

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 4/01/01 01/01/07
Section: Hospital Inpatient	Section: 25.02	
Subject: Accommodations	Pages: 2-1	Cross Reference:

## Hospitals with Multiple Accommodations

### 1. Private Room

When private room accommodations are furnished, the following rules will govern:

#### A. Private Room/Critical Care Units – Medically Necessary

The reasonable cost of a private room or other accommodations more expensive than semi-private are covered services when such accommodations are medically necessary. Private rooms will be considered medically necessary when the physician documents that the patient's condition requires him/her to be isolated for his/her own health or for the health of others. This includes the use of critical care units.

#### B. Private Room – Not Medically Necessary – Based on Availability

When accommodations more expensive than semi-private are furnished, the assigned accommodations are considered medically necessary and are covered by Medicaid if at the time of admission less expensive accommodations are not available (this includes hospitals with private rooms only.) The subsequent availability of semi-private or ward accommodations would offer to the hospital the right to transfer that patient to such accommodations or, at the express request of the patient, to allow him/her to continue occupancy of the private room as a private-room patient enjoying a personal comfort item and subject to be billed the room differential charge.

#### C. Private Room – Requested by Beneficiary

When a private room is not medically necessary but is furnished at the beneficiary's request, the hospital may charge the patient no more than the difference between the customary charge for the accommodations furnished and the customary charge for the semi-private accommodations at the rate in effect at the time services are rendered. No such charge may be made to the patient unless he/she requested the more expensive accommodations with the knowledge that he/she would be charged the differential. The patient's account file, over the signature of an authorized hospital employee, should reflect the patient's knowledge that the differential charge will be expected.

#### D. Deluxe Accommodations

The Medicaid program does not cover deluxe accommodations and/or deluxe services. These would include a suite/birthing suite, or a room substantially more spacious than is required for treatment, or specifically equipped or decorated, or serviced for the comfort and convenience of persons willing to pay a differential for such amenities.

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~~A room differential cannot be charged to the beneficiary when the differential is based on such factors as differences between older and newer wings, proximity to lounge, elevators or nursing stations, or a desirable view. Such rooms are standard one-bed units and not deluxe rooms for purposes of this instruction.~~

**~~2. Semi-private Room – Two (2) beds per room~~**

~~Medicaid will cover the reasonable cost of semi-private accommodations.~~

**~~3. Ward Accommodations – Three (3) or more beds per room~~**

~~If less than semi-private accommodations are furnished, Medicaid will cover the cost of the accommodation furnished only if the patient requests such or when semi-private accommodations are not available. If less than semi-private accommodations are furnished because all semi-private rooms are filled, the patient should be transferred to semi-private accommodations as soon as one becomes available.~~

When a private room is not medically necessary but is furnished at the beneficiary's request, the hospital may charge the patient no more than the difference between the customary charge for the accommodations furnished and the customary charge for the semi-private accommodations at the rate in effect at the time services are rendered. No such charge may be made to the patient unless he/she requested the more expensive accommodations with the knowledge that he/she would be charged the differential. The patient's account file, over the signature of an authorized hospital employee, should reflect that the patient was informed and consent was given by the beneficiary for the differential charge in accommodations from semi-private to private room.

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	<b>Revised: X</b>	<b>Date: 11/01/01</b>
	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.03</b>	
	<b>Pages: 1</b>	
<b>Subject: Discharge Against Medical Advice (AMA)</b>	<b>Cross Reference: Inpatient Prospective Payment Method 25.27</b>	

Discharge Against Medical Advice (AMA) occurs when a beneficiary leaves a hospital against the advice or consent of a physician. Mississippi Medicaid will reimburse covered inpatient or outpatient hospital services rendered to the beneficiary even though the beneficiary leaves against medical advice. Reimbursement will be made in accordance with the transfer policy outlined in Section 25.27.

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<b>State of Mississippi</b>	<b>Revised: X</b>	<b>Date: 11/01/01</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.04</b>	
<b>Subject: Ancillary Services</b>	<b>Pages: 1</b>	
	<b>Cross Reference: Inpatient Prospective Payment Method 25.27</b>	

Medically necessary ancillary services that are routinely furnished according to medically accepted standards of practice to inpatients by the hospital or by others under arrangements made by the hospital and in accordance with and subject to exclusions of this manual are covered services. Reimbursement for ancillary services is included within payment calculated under the Inpatient prospective payment method described in Section 25.27.

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<b>State of Mississippi</b>	<b>Revised:</b> X	<b>Date:</b> 01/01/07
<b>Provider Policy Manual</b>	<b>Current:</b>	
<b>Section: Hospital Inpatient</b>	<b>Section:</b> 25.05	
<b>Subject: Disproportionate Share Hospital (DSH)</b>	<b>Pages:</b> 1	
	<b>Cross Reference:</b>	

The Mississippi Medicaid State Plan defines the Disproportionate Share Hospital (DSH) program and the qualifications for participation in the DSH program. ~~Publicly owned and operated hospitals that qualify as DSH hospitals are considered to be High DSH hospitals. High DSH hospitals must participate in an inter-governmental transfer program to participate in the DSH program. Hospitals other than publicly owned and operated hospitals that qualify for the DSH program are considered to be Low DSH hospitals.~~

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<b>Provider Policy Manual</b>	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.06</b>	
	<b>Pages: 1</b>	
<b>Subject: Hospital Responsibilities for Physician Services</b>	<b>Cross Reference:</b>	

Physicians employed by or contracted with the hospital may not bill individually for services rendered to Medicaid beneficiaries. The hospital must bill for services provided by physicians employed by or contracted with the hospital (ex: hospitalists, lab directors, etc.). These services must be billed on the HCFA-1500 professional claim (i.e., CMS-1500 or X12N 837P) with the physician's individual Medicaid provider number as the servicing provider and the hospital's Medicaid provider number as the billing provider. This includes services provided in the emergency room by physicians employed on a full-time or part-time basis by the hospital and other physicians employed by or with a contractual arrangement with the hospital.

A hospital that accepts a Medicaid beneficiary for treatment accepts the responsibility for making sure that the beneficiary receives all medically necessary services that are covered by Medicaid. The conditions of participation that govern hospitals providing care to Medicare and Medicaid beneficiaries require that the governing body of the hospital assures accountability of the medical staff for the quality of care provided to beneficiaries. Accordingly, if a particular physician with whom the hospital contracts does not accept Medicaid, the hospital has the responsibility of assuring the delivery of these medically necessary services to a Medicaid beneficiary.

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	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.07</b>	
<b>Subject: Blood and Blood Components</b>	<b>Pages: 1</b>	
	<b>Cross Reference: <u>Inpatient</u> Prospective Payment Method 25.27</b>	

~~During each fiscal year, Medicaid will cover the first six (6) pints of whole blood and/or equivalent quantities of packed red blood cells for each eligible beneficiary, when they are not available from other sources (ex: family, autologous precollection, donor directed precollection, etc.). The term "whole blood" means human blood from which none of the liquid or cellular components have been removed. Where packed red blood cells are furnished, a unit of packed red blood cells is considered equivalent to a pint of whole blood. Other components of blood such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin are not subject to the quantity limits. However, these components of blood are covered and should be billed as biologicals.~~

~~Hospitals are encouraged to make every effort to have the blood that is used by a Medicaid beneficiary replaced. If it is the hospital's usual practice to require replacement of more blood than is actually used, the practice can be continued with Medicaid beneficiaries. However, if full replacement is not received, then pint for pint credit must be given.~~

Medically necessary blood and blood components are covered services without limit. Reimbursement for these products is included within payment calculated under the inpatient prospective payment method described in Section 25.27.

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<b>Provider Policy Manual</b>	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.08</b>	
<b>Subject: Newborn Child Eligibility</b>	<b>Pages: 2</b>	
	<b>Cross Reference:</b>	
	<b>Beneficiary Information 3.02</b>	

Newborn children may become Medicaid beneficiaries effective on his/her date of birth.

