Mississippi Medicaid Bulletin

Volume 8, Issue 3

September 2001

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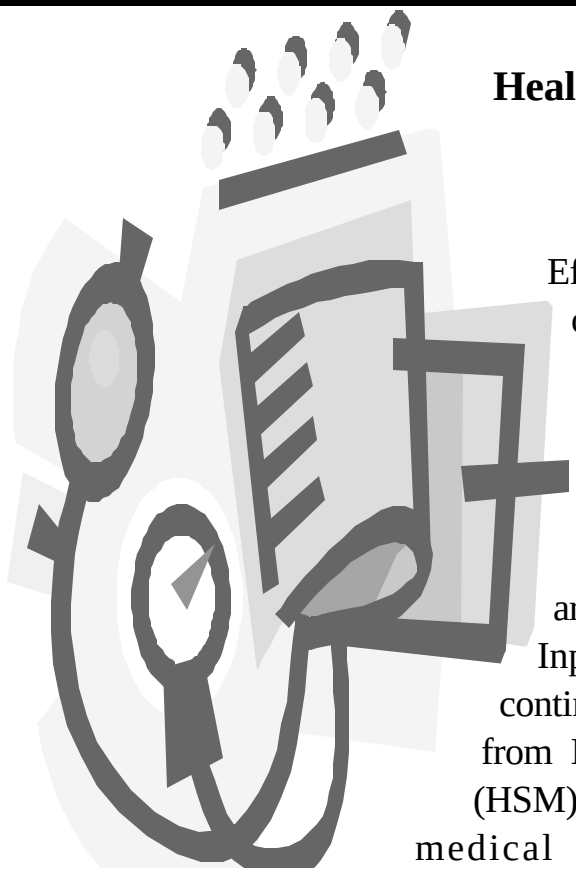


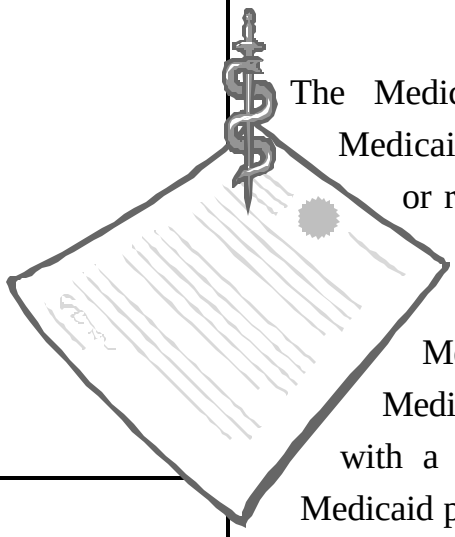
HealthMACS Changes for Inpatient Hospital Admissions

Effective with dates of service on or after October 1, 2001, inpatient claims no longer require the HealthMACS authorization of the assigned Primary Care Provider (PCP) for HealthMACS patients who are admitted to the hospital. Inpatient hospital admissions continue to require pre-certification from Health Systems of Mississippi (HSM). Because HSM determines medical necessity for inpatient admissions, it is no longer necessary that the PCP be contacted for HealthMACS authorization.

In August, HSM began providing written notification to the assigned HealthMACS PCP regarding their HealthMACS patients who have been certified by HSM for an inpatient hospital stay. This information must be filed in the patient's unified medical record and should be used by the PCP to assist in the effective case management of the primary health care needs of their patients.

MISSISSIPPI DIVISION OF MEDICAID

Third Party Liability Reminders



The Medicaid provider of medical services is required to protect Medicaid's interest when a third party source exists. Any medical bills or records furnished upon request and with the Medicaid patient's signature on an authorization of release must contain three (3) items of information: the person is a Medicaid beneficiary, the Medicaid Identification Number, and the bill has been paid by Medicaid or will be filed with Medicaid. Also, claims that are filed with a private insurer for Medicaid-covered services rendered to a Medicaid patient should show that the patient is a Medicaid beneficiary.

Any questions concerning release of medical records or claims filed to a private insurer should be directed to the Division of Medicaid, Third Party Liability Unit at (601) 359-6095.

