have been prevented with proper patient management by the physician prior to the immediate need for admission. The following information for July 1, 1997 - June 30, 1998 has been adjusted for age and gender and is presented as admissions per 1,000 members.

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Chart 1– Inpatient Admissions for ACS Conditions

HealthMACS enrollees have an overall lower rate of admission for ACS conditions.

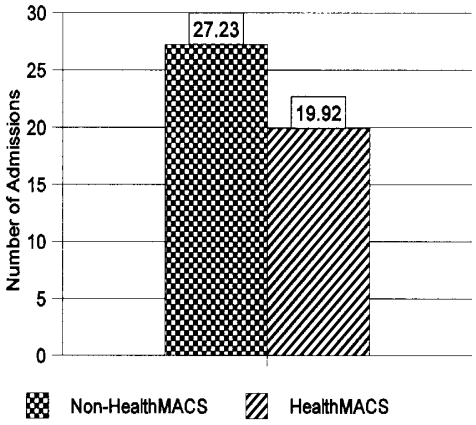
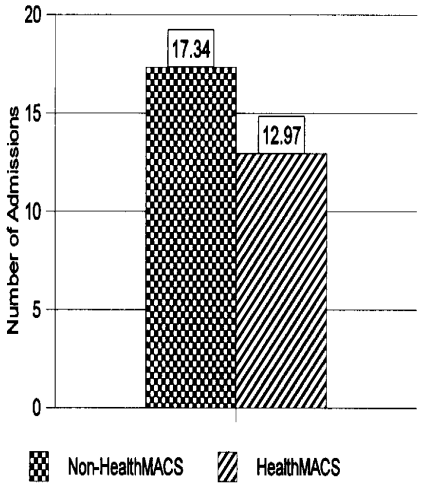
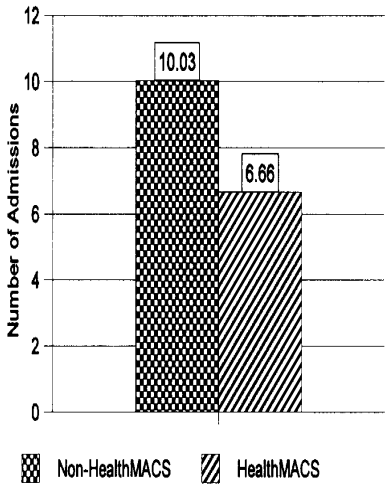


Chart 2– Inpatient Admissions for Rapid Onset ACS Conditions



Inpatient admissions for rapid onset ACS conditions for HealthMACS enrollees were lower than non-HealthMACS. Examples of rapid onset ACS conditions are bacterial pneumonia, kidney/urinary infection, and dehydration.

Chart 3– Inpatient Admissions for Chronic ACS Conditions

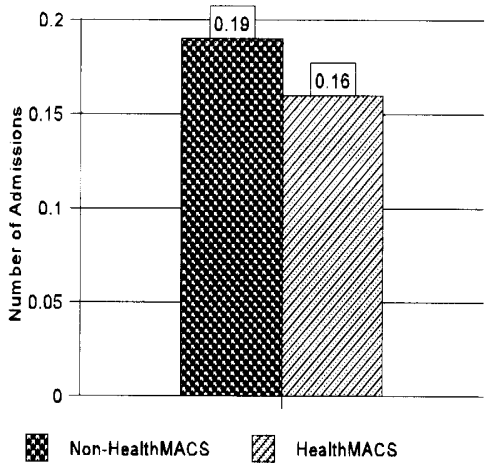


The number of admissions for chronic ACS conditions was lower for HealthMACS than for non-HealthMACS. Examples of chronic ACS conditions are tuberculosis, asthma, and congestive heart failure. This is a good indicator that the care of HealthMACS patients is being well managed.

HealthMACS enrollees have an overall lower rate of admission for ACS conditions. This is a good indicator that the care of HealthMACS patients is being well managed.

Chart 4– Inpatient Admissions for Preventable ACS Conditions

Inpatient admissions for preventable ACS conditions like nutritional deficiencies and anemia result in longer, more costly inpatient stays than any other ACS condition. Although the total number of preventable ACS conditions for the Medicaid population was fairly low, HealthMACS still showed fewer admissions.



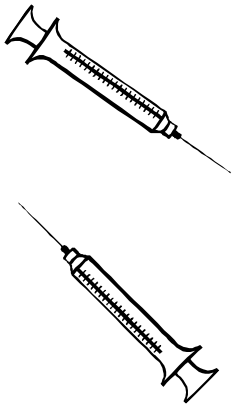
The Division of Medicaid appreciates the efforts of the HealthMACS PCPs toward achieving these goals.