**Newborn to a Medicaid-eligible Mother**

A child born to a Medicaid-eligible mother may automatically be eligible for Medicaid coverage for one year, provided the newborn continues to live with the mother. Following the birth of a child of a Medicaid beneficiary and before the mother is discharged from the birthing facility, hospitals must complete the Request for Newborn Health Benefits Identification Number form. This form authorizes the hospital to release information to the Division of Medicaid (DOM). The completed form should be faxed to the appropriate Medicaid Regional Office that serves the county where the mother and baby will reside. The Medicaid Regional Office will process the newborn information and assign a permanent Medicaid ID number within 7-10 days of receipt and fax the form back to the birthing facility initiating the form.

**NOTE:** Newborns adopted at birth are not automatically entitled to the one-year eligibility period. An application for the newborn must be filed with the appropriate certifying agency.

A hospital can verify eligibility through the AVRS line at 1-800-884-3222 for any Medicaid beneficiary.

**Newborn Who Is Not Medicaid-eligible at the Time of Birth**

Eligibility is established by submitting an application to the appropriate Medicaid Regional Office. Application forms are available at some hospitals, federally qualified health centers, health departments, and other provider offices as well as Medicaid regional offices. If eligibility criteria are met and there are unpaid bills, eligibility may be established for as much as three months prior to the date of application as described in Section 3.03 in this manual.

**REQUEST FOR NEWBORN HEALTH BENEFITS IDENTIFICATION NUMBER**

(Please print or type)

Regional Medicaid Office \_\_\_\_\_ Hospital \_\_\_\_\_

Fax Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**I. RELEASE OF INFORMATION – TO BE COMPLETED BY PARENT**

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
(Name of Parent) (Name of Hospital)

to release to the Mississippi Division of Medicaid information regarding my newborn child,

\_\_\_\_\_ for purposes of enrolling my child in Medicaid or the  
(Name of Child As It Appears on Birth Certificate)

Children's Health Insurance Program (CHIP).

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

**II. IDENTIFYING INFORMATION – TO BE COMPLETED BY HOSPITAL**

Newborn's Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_

Single Birth

Multiple Births How many? \_\_\_\_\_

Name and Address of Mother \_\_\_\_\_

County of Residence \_\_\_\_\_

Mother's Medicaid ID# \_\_\_\_\_ Mother's SSN \_\_\_\_\_

\*Your SSN will be used to ensure will be used to ensure that Medicaid correctly matches your baby's record to your record. Pursuant to the authority found in federal law at 42 U.S.C. 1320b-7(a) and federal regulations at 42 CFR 435.910, you are required to disclose the Social Security Number (SSN) for each person applying for Health Benefits. This is a mandatory requirement in order to be eligible for Medicaid benefits. If you cannot recall the SSN for each applicant or if the applicant does not have a SSN, the agency can assist you in applying for a SSN for each applicant. If the applicant has a well established religious objection for not providing his or her SSN, he or she should state the basis for such objection and the agency will review this request. The SSN will be used to verify information such as income and insurance coverage and to help maintain files regarding eligibility pursuant to the authority described in federal regulations 42 CFR 435.940 through 42 CFR 435.960. The SSN may also be used to match with records within the State Medicaid agency and in other state, federal, and/or local agencies, such as the Social Security Administration, Internal Revenue Services, and Employment Security.

Were parental rights terminated? \_\_\_\_\_ No \_\_\_\_\_ Yes

Hospital representative furnishing information \_\_\_\_\_  
Telephone number \_\_\_\_\_ Date \_\_\_\_\_

**III. HEALTH BENEFITS INFORMATION – TO BE COMPLETED BY MEDICAID REGIONAL OFFICE**

Newborn is eligible for  Medicaid  Children's Health Insurance  
Health Benefits ID# \_\_\_\_\_ Effective Date \_\_\_\_\_  
DOM Worker \_\_\_\_\_ Date \_\_\_\_\_

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Division of Medicaid State of Mississippi 239 N. Lamar St. Suite 801 Jackson, MS 39201-1311 1-800-421-2408

<b>Division of Medicaid</b>	<b>New:</b>	<b>Date:</b>
<b>State of Mississippi</b>	<b>Revised: X</b>	<b>Date: 11/01/01</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.09</b>	
<b>Subject: Maternity Epidurals</b>	<b>Pages: 2</b>	
	<b>Cross Reference: Conditions of Participation 4.01</b>	
	<b><u>Inpatient Prospective Payment Method 25.27</u></b>	

A maternity epidural is a covered procedure under Mississippi Medicaid for all pregnant Medicaid beneficiaries. All pregnant Medicaid beneficiaries must have access to this anesthesia service. Mississippi Medicaid considers maternity epidurals as a medically necessary service for treatment of labor pain. **A maternity epidural is not considered an elective procedure.** Reimbursement for epidurals is included within payment calculated under the inpatient prospective payment method described in Section 25.27.

### **Physician Responsibilities**

A physician who is participating in the Mississippi Medicaid program must take all reasonable measures to ensure that maternity patients are instructed and offered an epidural as an available and covered service under Mississippi Medicaid as part of the patient's prenatal counseling. The patient's options for pain relief medication during childbirth must be explained to her. If she requests an epidural, she should be instructed that this is a covered service under the Mississippi Medicaid program. Beneficiary problems with access to epidurals should be reported to the Program Integrity Unit hotline number at 1-800-880-5920 or 601-987-3962.

### **Anesthesiologist and CRNA Responsibilities**

Anesthesiologists/CRNAs may not refuse to provide a maternity epidural to a Medicaid beneficiary except when medically contraindicated. An anesthesiologist/CRNA who is participating in the Mississippi Medicaid program must make available and offer maternity epidural services to pregnant Medicaid beneficiaries and cannot require a pregnant Medicaid beneficiary to pay for an epidural. He/She must accept the Medicaid payment as payment in full and cannot require a co-payment for his/her services. Under federal Medicaid law, deductions, cost sharing, or similar charges are not permitted for Medicaid services furnished to pregnant women. Thus, a participating provider's demand for these additional payments would be in violation of the law.

The decision to have an epidural is to be decided between the beneficiary and her anesthesiologist/CRNA in consultation with the obstetrician. No means of coercion, dissuasion, or refusal by an anesthesiologist/CRNA to provide an epidural to a beneficiary in labor shall be utilized in determining this decision.

### **Hospital Responsibilities**

A hospital that accepts a pregnant Medicaid beneficiary for treatment accepts the responsibility for making sure that the beneficiary has access to an epidural. If an anesthesiologist does not accept a Medicaid patient for treatment, the hospital has the responsibility of assuring the delivery of this service. A pregnant beneficiary is entitled to receive the service from a provider who has accepted her as a patient without the imposition of deductibles, cost sharing, or similar charges.

The conditions of participation that govern hospitals providing care to Medicaid beneficiaries require that the governing body of the hospital assures accountability of the medical staff for the quality of care

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provided to patients. There must be an effective hospital-wide quality assurance program to evaluate the provision of patient care, and all organized services related to patient care, including services furnished by a contractor must be evaluated, and where deficiencies are identified, remedial action must be taken (42 CFR 482.12, 21 & 22).

