Mississippi Medicaid Bulletin

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January 2001

Implantable Programmable Pump

During the 2000 Legislative Session, House Bill (HB) 1280 was passed. This included an amendment to Section 43-13-117, Mississippi Code of 1972, regarding inpatient hospital services as follows:

Hospitals will receive an additional payment for the implantable programmable pump implanted on an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars ($10,000.00) per year per recipient. * * * This paragraph (c) shall stand repealed on July 1, 2001.

The Division of Medicaid began reimbursement for implantable programmable pumps on October 1, 2000. All implantable programmable pumps for Medicaid beneficiaries who are inpatients and who receive such pumps on or after October 1, 2000 are reimbursed as required by HB 1280.

To receive reimbursement for an implantable programmable pump, the hospital must:

- **Submit charges for the implantable pump on a paper UB-92 claim form, separate from all other charges**
- **When billing for the pump, use revenue code 220 ONLY**
- **Attach a written invoice from provider of the pump for pricing**
- **Mail claim to:**

Division of Medicaid
Attn: Denny Lea, Medical Services
239 North Lamar Street
Robert E. Lee Building, Suite 801
Jackson, MS 39201-1399

The Division of Medicaid will not reimburse for implantable programmable pumps for beneficiaries whose inpatient days are not certified by the peer review organization or for beneficiaries over age 21 who have used their 30 inpatient days for the year.

Inside this Issue

MISSISSIPPI DIVISION OF MEDICAID

Subject: Hyperbaric Oxygen Therapy
Status: New Policy
Effective Date: 01/01/01

Hyperbaric Oxygen Therapy (HBOT) involves placing a person into a special hyperbaric oxygen chamber with increased air pressure and administering 100 percent oxygen for the patient to breathe. Hyperbaric oxygen therapy is a covered service if documentation supports the following criteria:

Hyperbaric Oxygen Therapy (HBOT) involves placing a person into a special hyperbaric oxygen chamber with increased air pressure and administering 100 percent oxygen for the patient to breathe.

- HBOT is covered for specific medical diagnoses (see list below);
- The patient's entire body must be placed into the hyperbaric chamber (topical application of oxygen with portable chambers is NOT covered);
- HBOT must be performed in the hospital setting, either inpatient or outpatient;
- A physician must order HBOT treatments, document medical necessity, and establish the plan of care specifying the goals hyperbaric oxygen therapy is to accomplish and the estimated number of treatments, with revisions made as appropriate and justification for extending treatments;
- A cardiopulmonary resuscitation team and a fully equipped emergency cart must be immediately available where the hyperbaric chamber is located when a patient is receiving HBOT.

For services billed under CPT code 99183, the physician must be in constant personal attendance where the hyperbaric oxygen chamber is located while the patient is receiving HBOT. If the physician delegates administration of HBOT to hospital staff, such as respiratory therapists, and is not in constant personal attendance during the entire HBOT treatment, the facility may bill for the HBOT services, but the physician may not bill CPT code 99183.

Covered Medical Diagnoses for Hyperbaric Oxygen Therapy

Hyperbaric oxygen therapy is covered for the following medical diagnoses and ICD-9 codes only:

- acute carbon monoxide intoxication: 986
- decompression illness (Caisson disease) : 993.3
- air (gas) embolism: 958.0; 999.1
- gas gangrene: 040.0
- acute traumatic peripheral ischemia, as adjunctive treatment to accepted standard therapeutic measures when function, life, or limb is threatened: 902.53; 903.01; 903.1; 903.2; 903.3; 904.0; 904.1; 904.41; 904.51; 904.53

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- crush injuries and suturing of severed limbs, as adjunctive treatment to accepted standard therapeutic measures when function, life, or limb is threatened: 925 - 929.9; 996.90 - 996.99
- progressive necrotizing infections - necrotizing fasciitis: 728.86; meleney ulcer (pyoderma gangrenosum): 686.01
- acute peripheral arterial insufficiency: 444.21; 444.22; 444.81; 733.40-733.49
- preparation and preservation of compromised skin grafts: 996.52
- chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management: 730.10 - 730.19
- osteoradionecrosis as an adjunct to conventional treatment: 526.89; 909.2
- soft tissue radionecrosis as an adjunct to conventional treatment: 990
- cyanide poisoning: 987.7; 989.0
- actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment: 039.0 - 039.9

Documentation of medical necessity for hyperbaric oxygen therapy must be legible and available for review if requested.

Documentation of Medical Necessity for Hyperbaric Oxygen Therapy

Documentation must be legible and available for review if requested. Documentation must include the following:

- Specific written record that HBOT was performed in a hospital setting (inpatient or outpatient) utilizing a full body hyperbaric chamber;
- A written physician order and comprehensive history and physical report detailing the condition/diagnosis(es) requiring HBOT, including prior treatments and their results and additional treatments being rendered concurrently with HBOT;
- Physician progress notes and consult reports that describe the patient's response to treatment;
- Established goals for hyperbaric oxygen therapy and an estimated number of treatments, with revisions made as appropriate and justification for extending treatments;
- Wound description, if applicable, including wound size and appearance, for each day of service billed;
- Radiology and laboratory reports, including culture and sensitivity studies, to support the diagnosis when applicable;
- For CPT code 99183, specific written record of the physician's constant personal attendance where the hyperbaric chamber is located while the patient is undergoing HBOT;
- Specific written record of the availability of a cardiopulmonary resuscitation team and a fully equipped emergency cart where the hyperbaric chamber is located while the patient is undergoing HBOT.

