Mississippi Medicaid

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July 1999 Bulletin

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Serostim/Somatotropin Policy

The following policy on Serostim/Somatotropin will become effective July 1, 1999:

Serostim (Serono Laboratories) is a recombinant human growth hormone, somatotropin (rDNA origin) which is indicated for treatment of AIDS wasting or cachexea. It is given once daily at bedtime, subcutaneously, with sites of injection rotated.

Serostim will be reimbursed when **all** of the following criteria apply:

- The recipient has documented HIV infection with serum antibodies to HIV-1 as confirmed by Western Blot or other recognized confirmative tests.
- The recipient has unintentional weight loss of at least 10% from baseline premorbid weight, or weigh less than 90% of the lower limit of ideal body weight.
- The recipient has demonstrated lack of weight response to valid nutritional support therapies, including appropriately calculated caloric dietary needs, use of appetite stimulants and TPN infusion.
- The recipient has demonstrated failure of weight gain when under the care of a physician experienced in the treatment of AIDS-wasting and its complications.

The prescribing physician **must** maintain clear and legible documentation that indicates that there is **no** evidence of the following:

- Untreated or suspected serious systemic infection
- Persistent fever over 101 degrees during the preceding 30 day period
- GI bleeding, obstruction or malabsorption
- Active malignancy, with the exception of cutaneous Kaposi's Sarcoma
- Dementia with functional impairment
- Use of chemotherapy, interferon, anabolic therapy within the preceding 30 days
- Documented hypogonadism, although may be on replacement therapy if started 2 months previously
- Papilledema
- Diabetes Mellitus
- Unstable or untreated hypertension
- Carpal tunnel syndrome
- Angina, coronary artery disease, congestive heart failure
- Chronic renal failure
- Marked edema from any cause
- Known allergy to growth hormone
- Substance abuse history
- Pregnancy

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MISSISSIPPI DIVISION OF MEDICAID

Physicians/ recipients may obtain Serostim through a pharmacy that is a Medicaid provider.

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During treatment with Serostim, the documentation **must** show:

- that antiretroviral therapy has been maintained throughout the treatment.
- reevaluation of the recipient at the end of two weeks that shows a positive response to Serostim treatment.
- demonstrated lab values of:
  - * amalyse < 3 times the upper limit of normal
  - * creatinine < 2 mg/dl
  - * fasting triglyceride level < 5 mg/dl
  - * fasting glucose < 120 mg/dl
- that the recipient has a life expectancy of six (6) months or longer.
- at the end of the first 30 day period and each subsequent 30 day period that the recipient has demonstrated a satisfactory response to treatment evidenced by weight gain and/or lean body mass and the absence of complications. Recommendation to continue treatment must be made by the attending physician.

Rarely should the Serostim therapy be continued beyond the initial 12 weeks. However, in the event that it should, the above criteria will continue to apply.

Prescriptions must be handwritten by the physician for not more than 34 days with no refills. If it is to be continued at the 30 day evaluation or reevaluation, it must be rewritten.

Physicians/recipients may obtain Serostim through a pharmacy that is a Medicaid provider. This drug will apply to drug benefit limit.

Utilization Review will be done quarterly by the Division of Medicaid and physicians/ pharmacists must submit required documentation upon request.

*A provider's name and identification number **must** be entered on **all** claims exactly as it appears on the Remittance Advice.*

Provider Name/Number Mismatch

The Division of Medicaid is implementing a Provider Name/Number Mismatch claims processing edit. Effective June 14, 1999, the provider's name and identification number **MUST** be entered on ALL claims exactly as it appears in the upper left-hand corner of the Remittance Advice.

Please refer to billing procedures in the provider manual for further instructions on completing the claims processing edit change. Providers may call the EDS Correspondence Unit at 1-800-884-3222 to verify the correct provider name/facility on file.

*The 001-9999 number may be used **ONLY** when there is no prescribing provider number.*

Valid Prescribing Provider Number

A VALID prescribing provider number is required for all prescription claims. Reimbursement will not be made for claims submitted/processed after June 4, 1999, without a valid prescribing provider. Individual or group prescribing provider numbers are located in the list of prescribers' numbers that was mailed to providers on May 3, 1999. If you did not receive the list, please call EDS Customer Service at 1-800-884-3222.

The list has been updated to include clinic/ group numbers and hospital emergency room numbers. If the prescriber does not have an individual provider number, the clinic/group number assigned may be utilized; or if the prescriber is located at a hospital emergency room, the hospital's ER provider number may be utilized.

The 001-9999 number may be used **ONLY** when there is no prescribing provider number. As noted in the September 1998 Mississippi Medicaid Bulletin, pharmacies may be subject to penalties, including suspension of point of service (POS) billing capability, for abuse or misuse of the 001-9999 number.

Field Visit Review Engagement Letter Requests

In an effort to limit the amount of time required for the Provider Review Unit to perform field visit reviews, engagement letters will be forwarded to providers prior to the scheduled site visit. The field visit reviews will include nursing homes (which includes Intermediate Care Facilities for the Mentally Retarded and Psychiatric Residential Treatment Facilities), Federally Qualified Health Centers, and home health agencies. A number of items will be requested so that the reviewer will spend the minimum amount of time on site with the least amount of disruption to the providers. Please provide the requested information by the requested due date. If items are unavailable or too large to mail, contact the reviewer as soon as possible. The name of the reviewer, telephone number, and due date will be included in the engagement letter. Your cooperation is appreciated.

Please provide the requested field visit review information by the requested due date.

Prior Authorization Numbers for Elderly and Disabled Waiver Clients

Effective July 1, 1999, prior authorization numbers for Medicaid Elderly and Disabled Waiver clients will no longer be issued for home health visits. **This in no way changes the authorization process -** Waiver clients **MUST** continue to have home health visits prior authorized and approved by the Waiver Case Managers. The contact person at the Division of Medicaid is Kenni Howard, RN at 601-359-6050.

*Waiver clients **must** have home health visits prior authorized and approved by the Waiver Case Managers.*

Fee Schedule Change for Private Duty Nursing

Effective May 14, 1999, reimbursement for Private Duty Nursing services changed to:
$24.00 per hour for private duty services provided by a RN (W7000) and
$17.00 per hour for private duty services provided by a LPN (W7001).

Physicians' Fee Increase

House Bill 1332, approved during the 1999 legislative session, provides for the Division of Medicaid to increase all fees for physicians' services as follows:

"All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act), as amended, and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act), as amended, and which shall in no event be less than seventy percent (70%) of the adjusted Medicare payment established on January 1, 1994."

Dental Fee Reimbursement Rate Change

House Bill 1332, approved during the 1999 legislative session, provides for the Division of Medicaid to increase all dental fees by 160% of the reimbursement rate that was in effect on June 30, 1999. It is the intent of the Legislature to encourage more dentists to participate in the Medicaid program.

House Bill 1332 provides for the Division of Medicaid to increase all dental fees 160% of the reimbursement rate.

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

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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

EDS

July 1999

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				1 ESC Cut-Off 5 pm	2	3
4 4th of July	5 *DOM and EDS closed for 4th of July.* Checkwrite	6	7	8 ESC Cut-Off 5 pm	9	10
11	12 Checkwrite	13	14	15 ESC Cut-Off 5 pm	16	17
18	19 Checkwrite	20	21	22 ESC Cut-Off 5 pm	23	24
25	26 Checkwrite	27	28	29 ESC Cut-Off 5 pm	30	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.