**As referenced in Section 4.01, Conditions of Participation, of this manual: "The provider must agree to accept as payment in full the amount paid by the Medicaid program for all services covered under the Medicaid program within the beneficiary's service limits with the exception of authorized deductibles, co-insurance, and co-payments. All services covered under the Medicaid program will be made available to the beneficiary. Beneficiaries will not be required to make deposits or payments on charges for services covered by Medicaid. A provider cannot pick and choose procedures for which the provider will accept Medicaid. At no time shall the provider be authorized to split services and require the beneficiary to pay for one type of service and Medicaid to pay for another. All services provided to Medicaid beneficiaries will be billed to Medicaid only where Medicaid covers said service, unless some other resources, other than the beneficiary or the beneficiary's family, will pay for the service."**

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 11/01/04 01/01/07
Section: Hospital Inpatient	Section: 25.10	
Subject: Take Home Drugs, Supplies, and Equipment	Pages: 1	
	Cross Reference: Implantable Programmable Baclofen Pumps 25.20	
	<u>Inpatient Prospective Payment Method 25.27</u>	

## Drugs

~~Drugs for use in a hospital that are ordinarily furnished by the hospital for the care and treatment of the beneficiary are covered.~~ Reimbursement for drugs provided during an inpatient stay is included within payment calculated under the inpatient prospective payment method described in Section 25.27. Take home drugs are **NOT** covered. A beneficiary may, upon discharge from the hospital, take home remaining amounts of drugs that have been supplied for him/her either on prescription or doctor's order, if continued administration is necessary, since they already would have been charged to his/her account by the hospital.

## Supplies

~~Supplies ordinarily furnished by the hospital for the care and treatments of the beneficiary solely during his/her stay in the hospital are covered beneficiary hospital services. Under certain circumstances, supplies during the hospital stay are covered even though the beneficiary is discharged from the hospital with them. These are circumstances in which it would be unreasonable or impossible from a medical standpoint to limit the beneficiary's use of the item to the periods during which the beneficiary is an inpatient. Examples of items covered under this rule are cardiac valves, cardiac pacemakers, and such items as tracheotomy or drainage tubes which are temporarily installed in or attached to the patient's body while he/she is receiving treatment and which are also necessary to permit or facilitate the beneficiary's release from the hospital.~~ Reimbursement for supplies used during an inpatient stay is included within payment calculated under the inpatient prospective payment method described in Section 25.27. Supplies and appliances furnished to a beneficiary for use solely outside the hospital are **NOT** covered.

## Implantable Pumps

Refer to Section 25.20, Implantable Programmable Baclofen Pumps, in this manual.

## Oxygen

~~The reasonable cost of oxygen furnished for the care and treatment of the beneficiary solely during his/her stay in the hospital is covered.~~ Reimbursement for oxygen used during an inpatient stay is included within payment calculated under the inpatient prospective payment method described in Section 25.27. Oxygen furnished to a beneficiary for use solely outside the hospital is **NOT** covered.

## Durable Medical Equipment

~~Equipment ordinarily furnished by the hospital for the care and treatment of the beneficiary solely during his/her stay in the hospital is covered.~~ Reimbursement for durable medical equipment used during an inpatient stay is included within payment calculated under the inpatient prospective payment method described in Section 25.27. Equipment furnished to a beneficiary for use solely outside the hospital is **NOT** covered.

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	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.11</b>	
<b>Subject: Transplants</b>	<b>Pages: 2</b>	
	<b>Cross Reference: Transplants 28.01-28.18</b>	

Mississippi Medicaid benefits are provided for the following transplants if the facility obtains prior approval and satisfies all criteria:

PROCEDURE	COVERED	PA REQUIRED
Cornea	Yes	No
Heart	Yes	Yes
Heart/Lung	Yes	Yes
Kidney *	Yes	No
Liver	Yes	Yes
Lung – Single	Yes	Yes
Lung – Bilateral	Yes	Yes
Marrow or Peripheral Hematopoietic Stem Cell: Autologous, Syngeneic, or Allogeneic	Yes	Yes
Pancreas	No	No
Small Bowel	Yes	Yes

\* A kidney transplant done in conjunction with pancreas will be reimbursed as a kidney transplant only.

Requests for prior approval should be sent to DOM's ~~Peer Review Organization (PRO)~~ Utilization Management and Quality Improvement Organization (UM/QIO). Physicians are urged to submit their requests as soon as it is determined that the patient may be a potential candidate for transplant.

All transplant benefits are contingent upon:

1. The beneficiary's continued eligibility for Mississippi Medicaid;
2. The beneficiary's application for the transplant being approved by DOM's ~~PRO~~ UM/QIO;
3. All inpatient days being certified by DOM's ~~PRO~~ UM/QIO;
4. All conditions of third party liability procedures being satisfied;
5. All providers of services completing requirements for participation in the Mississippi Medicaid program; ~~all claims being completed according to the requirements of the Mississippi Medicaid program;~~

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6. All claims being completed according to the requirements of the Mississippi Medicaid program;
  7. All charges, both facility and physician, relating to procurement/storage must be billed by the transplant facility on the ~~UB92~~ institutional claim (e.g., UB92, UB-04, X12N 837I) form under the appropriate revenue code;
  8. The transplant facility providing appropriate medical records, progress or outcome reports as requested by DOM, the ~~PRO-UM/QIO~~ or the fiscal agent; and
  9. The transplant procedure being performed at the requesting facility.

**All terms of the Mississippi Medicaid program, including timely filing requirements, are applicable.**

Approval will not be given for:

- Transplant procedures for which medical necessity has not been proven;
- Transplant procedures which are still investigative, experimental, or still in clinical trial;
- Transplant procedures performed in a facility not approved by DOM;
- Inpatient or outpatient admissions for transplant procedures on which certification or re-certification is not obtained from the ~~PRO-UM/QIO~~.

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	<b>Current:</b>	<b><del>01/01/07</del></b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.12</b>	
<b>Subject: Transportation of Patients</b>	<b>Pages: 1</b>	
	<b>Cross Reference: Ambulance 8.03 and 8.04 and NET 12.01-12.17 NET 12.0</b>	

Refer to Ambulance, Sections 8.03 and 8.04, and ~~NET, Sections 12.01-12.17, of this manual-Non-Emergency Transportation, Section 12.0, of the Medicaid policy manual.~~

### **Nursing Facility Residents**

If a nursing facility resident is transferred from a nursing facility to a hospital, remains hospitalized for longer than fifteen (15) days, and is discharged from the nursing facility, transportation for these residents should be arranged by the hospital.

If there has not been a final discharge from the nursing facility and the resident had a hospital stay of less than fifteen (15) days, transportation back to the nursing facility must be arranged by the nursing facility staff.

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<b>Provider Policy Manual</b>	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.13</b>	
<b>Subject: Change of Ownership</b>	<b>Pages: 1</b>	
	<b>Cross Reference: Change of Ownership 4.03</b>	

Refer to Section 4.03, Change of Ownership, in ~~this manual~~ in the Medicaid policy manual.

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<b>State of Mississippi</b>	<b>Revised: X</b>	<b>Date: <del>11/01/01</del></b>
<b>Provider Policy Manual</b>	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.15</b>	
<b>Subject: Documentation Requirements</b>	<b>Pages: 2</b>	
	<b>Cross Reference: Maintenance of Records 7.03</b>	

All professional and institutional providers participating in the Medicaid program are required to maintain records that will disclose services rendered and billed under the program and, upon request, make such records available to representatives of DOM or the Office of the Attorney General in substantiation of any or all claims. These records should be retained a minimum of five (5) years in order to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligations to verify services rendered to Medicaid beneficiaries and paid for by Medicaid, the hospital must maintain legible and auditable records that will substantiate the claim submitted to Medicaid. At a minimum, the records must contain the following on each patient:

- Date of service;
- A comprehensive history and physical assessment/report, including the patient's presenting complaint;
- Diagnosis(es) to substantiate the hospitalization and all treatments/procedures rendered during the hospitalization;
- The specific name/type of all diagnostic studies (x-ray, lab, etc.) and the medical indication and results/finding of the studies;
- Documentation and consult reports to substantiate treatment/procedures rendered, the patient's response to the treatment/procedure, and the signature or initials of the appropriate health care worker providing the treatment/procedure (physician, nurse, therapist, dietitian, etc.);
- The name, strength, dosage, route (IM, IV, PO, topical, enteral, intracatheter, etc.), date and time, indication for, and the administration of all medications administered to the patient;
- Discharge planning and instructions, including the signature or initials of the health care worker performing the instruction, the name of the person being instructed, date, and time of instruction; whether the instructions are given in writing, verbally, by telephone or other means; and how much instruction was comprehended by the beneficiary, including level of proficiency on return demonstration when a procedure is being taught;
- Discharge orders for medications, treatments/procedures, etc., that indicate whether the orders/prescriptions are issued in writing, verbally, or by telephone, and to whom the orders are issued;
- Signed physician orders for all medications, treatments, and procedures rendered to the patient.