Subject: **Chelation Therapy**
Status: **New Policy**
Effective Date: **01/01/01**

Chelation therapy is the administration of an oral or injectable chelating agent to bind with a metal in the body to form a chelate so that the metal loses its toxic effect or physiological activity. Specific chelating agents are approved by the U. S. Food and Drug Administration (FDA) for treatment of certain types of heavy metal toxicity, cystinuria, Wilson's disease, and severe, active rheumatoid arthritis that has failed to respond to an adequate trial of conventional therapy. These agents include edetate calcium disodium, succimer, dimercaprol, D-penicillamine, trientine hydrochloride, and deferoxamine mesylate.

Currently, there is no conclusive scientific evidence that chelation therapy is an effective treatment for any other conditions, including, but not limited to, peripheral vascular disease, prevention of amputation due to diabetes mellitus or other circulatory disorders, atherosclerosis, calcinosis, arteriosclerosis, or similar conditions. No chelating agents are FDA-approved for treatment of these disorders.

The Division of Medicaid will reimburse only for FDA-approved chelation in an inpatient or outpatient hospital setting in accordance with current standards of medical practice. Conditions which may be treated with chelation include lead poisoning, iron overload, metallic mercury poisoning, copper poisoning, arsenic poisoning, gold poisoning, cystinuria, Wilson's disease, and severe, active rheumatoid arthritis that has failed to respond to an adequate trial of conventional therapy. Documentation in the medical records of symptoms and/or laboratory tests must support one of the listed diagnoses. Chelation therapy for the treatment of any other conditions is not a covered service.

Additions, Deletions and Description Changes to the 2001 HCPCS and CPT Codes

The additions, deletions and description changes to the 2001 HCPCS and CPT codes will be loaded into the Medicaid Management Information System (MMIS) in the near future. The 2000 codes should be utilized until the Division of Medicaid (DOM) provides further directions for filing the 2001 codes.

Billing Flu and Pneumonia Immunizations for Adults - Clarification

In the October 2000 Mississippi Medicaid Bulletin, the Division of Medicaid instructed providers about billing the flu and pneumonia immunizations for adults. For clarification, these policies are applicable to beneficiaries who have **only** Medicaid. For beneficiaries with both Medicare and Medicaid, providers should bill Medicare in accordance with their policies. The billing instructions in the October 2000 bulletin are not applicable to crossover claims.

Hospice Lock-Ins

Any Medicaid hospice beneficiary who is locked-in to the hospice program at home and then chooses to enter a nursing facility for hospice care at a later date will need a new enrollment form submitted to EDS to update the lock-in information. The provider number of the nursing facility hospice where the beneficiary resides is required in order for claims to process properly.

Diagnosis to Procedure Comparisons

In the October 2000 Mississippi Medicaid Bulletin, information was provided regarding Edit 446 which was activated on November 1, 2000. Providers were reminded that no more than two diagnosis codes could be reported on the HCFA-1500 claim form.

The Division of Medicaid and EDS, the fiscal agent, have worked to resolve these restrictions. Providers may now bill the four diagnosis codes on the HCFA-1500 claim form and will not have to bill a separate claim form to report the third and fourth diagnoses. This is applicable to both hard copy and electronic claims.

When filing electronically or hard copy, in item 21, file the primary diagnosis as #1 and the secondary diagnoses as #2, #3, and/or #4. In item 24E, reference the appropriate diagnosis code to the corresponding procedure code. Reference only one diagnosis code per line item.

Providers may now bill four diagnosis codes on the HCFA-1500 claim form and will not have to bill a separate claim form to report the third and fourth diagnoses.

HIPAA Update

The Clock is ticking...Are you ready for HIPAA?

The HIPAA legislation is designed to secure health information by making standard the interchange of electronic data for administrative and financial transactions and simplify the process of reporting healthcare data.

Starting in 2002, Health Care Financing Administration (HCFA) will require standardization in data transactions to effect health care claims, health care payments, collection and storage of data for eligibility, referral, authorization for care, enrollment, coordination of benefits and premium payments. HCFA will enforce financial penalties or imprisonment for non-compliance to HIPAA standards. Many expect a certification process will be administered.

Starting in 2002, Health Care Financing Administration (HCFA) will require standardization in data transactions to effect health care claims, health care payments, collection and storage of data for eligibility, referral, authorization for care, enrollment, coordination of benefits and premium payments.

What should you be doing?

- Educate your staff and constituents
- Get all the information you can from the Department of Health and Human Services (DHHS) web site to make sure you have and understand the legislation http://aspe.os.dhhs.gov/admnsimp/
- Start an awareness program to address security issues. Foster open reporting of potential security breaches and prioritization of issues
- Conduct a requirements analysis to determine the scope of changes your organization will be required to make
- Evaluate your current billing system for compliance
- Evaluate audit trails on your existing information systems
- Review existing vendor contracts for compliance
- Determine your capability to make the changes required. Bring in knowledgeable staff or vendors to assist in transition.

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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

EDS

January 2001

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hyperbaric oxygen and Chelation therapy policies go into effect.	1 DOM, EDS & HSM closed Checkwrite	2	3	4 ESC Cut-Off 5 pm	5	6
7	8 Checkwrite	9	10	11 ESC Cut-Off 5 pm	12	13
14	15  DOM & HSM closed Checkwrite	16	17	18 ESC Cut-Off 5 pm	19	20
21	22 Checkwrite	23	24	25 ESC Cut-Off 5 pm	26	27
28	29 Checkwrite	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.