Mississippi Medicaid Bulletin

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June 2001

Expanded EPSDT Mental Health Services

Children's mental health services, currently being provided through the Expanded EPSDT (Early Periodic Screening, Diagnosis, and Treatment) program, will be administered by the Division of Mental Health Services beginning July 1, 2001. Providers of outpatient mental health services for children are advised that all prior approvals (PA's) for current services will end on June 30, 2001. Children who need continued services beyond this date will be assigned a new PA number by the Division of Mental Health Services. These PA's will be faxed or mailed to your office.

Providers were mailed information about this change early in May. If you did not receive the mail-out and would like more information, please call the Division of Mental Health Services at 601-359-9547. Please note that this change applies only to Expanded EPSDT children's mental health services. All other EPSDT services will continue to be administered by the Bureau of Maternal Child Health through the Expanded EPSDT program.

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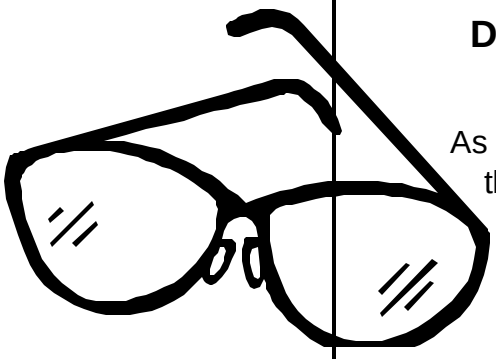
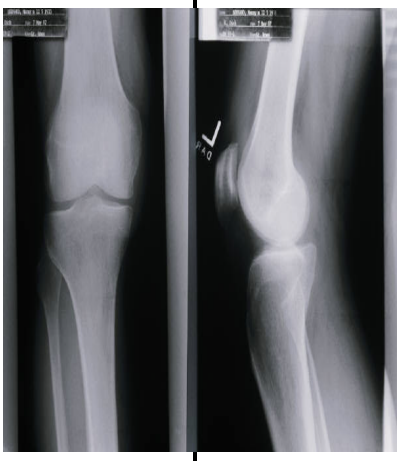


Denied Claims for Dual Eligibles Eyeglasses

As a follow-up to the **March 2001** Medicaid Bulletin, please note that effective **July 2001,** the Division of Medicaid will begin reimbursement for claims denied with **error code 265**. System changes are in place, and claims will be reprocessed retroactive to **July 1, 2000**, if applicable. The Division apologizes for any inconvenience to you as a provider and appreciates all medically necessary services rendered to our beneficiaries. If you require additional assistance, please contact Jeanette Williams at (601) 359-6050 or 1-800-421-2408, ext. 6138. Thank you for your patience.

MISSISSIPPI DIVISION OF MEDICAID



Independent Diagnostic Testing Facilities and Other Independent Mobile Diagnostic Units

The Division of Medicaid does not allow reimbursement to Independent Diagnostic Testing Facilities (IDTF) or other independent mobile diagnostic units, including portable x-ray providers, for services provided to beneficiaries with Medicaid only. Outpatient testing and diagnostic services will be reimbursed as ordered by the beneficiary'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.

An IDTF is defined by the Health Care Financing Administration (HCFA) as "a fixed location, a mobile entity, or an individual non-physician practitioner. It is independent of a physician's office or hospital" (42 CFR §410.33). These providers perform diagnostic tests such as ultrasounds, echocardiograms, pulmonary function tests, neurological and neuromuscular tests, x-rays, cardiac monitoring, and nuclear medicine. Prior to 1998, this type of provider was classified as an Independent Physiological Laboratory (IPL). In 1998, HCFA eliminated the IPL category, and providers that were classified as an IPL could be reclassified as an IDTF if they met new qualifications established by HCFA.

As a matter of health service policy, it is the experience of DOM that diagnostic services are best directed and managed by a patient's physician, hospital, or clinic. The physician, hospital, or clinic is thus responsible for assuring the medical necessity of the tests and maintaining test results in the patient's unified health record.

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A physician may contract with an IDTF or other independent mobile diagnostic unit to provide technical services and, assuming that there are no Stark II or other anti-kickback statute violations, may file a claim for (1) only the technical component (TC) or (2) the complete procedure if the physician also interprets the procedure.

The physician contracting with an IDTF or other independent mobile diagnostic unit may not be employed by or own any part of the IDTF or other independent mobile diagnostic unit.

When a physician bills for the technical component (TC) for services by an IDTF or other independent mobile diagnostic unit, the physician must check "Yes" in item #20 of the HCFA-1500 claim form and also enter the charge amount for the contracted services. The name of the company with whom the physician contracted must be recorded in the physician's records and be available upon request.

IDTFs and other independent mobile diagnostic units may not pay a fee to physicians for billing the technical charges.

For beneficiaries who are both Medicare and Medicaid eligible, DOM's fiscal agent will process "crossover claims" under the provider's Mississippi Medicaid Provider number.

Reduction Mammoplasty

DOM will cover reduction mammoplasty only when there is medical documentation that demonstrates the procedure is:

1. medically necessary, **AND**
2. reconstructive, **AND**
3. performed as a last means of attempting to alleviate a patient's symptomatology and dysfunction due to the excessive breast size.

Criteria

Justification for reduction mammoplasty should be based on the probability of relieving clinical signs and symptoms of macromastia.
The surgeon's documentation must include the following criteria:

- A complete and accurate patient history that includes complaints of pain and restriction of normal activity.
- Medical necessity for the removal of a minimum of 500 grams of tissue from each breast.
- Supra sternal notch to nipple measurement of 28 cm or greater.
- Frontal and lateral photographs of the breasts.

In addition to the above criteria, documentation of the following may support the determination of medical necessity:

- Documentation of a history of intertrigo (chronic irritation under or between breasts).
- Psychological assessment.
- Documentation of strap marks - as evidenced in photographs.

DOM recognizes the amount of breast tissue removed for relief of symptoms varies with height, weight and bra size and that, in some instances, the removal of less than 500 grams of tissue is appropriate for the relief of symptoms. In such instances, it is required that the physician must provide full documentation in the medical record that justifies reduction mammoplasty with removal of less than 500 grams. All other medically necessary criteria **must** be satisfied.

Prior Approval

Prior approval for reduction mammoplasty will not be required. The surgeon must retain all documentation supporting medical necessity in the medical record. The final determination of medical necessity will be made by the surgeon based on the criteria listed in this policy.

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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.

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June 2001

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

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.