**DOM requires that all x-ray images (films, digital images, etc.) be accessible at all times for review. In addition, DOM requires that the films or images be of such quality that they can be clearly interpreted.**

Providers must maintain proper and complete documentation to verify the services provided. The provider has full responsibility for maintaining documentation to justify the services provided.

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DOM, the PRQ- UM/QIO, and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or documentation of any services billed by the provider.

If a provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to the Mississippi Medicaid program any money received from the program for such non-substantiated services. If a refund is not received within 30 days, a sum equal to the amount paid for such services may be deducted from any future payments that are deemed to be due the provider, unless other arrangements are made and approved by DOM.

**Any hospital provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the hospital provider as a provider of Medicaid services.**

Refer to Section 7.0, General Policy for additional documentation requirements.

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<b>Provider Policy Manual</b>	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.16</b>	
<b>Subject: Therapy</b>	<b>Pages: 1</b>	
	<b>Cross Reference: Inpatient</b>	
	<b>Prospective Payment Method 25.27</b>	

~~Therapeutic services ordinarily furnished to inpatients by the hospital, or by others under arrangements made by the hospital, are covered. Reimbursement for therapeutic services provided to inpatients by the hospital, or by others under arrangements made by the hospital, is included within payment calculated under the inpatient prospective payment method described in Section 25.27.~~ These covered services include services not otherwise listed as covered inpatient services.

Inpatient services rendered by a psychologist or a therapist who is employed by the hospital and whose services are normally included in the billing of the hospital are covered on a reasonable basis in the same manner as the services of other non-physician hospital employees.

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Section: Hospital Inpatient	Section: 25.17	
Subject: Out of State Facilities	Pages: 1	
	Cross Reference: Inpatient	
	Prospective Payment Method 25.27	

~~Out-of-state hospitals in contiguous states are reimbursed at the lower of:~~

- ~~1. The average rate paid to a like-sized hospital in Mississippi OR~~
- ~~2. The inpatient rate established by the Medicaid agency of the domicile state.~~

~~The fiscal agent is responsible for verifying the rate with the Medicaid agency in the domicile state. Verification should be made each six (6) months.~~

~~Out-of-state hospitals in states other than contiguous states are reimbursed at the average rate paid a like-sized hospital in Mississippi.~~

Out-of-state hospitals are reimbursed under the inpatient prospective payment method described in section 25.27.

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b>	<b>Date:</b>
	<b>Revised: X</b>	<b>Date: 11/01/01</b>
	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.19</b>	
	<b>Pages: 1</b>	
<b>Subject: Non-Covered Procedures</b>	<b>Cross Reference:</b>	

In keeping with the Mississippi Medicaid policy for not providing reimbursement for services that are non-covered, any non-covered procedure performed in an inpatient or outpatient setting will result in this portion, or possibly the entire claim, being disallowed. Certification of a procedure by the ~~PRO~~ UM/QIO for Mississippi Medicaid does not guarantee payment or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.

Division of Medicaid	New: -X	Date: <del>11/01/01</del>
State of Mississippi	Revised: X	Date: <u>01/01/07</u>
Provider Policy Manual	Current:	
Section: Hospital Inpatient	Section: 25.20	
Subject: Implantable Programmable Baclofen Pumps	Pages: 1	
	Cross Reference:	

Effective July 1, 2001, the The cost of the implantable programmable baclofen drug pumps used to treat spasticity that are implanted in an inpatient hospital setting will be reimbursed outside the Hospital Medicaid per diem rate inpatient prospective payment method. Hospitals must submit a paper claim with a copy of the invoice and product description that validates that it is an implantable pump and an attachment that verifies the cost of the pump to the hospital. Hospitals must remove the cost of these pumps from the cost report filed with Medicaid. Reimbursement is limited to \$10,000 per state fiscal year (July 1- June 30) per Medicaid beneficiary. Claims submitted for beneficiaries who have exhausted their inpatient benefit limit or for non-certified days will be denied.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 11/01/04 01/01/07
Section: Hospital Inpatient	Section: 25.23	
Subject: <del>Canceled Procedures</del> Reserved for Future Use	Pages: 1	Cross Reference:

**~~Elective Cancellation of Procedures Not Related to the Beneficiary's Medical Condition~~**

~~When a surgical or other procedure is canceled due to scheduling conflicts of the operating suite or physician, beneficiary request, or other reason not related to medical necessity, the procedure may not be billed to Medicaid and no payment will be made for the procedure. Services provided prior to the procedure may be billed and will be covered subject to usual Medicaid policies for those services. If the cancellation causes the beneficiary to stay in the hospital for additional time until the procedure is rescheduled, these additional days will not be covered.~~

**~~Canceled or Incomplete Procedures Related to the Beneficiary's Medical Condition~~**

~~When a surgical or other procedure is canceled or terminated before completion due to changes in the beneficiary's medical condition that threaten his/her well-being, the services that were actually performed may be billed and will be covered subject to usual Medicaid policies for those services. There must be clear documentation regarding the medical necessity for cancellation or termination of the procedure.~~

**Section 25.23 is RESERVED FOR FUTURE USE.**



<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised:</b> X <b>Current:</b>	<b>Date:</b> <b>Date:</b> 06/01/06 <b>_____</b> 01/01/07
<b>Section: Hospital Inpatient</b>	<b>Section:</b> 25.25	
<b>Subject: Prior Authorization of Inpatient Hospital Services</b>	<b>Pages:</b> 2	<b>Cross Reference: Utilization Quality Improvement Organization Information 1.10</b>

Prior authorization serves as a utilization review measure and quality assurance mechanism for the Mississippi Medicaid program. Federal regulations permit the Division of Medicaid (DOM) to require prior authorization for any service where it is anticipated or known that the service could either be abused by providers or beneficiaries, or easily result in excessive, uncontrollable Medicaid costs.

~~As a condition for reimbursement, DOM requires that all inpatient hospital admissions require prior authorization. Failure to obtain the prior authorization will result in denial of payment to all providers billing for services, including the hospital and the attending physician.~~

### Prior Authorization and Beneficiary Eligibility

- ~~As a condition for reimbursement, DOM requires that all inpatient hospital admissions require prior authorization- hospitals obtain prior authorization for inpatient services as described in this section.~~ Failure to obtain the prior authorization will result in denial of payment to all providers billing for services, including the hospital and the attending physician.

#### Note:

- When a beneficiary has third party insurance and Medicaid, prior authorization must be obtained from Medicaid.
- Prior authorizations are not required for Medicaid beneficiaries who are also covered by both Medicare Part A & B unless inpatient Medicare benefits are exhausted. Prior authorizations are required for Medicaid beneficiaries who are also covered by Medicare Part A only or Medicare Part B only.
- ~~Effective June 1, 2005, inpatient days for more than a two (2) day stay for vaginal deliveries or four (4) day stay for Cesarean section deliveries must be certified through the Utilization Management and Quality Improvement Organization (UM/QIO).~~
- ~~Effective July 1, 2005, the provider must certify all maternity stays. (See Maternity Related Services on page 2 of this manual section.)~~

### Submitting a Prior Authorization Request

~~Prior authorization is required for all inpatient hospital admissions except obstetrical deliveries. A person is considered an inpatient if formally admitted as an inpatient with the expectation that he/she will remain at least overnight and occupy a bed even though it later develops that he/she can be discharged or is transferred to another hospital and does not actually use a hospital bed overnight. Emergent and urgent admissions must be authorized on the next working day after admission.~~

~~Certification acknowledges only the medical necessity and appropriateness of the setting and does not guarantee payment.~~

~~To receive authorization for an inpatient request, the hospital must contact the UM/QIO as identified in Section 1.10.~~

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## Receiving Approval or Denial of a Request

Letters of approval will be sent to the provider indicating the approved treatment authorization number (TAN) and dates of service. This information should be used when filing the claim form.