If you are interested in participating in HealthMACS as a PCP, please contact:

Managed Care Division
601-359-6133

If you want other information about HealthMACS, please submit your request in writing to:

Division of Medicaid
239 North Lamar Street
Robert E. Lee Building, Suite 801
Jackson, MS 39201-1399



Hyaluronate Joint Injection

Effective May 1, 1999, the following policy will be applicable to Hyaluronate Joint Injections. (Refer to HCPCS codes J7320 and J7315).

Hyaluronate is a synthetic synovial fluid approved by the FDA as a medical device and not as a drug. It is approved for the treatment of pain in osteoarthritis of the knee joint only, in those patients who have not responded adequately to conservative therapy (ex: physical therapy, weight loss, simple analgesics, such as acetaminophen, etc). This device is not indicated for use in end-stage degenerative joint disease and is not approved for injection into any other joint or for any other use.

The literature suggests that maximum benefits may not be obtained for several weeks after injection, and that after a course of treatment, the relief may last for 6 to 8 months in those patients who respond to the treatment.

Effective May 1, 1999, the following policy will be applicable to Hyaluronate Joint Injections. (Refer to HCPCS codes J7320 and J7315)

The following criteria for coverage apply to Hyaluronate:

1. The patient is being treated for pain which is caused by osteoarthritis of the knee joint.
2. The patient does not have end-stage degenerative joint disease.
3. The patient has not responded adequately to conservative therapy (ex: physical therapy, weight loss, and/or simple analgesics, etc.).
4. The treatment is performed in accordance with acceptable standards of practice (ex: Synvisc is given once a week for 3 weeks, and Hyalgan is given once a week for 5 weeks).
5. The medical necessity is documented on the claim by reporting ICD-9 Diagnosis Code 715.16.
6. Modifier 50, when applicable, is used with the appropriate CPT code which identifies an arthrocentesis of a major joint (injection into joint).
7. For patients receiving the treatment more than once, the previous series of injections proved beneficial. If the first series of injections failed to prove beneficial, repeat injections are considered not medically necessary.

An initial evaluation and management (E&M) code, in the physician's office, may be billed in addition to the arthrocentesis codes for new patients. For subsequent visits in the physician's office, an evaluation and management (E&M) code will not be allowed with the arthrocentesis.

(Continued on page 5)

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For Mississippi Medicaid, the provider may bill separately for each date of service rather than combining and billing after the completion of the full series of injections. Otherwise, the provider must report using the from and through dates for the series and report the total number of units.

The physician performing the procedure must maintain, at a minimum, the following documentation relating to the medical necessity for the procedure.

- Patient History
- Physical Examination
- Diagnosis (es)
- Examination notes documenting the evaluation and management of the condition/diagnosis (es)
- Relevant clinical signs and symptoms
- Abnormal laboratory, x-ray, and/or other diagnostic test results
- Documentation supporting failure of conservative treatment (Ex: physical therapy, weight loss, simple analgesics, etc.)

Documentation must be legible and medical records must be available to the Division of Medicaid, the Fiscal Agent, and/or the Peer Utilization Review Organization upon request.

Hyaluronate Joint Injection

HCPCS Codes for Durable Medical Equipment

Effective July 1, 1999, the following HCPCS codes for Durable Medical Equipment will be closed and no longer valid for Mississippi Medicaid.

E0115	E0300	E0330	E1020	E1080
E0190	E0320	E0515	E1040	E1396

Y2K Status

Recently the Health Care Financing Administration (HCFA) completed an on-site Independent Verification and Validation assessment of the Y2K renovation by Medicaid and its supporting systems. These systems were assessed as "low risk". A "low risk" assessment indicates the potential for services being interrupted is minimal due to Y2K issues. Please read the Medicaid Provider Bulletins and RA Banner Messages, or visit the DOM web page at **www.dom.state.ms.us** for updates on the Y2K initiative.

Y2K **Status**

Home Blood Glucose Monitor

Effective May 1, 1999, the allowance for purchase of a Home Blood Glucose Monitor, HCPCS Code E0607, will change from $180.00 to $50.98 for new equipment and from $90.00 to $25.49 for used equipment. This equipment requires prior approval through HealthSystems of Mississippi (HSM), and if HSM approves the item based on medical necessity criteria being satisfied, approval will be given for purchase only. Providers should submit their requests to HSM using either modifier 3 for purchase of new equipment or modifier 6 for purchase of used equipment.

Community Mental Health Centers PASSRR Level II Billing

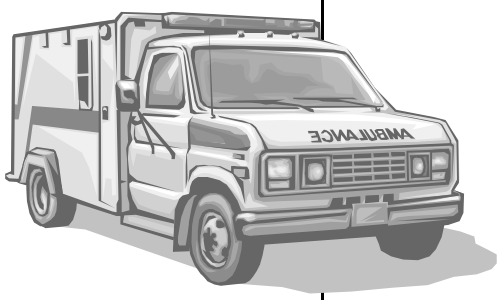
The Division of Medicaid is responsible for ensuring PASSRR Level II- Mental Illness (MI) billing is submitted correctly and that supporting documentation is sufficient.

