

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New: X</b>	<b>Date: 05/01/06</b>
	<b>Revised:</b>	<b>Date:</b>
	<b>Current:</b>	
<b>Section: Beneficiary Health Management (BHM)</b>	<b>Section: 32.01</b>	
	<b>Pages: 1</b>	
<b>Subject: Introduction</b>	<b>Cross Reference:</b>	

Medicaid, authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

In accordance with 42 CFR 431.54 (3)(e), a state has the authority to lock-in beneficiaries who over utilize Medicaid services. If a Medicaid agency finds that a beneficiary has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that beneficiary for a reasonable period of time to obtain Medicaid services from designated providers only.

Beneficiary Health Management is the program implemented by the Division of Medicaid to closely monitor program usage and to identify beneficiaries who may be potentially over utilizing or misusing their Medicaid services and benefits. The purpose of Beneficiary Health Management (BHM) is to:

- promote quality health care
- prevent harmful practices such as duplication of medical services, drug interaction, and possible drug abuse
- identify beneficiaries for review who may misuse or over utilize their Medicaid benefits
- analyze beneficiary pattern of utilization of health services
- modify the beneficiary's improper utilization of Medicaid services through educational contacts and monitoring
- prevent fragmentation of services and improve the continuity of care and coordination of services, and
- assure beneficiaries are receiving only health care services which are medically necessary and justified, thereby curtailing unnecessary costs to the program.

"Medical Necessity" is defined as the determination by the Medical Assistance Program that a service is reasonably necessary to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap or cause physical deformity or malfunction. There must also be no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service.

The Division of Medicaid's Bureau of Program Integrity has the responsibility of initiating and coordinating BHM.

This program may include physician only, pharmacy only or physician and pharmacy type beneficiary health management.

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<b>Section: Beneficiary Health Management(BHM)</b>	<b>Section: 32.02</b>	
<b>Subject: Covered Services</b>	<b>Pages: 1</b>	
	<b>Cross Reference:</b>	

Beneficiaries will be placed in the Beneficiary Health Management for a period of 18 months with ongoing reviews to monitor pattern of care.

Beneficiaries in the BHM program are allowed 2 counseling sessions per month per lockin provider-physician and/or pharmacy during the eighteen (18) month lockin.

### **Mental Health Services**

DOM will reimburse for inpatient hospitalization for treatment of alcohol and/or drug abuse when the primary diagnosis is a mental health diagnosis (DSM-IV diagnosis) and the inpatient hospital stay is approved by the Division of Medicaid Utilization Management and Quality Improvement Organization (UM/QIO). In addition, the Division will pay for mental health services up to twelve (12) visits per fiscal year, where counseling can be received for addiction problems.

**Beneficiaries in BHM will continue to have access to emergency room, inpatient and outpatient hospitalizations, dental, optical, psychiatric, home health, hospice, Medicaid Waiver and DME services. All service limits are applicable.**

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<b>Section: Beneficiary Health Management(BHM)</b>	<b>Section: 32.03</b>	
<b>Subject: Exclusions</b>	<b>Pages: 1</b>	
	<b>Cross Reference:</b>	

The following are excluded from BHM:

- Beneficiaries who have received a utilization review completed within the past year are not eligible for re-review of benefits in BHM until after twelve (12) months.
- Beneficiaries no longer eligible for Medicaid benefits.

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Subject: Providers	Pages: 2	Cross Reference:

Beneficiaries are required to specify one (1) physician and/or one (1) pharmacy and up to five (5) physician specialists (if requested) for his/her medical/pharmaceutical services while in the BHM program.

The beneficiary has 30 days to choose his/her provider(s). When the beneficiary does not specify within the 30-day time frame, the DOM may designate a provider or providers for him/her.

### Change of Provider

The beneficiary may request a change in his/her specified physician and/or pharmacy if any of the following occurs:

- Change in geographical location of the beneficiary or the provider(s);
- Death, retirement, or closing of the specified physician, pharmacy or specialist;
- Irreconcilable differences between the beneficiary and the provider(s) that may affect the quality of medical care the beneficiary receives;
- Primary diagnosis changes and therefore requires different specialist;
- Specified provider(s) stop(s) participating in the Mississippi Medicaid Program; and
- Specified provider(s) lose(s) eligibility to participate in the Mississippi Medicaid Program.

### Referrals

Beneficiaries in BHM may be referred to another provider for consultation by the specified physician or specialists by using the BHM Referral Form. Prior approval is required before the beneficiary can be seen by the referral physician. **Emergency situations are excluded from this requirement.**

The referral may cover one visit or may cover multiple visits as long as those visits are a part of the referral physician's plan of care and are medically necessary. No referral can last for more than one year.

**Division of Medicaid  
Beneficiary Health Management Program**

**Medical Referral Form**

This form is to be completed and signed by the authorized specified physician when referral to another provider is medically necessary.

Mail a copy to:

Division of Medicaid, Bureau of Program Integrity  
Beneficiary Health Management Unit  
Suite 801, Robert E. Lee Building  
239 North Lamar Street  
Jackson, MS 39201-1399



**Beneficiary Information**

**Name (Last, First and Middle Initial)**

1.) \_\_\_\_\_

**Medicaid Identification #**

2.) \_\_\_\_\_

**Specified Physician Making Referral**

3.) \_\_\_\_\_

**Specified Physician Provider #**

4.) \_\_\_\_\_

**Specified Physician's Signature**

5.) \_\_\_\_\_

**Date**

6.) \_\_\_\_\_

**Reason for referral**

7.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Referring to: (Physician's Name)**

8.) \_\_\_\_\_

**Address**

9)




This referral form must accompany each claim as a paper attachment for service rendered to any beneficiary in the Beneficiary Health Management Program in order for the physician receiving the referral to get payment for his or her claim. A copy must be mailed to the Beneficiary Health Management Unit at the address listed above. **This referral is good for one year.**

When billing Mississippi Medicaid, the referred consultant should place the specified physician's Medicaid provider number in block 17A of the CMS-1500 or block 2 of the UB-92 claim.

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<b>Section: Beneficiary Health Management(BHM)</b>	<b>Section: 32.05</b>	
<b>Subject: Reimbursement</b>	<b>Pages: 1</b>	
	<b>Cross Reference:</b>	

Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written by the specified physician or by the consultant physician, except on an emergency basis.

Payment will be made to provider(s) other than the specified provider(s) in the following instances:

- Emergency care is required and the specified provider is not available, or
- The specified provider requires consultation with another provider

### **Billing Guidelines**

Providers of BHM services are required to bill CPT codes 99401 or 99402 for the two required counseling sessions per month. These codes can be billed in conjunction with any other service the physician provides to the beneficiary. Documentation must support billing of CPT codes 99401 and 99402 by the physician and/or pharmacy.

**CPT 99401 or 99402 may be billed two (2) times per month for each provider.**