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. Refer to Provider Policy Manual Section 3.03 for Beneficiary Retroactive Eligibility policy.

REQUEST FOR NEWBORN HEALTH BENEFITS IDENTIFICATION NUMBER

Regional Medicaid Office _____ Hospital _____

Fax _____

I. RELEASE OF INFORMATION – TO BE COMPLETED BY PARENT

I, _____ (Name of Parent), hereby authorize _____ (Name of Hospital)

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

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

_____

Mother's Medicaid ID# _____ Mother's SSN _____

Were parental rights terminated? No ❑ Yes ❑

Hospital Representative Furnishing Information _____

Telephone # _____ 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 _____

Division of Medicaid **State of Mississippi** **Provider Policy Manual**	**New:** **Revised: X** **Current:**	**Date:** **Date: 10/01/09**
Section: Hospital Inpatient **Subject: Documentation Requirements**	**Section: 25.15** **Pages: 2** **Cross Reference: Maintenance of Records 7.03**	

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.

DOM, the 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.

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 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.

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 UB-04 claim form using revenue code 470. Reimbursement is included in the hospital's per diem rate.

Outpatient Hospital - Hearing screens performed after discharge in the outpatient department of a hospital must be billed on the UB-04 claim form 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 claim form 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 UB-04 claim form using revenue code 471. Reimbursement for inpatient services is included in the hospital's per diem rate. Reimbursement for outpatient services is made according to the hospital's outpatient reimbursement rate.

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.