Letters of denial will be sent to the provider and beneficiary. Letters to the provider will indicate the reason for denial.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s) to the UM/QIO.

Requests for administrative review by DOM must be made within 30 days from the final UM/QIO reconsideration decision letter.

## Billing for Non-Approved Services

Medicaid beneficiaries in hospitals may be billed for inpatient care occurring after they have received written notification of Medicaid non-approval of hospital services. If the notice is issued prior to the beneficiary's admission, the beneficiary is liable for full payment if he/she enters the hospital. If the notice is issued at or after admission, the beneficiary is responsible for payment for all services provided after receipt of the notice.

In the event that the Utilization Management and Quality Improvement Organization's retrospective review determines that the admission did not meet the inpatient care criteria, Medicaid beneficiaries may not be billed for inpatient stay.

Medicaid beneficiaries may not be billed for inpatient care because the hospital failed to obtain the required admission and continued stay authorization.

This does not apply to Medicaid non-covered services such as geropsychiatric services.

## Maternity-Related Services

Effective July 1, 2005, hospitals must report all admissions for deliveries, both vaginal and Cesarean section, to the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO). The hospitals must report the admissions in accordance with the requirements provided by the UM/QIO. A Treatment Authorization Number (TAN) will be issued to cover up to two (2) days for a vaginal delivery or up to four (4) days for a Cesarean section delivery.

For admissions exceeding two (2) days for a vaginal delivery or four (4) days for a Cesarean section delivery, providers must submit a request for a continued stay in accordance with the policies and procedures provided by the UM/QIO.

Newborns delivered in the hospital are covered under the mother's Medicaid number for the purposes of certification and billing. When the mother is discharged and the newborn remains hospitalized, the mother's discharge date becomes the newborn's beginning date for authorization purposes.

When seeking authorization for newborns, the infant's full name must be given to the UM/QIO. Baby Boy or Baby Girl is not acceptable. The infant's name given to the UM/QIO must be the same as the name on the claim submitted to Medicaid.

Newborns delivered outside the hospital, those remaining after the mother is discharged, and those

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~~admitted to accommodations other than well baby must be authorized by the UM/QIO separately from the mother.~~

~~Newborns delivered to mothers eligible for Medicare are covered under the mother's Medicare claim and do not require certification unless they meet the requirements as noted above.~~

~~Unless the newborn infant needs medically necessary specialized care, no additional billings by the hospital for inpatient services are allowed while the mother is an inpatient.~~

### **Prior Authorization Process**

When prior authorization is required, the hospital must contact the UM/QIO as identified in Section 1.10 of the Medicaid Policy Manual. Letters of approval will be sent to the provider indicating the approved treatment authorization number (TAN) and dates of service. This information should be used when filing the claim form. Certification acknowledges only the medical necessity and appropriateness of the setting and does not guarantee payment.

Requests for reconsideration of a denied request may be sent with additional information that justifies the need for requested service(s) to the UM/QIO within thirty (30) calendar days of the date of the denial notice, or in certain situations, three (3) business days for an expedited reconsideration.

The UM/QIO will notify all involved parties in writing of the reconsideration review determination. If the denial is upheld, the notice will contain information for the facility and the physician that the Medicaid beneficiary has the right to request an Administrative Appeal to DOM within 15 calendar days of the notification date and directions for how the beneficiary may request such an appeal.

Medicaid beneficiaries in hospitals may be billed for inpatient care occurring after they have received written notification of Medicaid non-approval of hospital services. If the notice is issued prior to the beneficiary's admission, the beneficiary is liable for full payment if he/she enters the hospital. If the notice is issued at or after admission, the beneficiary is responsible for payment for all services provided after receipt of the notice.

In the event that the UM/QIO's retrospective review determines that the admission did not meet the inpatient care criteria, Medicaid beneficiaries may not be billed for inpatient stay.

Medicaid beneficiaries may not be billed for inpatient care because the hospital failed to obtain the required admission and continued stay authorization.

This does not apply to Medicaid non-covered services such as Geriatric Psychiatric services.

### **Authorization for Admission**

- A person is considered an inpatient if formally admitted as an inpatient with the expectation that he/she will remain at least overnight and occupy a bed even though it later develops that he/she can be discharged or is transferred to another hospital and does not actually use a hospital bed overnight.
- When a beneficiary is initially admitted to outpatient status, and subsequently is converted to inpatient status, the date of admission is defined as the date the beneficiary is converted to inpatient status as documented by the physician's order.

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Emergent and urgent admissions must be authorized on the next working day after admission.

- In general, all admissions require prior authorization, with two exceptions.
  - Vaginal deliveries with length of stay less than three days and cesarean deliveries with length of stay less than five days do not require prior authorization. These admissions must, however, be reported to the UM/QIO in accordance with the requirements set by the UM/QIO.
  - Normal newborn admissions require neither authorization nor reporting to the UM/QIO. A normal newborn is defined as a patient born within the treating hospital with length of stay less than five days. In situations where the length of stay for a normal newborn is five days or more because the mother has not been discharged (baby is considered "boarding in"), the hospital must contact the UM/QIO.
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- When length of stay exceeds two days (vaginal delivery) or four days (cesarean delivery or normal newborn) the hospital must contact the UM/QIO for authorization of continued inpatient care.
- For admissions of newborns delivered outside the hospital, the admitting hospital must contact the UM/QIO for authorization of inpatient care.
- When seeking authorization for newborns, the infant's full name must be given to the UM/QIO. Baby Boy or Baby Girl is not acceptable. The infant's name given to the UM/QIO must be the same as the name on the claim submitted to Medicaid.

#### Authorization for Length of Stay

In general, authorization of length of stay is not required. The exception is that authorization for additional days is required if the stay extends past the Long Stay Threshold value that will be specified by DOM.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 11/01/01 01/01/07
Section: Hospital Inpatient	Section: 25.26	
Subject: Split Billing	Pages: 1	
	Cross Reference: 23 Hour Observation Services 26.14	

Mississippi Medicaid requires split billing for Medicaid and crossover claims in the following situations:

- If dates of service span Medicaid's fiscal year, July 1 through June 30. For example, if the patient is admitted on June 29 and discharged July 3, the hospital must submit a bill for June 29—30 and a separate bill for July 1—3.
- If dates of service span the hospital's fiscal year. For example, if the hospital's fiscal year begins October 1 and a patient is admitted on September 29 and discharged October 3, the hospital must submit a bill for September 29—30 and a separate bill for October 1—3.

For Mississippi Medicaid, the 23-hour observation stay is not considered a split bill. See 23 Hour Observation Services, Section 26.14, in this manual for detailed billing instructions.

Mississippi Medicaid will accept interim billing for a single hospital admission in the following situations:

- When the initial claim is billed to Medicare and Medicare exhausted days are billed to Medicaid.
- When the length of stay exceeds the DRG Interim Claim Threshold as determined by DDM. In this instance, an interim claim will be paid an interim per diem rate for the initial bill times the number of days. At the time the patient is discharged, the hospital must replace or void the interim claim or claims and submit a single admit-through-discharge claim for which payment will be calculated under the inpatient prospective payment method.

Providers are no longer required to do split billing for inpatient stays that span the Medicaid fiscal year.