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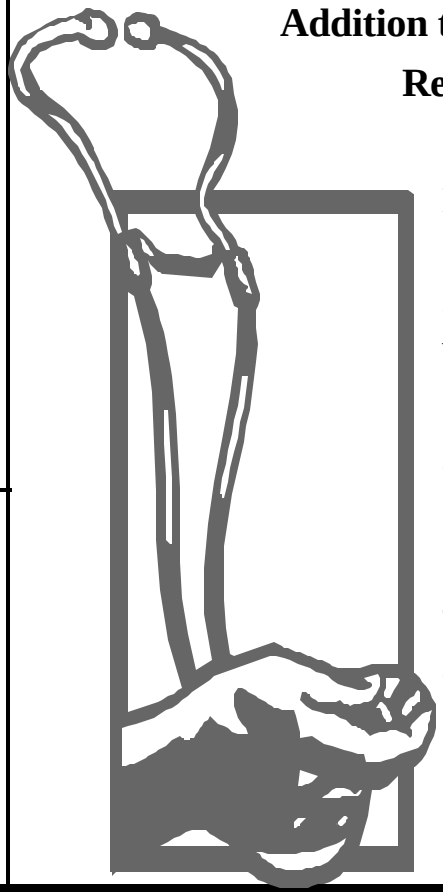
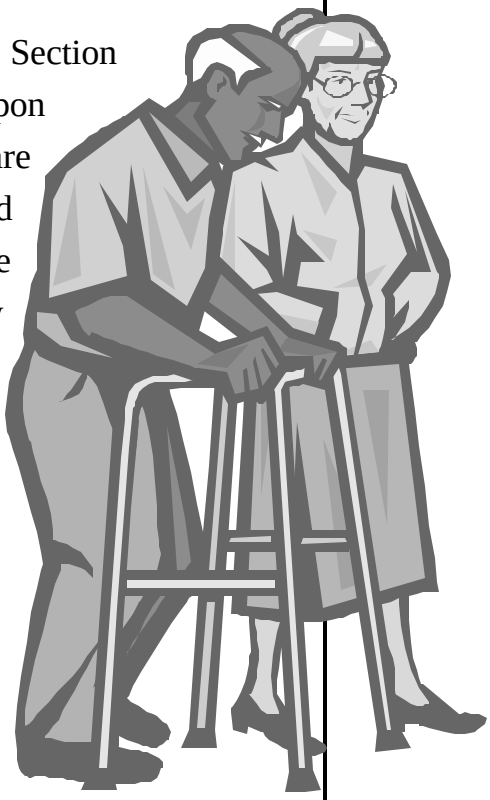
Addition to the ER Procedure Codes that Do Not Require HealthMACS Authorization



Effective with dates of service on or after October 1, 2001, procedure code 99291 has been added as a procedure code that can be used for billing emergency room (ER) professional services that no longer require the HealthMACS authorization of the assigned PCP. Professional services provided in the ER billed with procedure code 99291 or procedure codes in the range of 99281 through 99285 do not require the authorization of the HealthMACS PCP.

House Bill 881 Authorizes Interest on Civil Money Penalties for Nursing Facilities



Effective July 1, 2001, House Bill 881 authorizes under Section 43-13-121(1)(o) that the Division shall impose penalties upon Medicaid only, Title XIX participating long-term care facilities found to be in noncompliance with division and certification standards in accordance with federal and state regulations, including interest at the same rate calculated by the Department of Health and Human Services and/or the Centers of Medicare and Medicaid Services (formerly, Health Care Financing Administration) under federal regulations. The current rate is 13.75 % as published in the Federal Register dated April 26, 2001, Vol. 66, No. 81. This rate may be revised quarterly by the Secretary of the Treasury and shall be published quarterly by the Department of Health and Human Services in the Federal Register.

The interest shall be assessed on the unpaid balance of the penalty, beginning on the due date as noted in the formal notice from the Division if not paid and received by the end of the business day of the due date.

The interest shall continue to accrue on the unpaid balance until the principal amount is paid in full. Also, this applies to any funds that are recouped via the facility's account when not received from the facility.

Please direct any questions regarding information in this bulletin to the EDS Correspondence Unit at **601-960-2800 or 1-800-884-3222.**

Nursing Facilities and Intermediate Care Facilities for Mentally Retarded (ICF/MR) Home/Therapeutic Leave Deletes Physician Authorization

House Bill 881: If you have any questions, please contact Evelyn Silas, Institutional Long Term Care, at 601-359-6750 or Anthony Terry, Accounting and Finance, at (601) 359-6111.