The Level II MI evaluation must include the following:

- a medical history and physical examination conducted by a physician;
- a psychosocial history completed by a licensed social worker (LSW) or licensed psychologist; and
- a psychiatric evaluation completed by a psychiatrist or a licensed psychologist.

The first page of the Level II Mental Illness Pre-admission Screening Report must be attached to the billing. In addition to the identifying information, the evaluator's name and title and the assessment date must be included. PASSRR billing submitted without evidence of a psychiatric evaluation completed by a psychiatrist or psychologist will not be reimbursed.

If you have any questions about PASSRR billing contact Sherrell Wright, Long Term Care/Medical Services Division at 601-359-5251.



Non-Emergency Ambulance Transport

As a reminder, to qualify as non-emergency ambulance transport or for transport to a dialysis facility, the trip must be:

1. Prior approved by the Division of Medicaid;
2. For patient loaded miles only;
3. For medically necessary non-emergency services to the appropriate facility for treatment; and
4. In an appropriate Advanced Life Support (ALS) or Basic Life Support (BLS) vehicle.

For authorization contact Wavis Fair at:
phone (601) 359-6146
fax (601 359-6147

Billing Tips

1. Verify beneficiary eligibility for Medicaid benefits and services at the beginning of each month or at each visit. Beneficiaries may be enrolled in programs with restricted services (i.e. HMOs or HealthMACS) which require appropriate prior approval for reimbursement. If the beneficiary is enrolled in a Mississippi Medicaid Managed Care program, be sure to get and use the appropriate authorization numbers. This information may be obtained from the audio voice response system (AVRS), the EDS Correspondence Unit or the eligibility swipe card device.
2. When verifying eligibility for a newborn with a swipe card device, be sure to use the mother's Medicaid ID number and a "K" along with the baby's date of birth. Numbers beginning with 2XX are temporary numbers for newborns only. Do not use a "K" with numbers that begin with 2XX when verifying eligibility.
3. When a beneficiary receives retroactive eligibility, attach a copy of the retroactive eligibility letter with each claim being submitted. Indicate "***Retroactive Letter Attached***" in the body of the claim form.

If you have questions about billing, please call the EDS Correspondence Unit at 1-800-884-3222 or send them to EDS Provider Relations Unit, P O Box 23061, Jackson, MS 39225-3061 or fax them to (601) 960-2807. These questions and others will be answered under "**Billing Tips**" in other issues of the Mississippi Medicaid Bulletin.

Misuse of Medicaid Cards

Please remember that it is the provider's responsibility to verify that a patient presenting a Medicaid card for payment of services, supplies, pharmaceuticals, etc., is the Medicaid beneficiary. The following procedures are suggested to verify identification of the beneficiary.

1. Use AVRS, to check the two-digit card numbers to be sure it matches the number on the card.
2. Ask for a driver's license or other form of photo identification.
3. Call Medicaid's Fraud Hotline 1-800-880-5920, if you suspect misuse.

Apnea Monitor

Effective April 1, 1999, the Medicaid allowance for HCPCS Code E0608 (Apnea Monitor) increased as follows:

Modifier 1 -	$ 224.62	Modifier 5 -	$ 44.92
Modifier 2 –	$ 7.49	Modifier 6 -	$1,123.12
Modifier 3 -	$2,246.92		

Providers Not Allowed To Bill For Missed Appointments

According to Health Care Financing Administration (HCFA) policy, providers are not allowed to bill beneficiaries for missed appointments. A missed appointment is not a distinct reimbursable Medicaid service but a part of a provider's overall costs of doing business.

Mississippi Medicaid Bulletin

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If you have any questions related to the topics in this bulletin, please contact the EDS Correspondence Unit at 1-800-884-3222 or 601-960-2800.

Mississippi Medicaid Bulletins and Manuals are on the Web !
www.dom.state.ms.us

Contact EDS Publications if you would like to receive the Mississippi Medicaid Bulletin, or have an interest in what you would like to see.
Fax EDS Publications at 601-960-2807, or e-mail publications@msxix.hcg.eds.com.

EDS

May

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Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				ESC Cut-Off 5 pm		1
2	3 Checkwrite	4 Hospital Workshop Grenada	5	6 ESC Cut-Off 5 pm	7	8
9	10 Checkwrite	11	12	13 ESC Cut-Off 5 pm	14	15
16	17 Checkwrite	18	19	20 ESC Cut-Off 5 pm	21	22
23 30	24 Memorial Day 31	25	26	27 ESC Cut-Off 5 pm	28	29

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