For Mississippi Medicaid, the 23-hour observation stay is not considered a split bill. See 23 Hour Observation Services, Section 26.14, in the Medicaid policy manual for detailed billing instructions.

<b>Division of Medicaid</b>	<b>New:</b>	<b>Date:</b>
<b>State of Mississippi</b>	<b>Revised: X</b>	<b>Date: -08/01/06</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.27</b>	
<b>Subject: <del>Inpatient Per Diem Rates</del></b>	<b>Pages: -1- 4</b>	
<b><del>Prospective Payment Method</del></b>	<b>Cross Reference:</b>	
	<b>Transplants 28.15</b>	

~~DOM uses a prospective method of reimbursement. This method does not allow for retrospective adjustments. The rates are determined from cost reports and appropriate audits or by other means approved by the grantor agency. Per diem rates will be determined annually with an effective date of October 1.~~

~~In no case may the reimbursement rate for services provided under this manual exceed an individual facility's customary charge to the general public for such services in the aggregate except for those public facilities rendering such services free of charge or at a nominal charge.~~

~~DOM may adjust prospective rates pursuant to changes in federal and/or state laws or regulations. All plan changes must be approved by the federal grantor agency. Based on allowable and reasonable costs or by other means approved by the grantor agency, DOM establishes a per diem reimbursement rate for each facility. Each facility is furnished a copy of the Attachment 4.10-A of the State Plan that is also known as the Hospital State Plan.~~

~~In cases of a change of ownership, the first cost report filed by the new owner will be used to set the per diem reimbursement rate retroactive to the date of the change of ownership.~~

~~Providers should refer to Section 28.15 for information on transplant reimbursement.~~

### **Applicability**

Except as specified in this paragraph, the inpatient prospective payment method applies to all inpatient stays for all acute care services in general, rehabilitation and freestanding psychiatric hospitals. It does not apply to stays where Medicare is the primary payer or to "swing bed" stays. It also does not apply to Indian Health Services hospitals, where payment is made on a per-diem basis per federal law.

### **Primacy of Medicaid Policy**

Many features of the Medicaid inpatient prospective payment method are patterned after the similar method used by the Medicare program. When specific details of the payment method differ between Medicaid and Medicare, then the Medicaid policy prevails.

### **Diagnosis Related Groups**

Under the inpatient prospective payment method, the most important step in determining payment is the classification of each patient's case into a diagnosis related group (DRG). The case is assigned to a DRG based on information contained in each beneficiary's claim including diagnoses and procedures performed as well as age, sex, and discharge status. The information is processed through the All Patient Refined Diagnosis Related Group (APR-DRG) grouper program that assigns a single APR-DRG to each stay.

### **APR-DRG Relative Weights**

For each APR-DRG, a relative weight factor is assigned. The relative weight is applied to determine the APR-DRG Base Payment that will be paid for each admit-through-discharge case regardless of the specific services provided or the exact number of days of care. The APR-DRG relative weight reflects the

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typical resources consumed per case.

APR-DRG relative weights are reviewed and updated periodically by DOM. The weights are adapted from national databases of millions of inpatient stays and then "re-centered" so that the average Mississippi Medicaid stay in a base year has a weight of 1.00. When DOM determines that adjustments to relative weights for specific APR-DRG's are appropriate to meet Medicaid policy goals, a "policy adjustor" may be applied to increase or decrease these relative weights.

### **APR-DRG Base Price**

The same base price is used for all stays in all hospitals. The base price will be reviewed and updated periodically.

### **APR-DRG Base Payment**

For each stay, the APR-DRG Base Payment equals the APR-DRG Relative Weight multiplied by the APR-DRG Base Price. Additional payments and adjustments are made as described below.

### **Cost Outlier Payments**

It is recognized that there are occasional cases that are extraordinarily costly in relation to other cases within the same APR-DRG because of the severity of the illness or complicating conditions. These variations are recognized by the cost outlier payment that is an add-on payment for expenses that are not predictable by the diagnosis, procedures performed, and other statistical data captured by the APR-DRG grouper.

The additional payment for a cost outlier is determined by calculating the hospital's estimated loss. The estimated loss is determined by multiplying the billed charge by the hospital's cost-to-charge ratio minus the APR-DRG base payment. If the estimated loss is greater than the APR-DRG cost outlier threshold established by the DOM, then the cost outlier payment equals the estimated loss times the APR-DRG Marginal Cost Percentage.

Stays assigned to mental health APR-DRGs are not eligible for cost outlier payments.

### **Day Outlier Payments**

Only stays assigned to mental health APR-DRGs are eligible for day outlier payments, in recognition of the fact that exceptionally expensive mental health stays tend to be characterized by long lengths of stay.

A stay becomes a day outlier stay when it exceeds the DRG Long Stay Threshold determined by the DOM. In addition to the APR-DRG base payment, all certified days after the threshold are paid per diem at the APR-DRG Day Outlier Statewide Amount.

### **Transfer Payment Adjustment**

The transfer payment adjustment applies (1) when a patient is transferred to another hospital or to a distinct unit within the same hospital, other than a federal health care facility, for Mississippi Medicaid covered acute care services, or (2) when a patient is discharged against medical advice.

Transfers to another hospital or distinct unit are distinguished by the following discharge status codes to

indicate the transfer status:

<u>Discharge Status Code</u>	<u>Description</u>	<u>Discharging Hospital / Transfer Payment Adjustment</u>	<u>Receiving Hospital</u>
<u>02</u>	<u>Discharged/Transferred to a Short-Term General Hospital for Inpatient Care</u>	<u>The transfer payment adjustment will apply to the discharging / transferring hospital if the beneficiary is hospitalized less than the national average length of stay.</u>	<u>APR/DRG benefits will be paid to hospitals enrolled as a Mississippi Medicaid hospital provider for only covered acute care services as certified by the UM/QIO.</u>
<u>07</u>	<u>Left Against Medical Advice or Discontinued Care</u>	<u>The transfer payment adjustment will apply to the admitting hospital if the beneficiary is hospitalized less than the national average length of stay.</u>	<u>NA</u>
<u>62</u>	<u>Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) Including Rehabilitation Distinct Part Units of a Hospital</u>	<u>The transfer payment adjustment will apply to the discharging / transferring hospital if the beneficiary is hospitalized less than the national average length of stay.</u>  <u>Beneficiary must be discharged and readmitted to a separate inpatient rehab hospital or distinct rehab unit within the same hospital.</u>	<u>APR/DRG benefits will be paid to hospitals enrolled as a Mississippi Medicaid hospital provider for only acute care covered services as certified by the UM/QIO.</u>
<u>63</u>	<u>Discharged/Transferred to a Medicare Certified Long Term Care Hospital (LTCH)</u>	<u>The transfer payment adjustment will apply to the discharging / transferring hospital if the beneficiary is hospitalized less than the national average length of stay.</u>	<u>APR/DRG benefits will be paid to hospitals enrolled as a Mississippi Medicaid hospital provider for only covered acute care services as certified by the UM/QIO.</u>
<u>65</u>	<u>Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital</u>	<u>The transfer payment adjustment will apply to the discharging / transferring hospital if the beneficiary is hospitalized less than the national average length of stay.</u>	<u>APR/DRG benefits will be paid to hospitals enrolled as a Mississippi Medicaid hospital provider for only covered acute care services as certified by the UM/QIO.</u>  <u>Mississippi Medicaid does not reimburse for inpatient</u>

		<u>Beneficiary must be discharged and readmitted to a psychiatric hospital or psychiatric distinct part unit of a hospital.</u>	<u>geriatric psychiatric services.</u> <u>Mississippi Medicaid does not reimburse for rehabilitation services for substance abuse.</u>  <u>The APR/DRG methodology is not applicable to a Psychiatric Residential Treatment Facility (PRTF).</u>
<u>66</u>	<u>Discharges/Transfers to a Critical Care Hospital (Effective January 1, 2006)</u>	<u>The transfer payment adjustment will apply to the discharging / transferring hospital if the beneficiary is hospitalized less than the national average length of stay.</u>	<u>APR/DRG benefits will be paid to hospitals enrolled as a Mississippi Medicaid hospital provider only for acute care services as certified by the UM/QIO.</u>

The transfer payment adjustment does not apply when a patient is moved to a "scatter bed" within the same hospital. The transfer payment adjustment does not apply when a patient is discharged to a post-acute setting such as a skilled nursing facility.