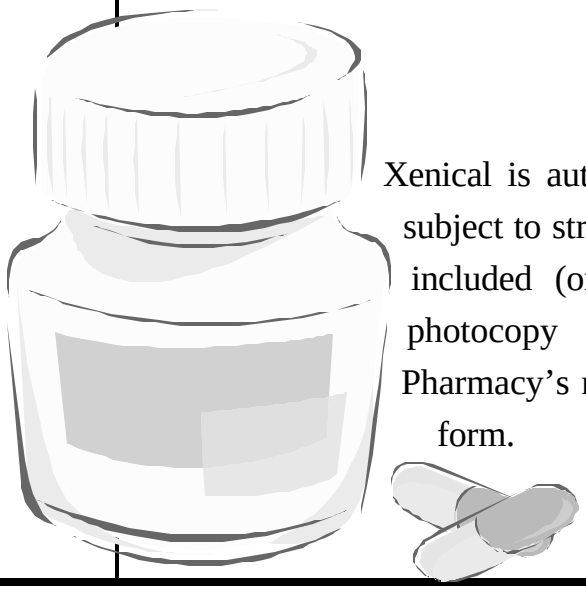
Under House Bill 881, Sections 43-13-117(4)(a) for Nursing Facilities and 43-13-117 (12)(a) for ICF/MRs, the requirement to provide the physician's authorization for leave has been DELETED. Revision of the Provider Manual will reflect the deletion of this provision in Section 5.07.2(2) of the Nursing Facility Provider Manual and Section 509.2(2) of the ICF/MR Provider Manual.

These sections are being revised to comply with House Bill 881 with deletion of the following:

> ...However, more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility. This authorization must be on file with the DOM fiscal agent before payment for the leave will be made and must be dated within ninety (90) days of the leave period.

The Division will continue to monitor home leave physician authorization.

If you have any questions, please contact Evelyn Silas, Institutional Long Term Care, at 601-359-6750 or Anthony Terry, Accounting and Finance, at (601) 359-6111.



Xenical Criteria for Use

Xenical is authorized only for use in treating dyslipidemia, subject to stringent criteria. The prior authorization form is included (on page 5) in this bulletin. Providers may photocopy the form to submit requests. Medicaid Pharmacy's mailing address and fax number appear on the form.

ORLISTAT (XENICAL)
PRIOR AUTHORIZATION REQUEST FORM

FAX OR MAIL TO:
DIVISION OF MEDICAID, PHARMACY PRIOR APPROVAL
239 NORTH LAMAR ST, SUITE 801, JACKSON, MS 39201
FAX # 601-359-9555

Patient's Name:	Prescriber's Phone #:
Patient's Medicaid #:	Prescriber's FAX #:
Prescriber's Name:	Pharmacy Name:
Prescriber's Address:	Pharmacy Phone #:

Prior Approval Requirements: (check (**T** or **X**)box if requirement met)*
*NOTE: All 4 requirements must be met in order to receive approval.

- Diagnosis of dyslipidemia, including all of the following:
  Total cholesterol greater than 240 mg/dL
  LDL cholesterol greater than 130 mg/dL
  HDL cholesterol less than 40 mg/dL

- Failed therapy with at least one drug product from each of the following four therapeutic drug categories: (1) niacin products (2) fibric acid derivatives (3) bile acid sequestrants (4) HMG CoA Reductase Inhibitors. If any of these drug products are contraindicated, please submit documentation.

- Patient has been instructed in low fat, low cholesterol diet therapy.

- If patient is a smoker, has been counseled on smoking cessation.

For initial authorization, copies of pertinent medical records documenting the above criteria, **including lab results within the previous 30 days**, must be submitted with this form. The initial authorization is for a sixty (60) day supply of orlistat. For authorization of an additional sixty (60) day supply, lab results showing a minimum seven (7) per cent decrease in the LDL-cholesterol level must be submitted.

PLEASE NOTE: By signing this form, the prescriber agrees to the best of his/her knowledge that this drug is for this patient's use only. Approval of medical necessity does not guarantee Medicaid eligibility or payment. The pharmacy provider is responsible for verifying Medicaid eligibility and program enrollment (i.e., FFS, PCCM, etc.).

A physician or other provider who knowingly or willfully makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the ordering prescriber identified above. I certify that the medical necessity information contained herein is true, accurate, and complete to the best of my knowledge. I certify that I am familiar with Orlistat package labeling and that this drug is medically necessary for the patient listed above. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines, or criminal prosecution.

Prescriber's Signature: _____ **DATE OF APPLICATION:** _____

(SPACE BELOW FOR MEDICAID USE ONLY)

- MEDICAID ELIGIBILITY VERIFIED **P. A. #**_____
- Approve request
- Deny request
- Modify request

_____ _____
Reviewer's Signature Response Date/Hour

Mississippi Medicaid Bulletin

PRSRT STD
U.S. POSTAGE PAID
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PERMIT NO. 584

EDS
111 East Capitol, Suite 400
Jackson, MS 39201-2121

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

September

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Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
						1
2	3 DOM, EDS & HSM closed Checkwrite	4	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 Checkwrite	25	26	27 ESC Cut-Off 5 pm	28	29

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.