The policy on payment for transfer cases is based on the rationale that, in general, the transferring hospital provides a limited amount of treatment in comparison to the final discharging hospital. The receiving hospital is not impacted by the transfer payment policy unless it transfers the patient to another hospital.

In the transfer payment adjustment, payment is calculated as if the beneficiary was not a transfer, and then payment is adjusted. The payment is divided by the nationwide average length of stay for that APR-DRG to arrive at a per diem amount. The per diem amount is then multiplied by the actual length of stay, except that payment is doubled for the first day. If the transfer payment adjustment results in a payment amount greater than the amount without the adjustment, then the transfer payment adjustment is disregarded.

### **Prorated Payment Adjustment**

Situations sometimes arise either when a beneficiary has coverage for fewer days than the length of stay, because the individual exhausts his or her annual inpatient benefit or because the individual has Medicaid eligibility for only some days of the stay.

In the prorated payment adjustment, payment is calculated as if the beneficiary had coverage for all days, and then payment is prorated. The payment is divided by the nationwide average length of stay for that APR-DRG to arrive at a per diem amount. The per diem amount is then multiplied by the actual length of stay, except that payment is doubled for the first day. If the prorated payment adjustment results in a payment amount greater than the amount without the adjustment, the prorated payment adjustment is disregarded.

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### **APR-DRG Payment, Allowed Amount and Paid Amount**

The APR-DRG Payment equals the APR-DRG Base Payment, plus outlier payments if applicable, with transfer and/or prorated adjustments made if applicable. The allowed amount equals the APR-DRG Payment plus applicable add-on payments such as medical education or DSH. The Paid Amount equals the Allowed Amount minus co-payments or third-party.

### **Three-day-Window**

Diagnostic services provided to a beneficiary by the admitting hospital or by an entity wholly owned or operated by the hospital or under arrangements with the hospital within three days prior to the date of admission are deemed to be inpatient and are included in the inpatient APR-DRG payment. Additionally, non-diagnostic services provided during the three-day window are deemed inpatient if the principal diagnosis billed is identical for both the inpatient and outpatient services. When a patient is admitted through the emergency room, the ER services are not payable separately.

Exclusion to the three-day window is dialysis services.

### **Graduate Medical Education**

Graduate Medical Education costs will be paid to qualified hospitals as defined by DOM.

Division of Medicaid State of Mississippi Provider Policy Manual	New: Revised: X Current:	Date: Date: 11/01/04 01/01/07
Section: Hospital Inpatient	Section: 25.28	
Subject: Cost Reports	Pages: 2	
	Cross Reference:	

Each hospital participating in the Mississippi Medicaid Hospital Program will submit a Uniform Cost Report to DOM. The year-end adopted for the purpose of this program shall be the same as for Title XVIII (Medicare). Any deviations to the reporting year such as a Medicare approved change in fiscal year end should be submitted to DOM in writing. ~~In cases where there is a change in the fiscal year end, the most recent cost report will be used to determine the prospective rate.~~ All other filing requirements shall be the same as those for Title XVIII unless specifically outlined in the Hospital State Plan.

Each facility must submit a cost report on or before the last day of the fifth (5<sup>th</sup>) month following the close of the reporting period. Should the due date fall on a weekend, a State of Mississippi holiday, or a federal holiday, the due date shall be the first business day following such weekend or holiday. DOM will not grant extensions for cost reports, ~~except extensions~~ unless granted by Medicare, beyond the five (5) months given to complete the cost report.

Cost reports that are either postmarked or hand delivered after the due date will be assessed a penalty in the amount of \$50.00 per day the cost report is delinquent.

A hospital that does not file a cost report within six (6) calendar months after the close of its reporting period may be subject to cancellation of its Provider Agreement at the discretion of DOM.

All cost reports are required to detail ~~their~~ the entire reporting year period making appropriate adjustments as required by the Hospital State Plan for determination of allowable costs. The cost report must be prepared ~~in accordance with~~ using the methods of reimbursement and cost findings in accordance with Title XVIII (Medicare) Principles of Reimbursement, except where further interpreted by the Provider Reimbursement Manual, Section 24.14 or as modified by the State Plan.

All cost reports must be filed with DOM. When it is determined, upon initial review for completeness, that a cost report has been submitted without all the required information, providers will be allowed a specific period of time to submit the requested information without incurring a penalty for a delinquent cost report. For cost reports submitted by the due date, ten (10) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If there is no response to the request, an additional five (5) working days will be allowed for submission of the requested information. ~~Hospitals that do not respond will not be allowed to submit the information at a later date.~~

For cost reports submitted after the due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If there is no response to the request, an additional five (5) working days will be allowed for submission of the requested information. ~~Hospitals that do not respond will not be allowed to submit the information at a later date.~~

Cost reports that are incomplete will be subject to the penalty provisions for delinquent cost reports until the required additional information is submitted. All cost reports must be filed using the appropriate Medicare/Medicaid forms and instructions. The cost reports and the related information should be mailed to:

Division of Medicaid  
Attn: Bureau of Reimbursement

<b>Division of Medicaid</b>	<b>New:</b>	<b>Date:</b>
<b>State of Mississippi</b>	<b>Revised: X</b>	<b>Date: 11/01/05</b>
<b>Provider Policy Manual</b>	<b>Current:</b>	<b>01/01/07</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.32</b>	
<b>Subject: Newborn Hearing Screens</b>	<b>Pages: 2</b>	
	<b>Cross Reference: Inpatient</b>	
	<b>Prospective Payment Method 25.27</b>	
	<b>Maintenance of Records 7.03</b>	

Hearing screens should be conducted on all newborns to detect hearing impairment and to alleviate the adverse effects of hearing loss on speech and language development, cognitive and social development, and academic performance. Screening consists of a test or battery of tests administered to determine the need for in-depth diagnostic evaluation. Screens may be performed using auditory brainstem response, evoked otoacoustic emissions, or other appropriate technology approved by the United States Food and Drug Administration.

Newborn hearing screens should be administered as follows:

- The initial screen should be conducted during the same hospital admission as the infant's birth.
- If the infant fails the initial screen, a second screen should be administered prior to hospital discharge.
- If the infant fails the second screen, a third screen should be scheduled in a setting other than inpatient hospital.
- If the infant fails the third screen, the infant should be referred to a physician or audiologist for diagnostic testing.

Hearing screens are a covered service for all Medicaid eligible infants. No prior authorization is required.

### **Billing Requirements for Newborn Screens**

**Inpatient Hospital** - Hearing screens performed during the same hospital admission as the infant's birth must be billed on the ~~UB92 claim form~~ institutional claim (e.g., UB-92, UB-04, X12N 837I) using revenue code 470. Reimbursement is included ~~in the hospital's per diem rate~~ within the payment calculated under the inpatient prospective payment method described in Section 25.27.

**Outpatient Hospital** - Hearing screens performed after discharge in the outpatient department of a hospital must be billed on the ~~UB92 claim form~~ institutional claim using revenue code 470. The hospital receives an outpatient reimbursement rate.

**Non-Hospital Based Providers** - Hearing screens performed in the office of a physician or audiologist must be billed on the CMS-1500 professional claim form (e.g., CMS-1500 or X12N 837P) using HCPCS V5008. Physicians and audiologists receive fee for service reimbursement.

### **Billing Requirements for Diagnostic Testing**

Infants failing three (3) hearing screens should be referred to a physician or audiologist for in-depth diagnostic testing.

**Inpatient/Outpatient Hospital** - Diagnostic testing performed in the hospital (inpatient or outpatient) must be billed on the ~~UB92 inpatient claim form~~ using revenue code 471. Reimbursement for inpatient services is included in the hospital's ~~per diem rate~~ prospective payment rate. Reimbursement for outpatient services is made according to the hospital's outpatient reimbursement rate.

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**Non-Hospital Based Providers** - Diagnostic testing performed in the office of a physician or audiologist must be billed on the CMS-1500 claim form using the appropriate code(s). Physicians and audiologists receive fee for service reimbursement.

### **Documentation**

In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and paid for by Medicaid, the provider must maintain legible and auditable records that will substantiate the claim submitted to Medicaid. At a minimum, medical record documentation must contain the following on each beneficiary:

- Date(s) of service;
- Demographic information (Example: name, Medicaid number, date of birth, etc.);
- Reason for testing (i.e., universal or hearing loss risk factors);
- Interpretation/Results of testing;
- Recommendations;
- Follow-up, if applicable;
- Parent's or guardian's refusal of services, if applicable; **AND**
- Provider's signature or initials.

Records must be maintained a minimum of five (5) years to comply with all state and federal regulations and laws. DOM, the UM/QIO, and/or the fiscal agent have the authority to request patient records at any time to conduct a random review and/or documentation of services billed by the provider.

Refer to Section 7.0, General Policy for additional documentation information.

**MISSISSIPPI DEPARTMENT OF HUMAN SERVICES COUNTY DIRECTORY 2000**

<u>COUNTY</u>	<u>PHONE/FAX</u>
ADAMS	(601) 442-1481 FAX: 446-6111
ALCORN	(601) 286-2206 FAX: 286-7724
AMITE	(601) 667-8066 FAX: 667-8086
ATTALA	(662) 289-4881 FAX: 289-1675
BENTON	(662) 224-6246 FAX: 224-6308
EAST BOLIVAR	(662) 843-8311 FAX: 846-0990
WEST BOLIVAR	(662) 759-3552 FAX: 759-3465
GALHOUN	(662) 412-3169 FAX: 412-3176
GARROLL	(662) 464-5961 FAX: 464-5342
——— Carrollton Branch	(662) 237-9235
CHICKASAW	(662) 466-3724 FAX: 466-2874
——— Okolona Branch	(662) 447-5611
CHOCTAW	(662) 285-6269 FAX: 285-3962
CLAIBORNE	(601) 437-5116 FAX: 437-4162
CLARKE	(601) 776-3766 FAX: 776-6111
GLAY	(662) 494-3843 FAX: 494-1747

<u>COUNTY</u>	<u>PHONE/FAX</u>
COAHOMA	(662) 624-3060 FAX: 624-3038
CORLAH	(601) 894-2321 FAX: 894-3429
COVINGTON	(601) 765-6585 FAX: 765-5004
DESOTO	(662) 429-4461 FAX: 449-1407
FORREST	(601) 554-4350 FAX: 554-4367
FRANKLIN	(601) 384-5837 FAX: 384-3734
GEORGE	(601) 947-7551 FAX: 947-7406
GREENE	(601) 394-2362 FAX: 394-4069
GRENADA	(662) 226-1974 FAX: 227-2866
HANCOCK	(228) 467-4566 FAX: 467-7530
HARRISON	
——— Gulfport Branch	(228) 897-5600 FAX: 897-5780
——— Biloxi Branch	(228) 374-8105 FAX: 435-8423
HINDS	(601) 362-9892 FAX: 364-7615
——— Bolton Branch	(601) 866-4454 FAX: 866-2290
HOLMES	(662) 834-1221 FAX: 834-3869
HUMPHREYS	(662) 247-2323 FAX: 247-3908
ISSAQUENA	(662) 873-6296 FAX: 873-9399
ITAWAMBA	(662) 862-9781 FAX: 862-4888

<u>COUNTY</u>	<u>PHONE/FAX</u>
JACKSON	(228) 769-3275 FAX: 769-3366
JASPER	(601) 764-2151 FAX: 764-4869
JEFFERSON	(601) 786-3571 FAX: 786-6006
JEFFERSON-DAVIS	(601) 792-4206 FAX: 792-2472
JONES	(601) 426-1200 FAX: 426-1207
KEMPER	(601) 743-5826 FAX: 743-9166
LAFAYETTE	(662) 234-1864 FAX: 236-0228
LAMAR	(601) 794-1050 FAX: 794-1066
LAUDERDALE	(601) 483-3337 FAX: 484-5117
LAWRENCE	(601) 587-7632 FAX: 587-3008
LEAKE	(601) 267-3242 FAX: 267-8884
LEE	(662) 841-9050 FAX: 680-5790
LEFLORE	(662) 453-3124 FAX: 455-7972
LINCOLN	(601) 833-3311 FAX: 835-0244
LOWNDES	(662) 328-5278 FAX: 245-4624
MADISON	(601) 859-1276 FAX: 859-0324
MARION	(601) 736-6383 FAX: 736-6384
MARSHALL	(662) 252-4514 FAX: 252-1114

<u>COUNTY</u>	<u>PHONE/FAX</u>
MONROE	(662) 369-2872 FAX: 369-7039
— Amery Branch	(662) 256-0311 FAX: 256-7836
MONTGOMERY	(662) 283-2922 FAX: 283-4006
NESHOBA	(601) 656-1461 FAX: 656-6515
NEWTON	(601) 635-2746 FAX: 635-4014
NOXUBEE	(662) 726-5884 FAX: 726-2936
OKTIBBEHA	(662) 323-1566 FAX: 324-0003
PANOLA	(662) 487-2006 FAX: 487-2002
PEARL RIVER	(601) 795-4607 FAX: 795-3039
— Picayune Branch	(601) 798-7847 FAX: 798-4449
PERRY	(601) 964-8374 FAX: 964-8376
PIKE	(601) 684-7100 FAX: 249-4632
PONTOTOC	(662) 489-4182 FAX: 489-3918
PRENTISS	(662) 728-3118 FAX: 728-3119
QUITMAN	(662) 326-8021 FAX: 326-7904
RANKIN	(601) 825-7210 FAX: 825-7216
SCOTT	(601) 469-2771 FAX: 469-3118
SHARKEY	(662) 873-2666 FAX: 873-6136

<u>COUNTY</u>	<u>PHONE/FAX</u>
SIMPSON	(601) 847-3815 FAX: 847-3864
SMITH	(601) 782-4505 FAX: 782-4918
STONE	(601) 928-4006 FAX: 928-6460
SUNFLOWER	(662) 887-2051 FAX: 887-7056
—— North Branch (Ruleville):	(662) 756-4301 FAX: 756-4222
TALLAHATCHIE	(662) 647-5571 FAX: 647-2204
TATE	(662) 562-4478 FAX: 562-7222
TIPPAH	(662) 837-9307 FAX: 837-1192
TISHOMINGO	(662) 423-7020 FAX: 423-7067
TUNICA	(662) 363-1771 FAX: 363-9792
UNION	(662) 534-1984 FAX: 534-1988
WALTHALL	(601) 876-2191 FAX: 876-3262
WARREN	(601) 636-1512 FAX: 638-0108
WASHINGTON	(662) 335-6051 FAX: 334-3554
WAYNE	(601) 735-4758 FAX: 735-6260
WEBSTER	(662) 258-4771 FAX: 258-9700
WILKINSON	(601) 888-4311 FAX: 888-4371
WINSTON	(662) 773-8034 FAX: 773-8839

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**COUNTY**

**PHONE/FAX**

YALOBUSHA

(662) 473-2951  
FAX: 473-6027

YAZOO

(662) 746-5821  
FAX: 746-2141

Section 25.33 is RESERVED FOR FUTURE USE.