1. The Division of Medicaid will reimburse a chiropractor's manual manipulation of the spine to correct a subluxation, if the x-ray demonstrates that a subluxation exists and if the subluxation has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment.

   Reimbursement will not exceed seven hundred dollars ($700.00) per fiscal year (July 1 - June 30) per beneficiary. Providers participating in the Medicaid program agree to accept, as payment in full, the amounts paid by the agency plus any co-payment required by the program to be paid by the beneficiary. The provider may not deny services to any eligible individual based on the individual's inability to pay the co-payment.

2. The CMS-1500 Claim Form must be completed and submitted to the fiscal agent.

3. ~~The following~~ CPT-4 codes 98940, 98941, and 98942 are the only codes that will be acceptable and covered under the Mississippi Medicaid program. A chiropractor should use only **one** procedure code that encompasses the entire treatment for any given day.

~~CODE~~	~~DESCRIPTION~~
~~98940~~	~~Chiropractic manipulative treatment (CMT); spinal, one to two regions~~
~~98941~~	~~Chiropractic manipulative treatment (CMT); spinal, three to four regions~~
~~98942~~	~~Chiropractic manipulative treatment (CMT); spinal, five regions~~

4. Necessity of treatment must be documented by use of the proper ICD-9 CM diagnosis coding to report (1) treatment area, (2) symptoms associated with subluxation, and (3) complicating factors.

   A. The **primary** diagnosis must always identify the treatment area by use of one of the following ICD-9 CM codes:

CODE	DESCRIPTION
739.0	Head Region (Occipital)
739.1	Cervical Region (C1-7)
739.2	Thoracic Region (T1-12 or D1-12)
739.3	Lumbar Region (L1-5)
739.4	Sacral Region (S1)
739.5	Pelvic Region (I-L or I-R)

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In addition, the exact level of subluxation must be indicated in the narrative form. An example of correct reporting is 739.1 (C-2).

B. The **second** ICD-9 CM diagnosis code must report the symptoms associated with subluxation. A description of the symptoms pertinent to the diagnosis of subluxation should bear a direct relationship to the level of subluxation.

C. The **third** ICD-9 CM diagnosis must document complication factors.

5. Under law, an x-ray is required to demonstrate that a subluxation exists. Three exceptions which will be acceptable under Medicaid are: (1) patient is pregnant, (2) patient suspects pregnancy which has not yet been confirmed, and (3) child is age 12 years or less.

   The date of x-ray or the exceptions must be properly documented in the medical record. This includes, but is not limited to, the date of x-ray (must be within 12 months of the date of service), expected date of delivery (if patient is pregnant), date of last menstrual period (if pregnancy is suspected but not confirmed), and child's birth date (when the child is 12 years of age or less, x-ray is at the discretion of the chiropractor).

Chiropractors may bill ~~the following codes~~ 72010, 72040, 72070, 72080, and 72100 for x-rays. Payments for these codes along with payments for 98940, 98941 and 98942 will be applied toward the $700.00 per year per beneficiary limit.

~~CPT CODE~~	~~DESCRIPTION~~
~~72010~~	~~Radiologic examination, spine, entire; survey study, anteroposterior and lateral~~
~~72040~~	~~Radiologic examination, spine, cervical; anteroposterior and lateral~~
~~72070~~	~~Radiologic examination, spine, thoracic; anteroposterior and lateral~~
~~72080~~	~~Radiologic examination, spine, thoracolumbar; anteroposterior and lateral~~
~~72100~~	~~Radiologic examination, spine, lumbosacral; anteroposterior and lateral~~

If the chiropractor is billing for only the professional component, the modifier 26 should be used following the code. If the chiropractor is billing for only the technical component, modifier TC should be used following the code.

Codes 72040, 72070, 72080, or 72100 may not be billed with 72010 for the same date of service.

6. The place of service code for office is eleven (11).

7. The claims will be processed up to the maximum of $700.00 without pending for medical records, The utilization review process will be on a post payment basis.

8. If the patient is less than 21 years of age, the chiropractor may apply for or request extended services through the EPSDT (Early Periodic Screening Diagnostic Treatment) Program after the $700.00 maximum is utilized, if the patient's condition is such that additional spinal manipulation services for the correction of subluxation is required. To apply for or request the expanded services through EPSDT, the chiropractor must submit a completed Plan of Care/Prior Authorization Form and all office records/x-ray reports since the initiation of treatment, to the Division of Medicaid for review. This should be done as soon as the chiropractor identifies that

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expanded services will be required in order for continuity of care to be uninterrupted. **Prior approval is required for these services.**

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For beneficiaries covered under Medicare and Mississippi Medicaid (dual eligibles), chiropractic providers may not file a claim with Medicaid for the manipulation of the spine procedures not covered by Medicare. Mississippi Medicaid benefits are not available for services that do not satisfy Medicare's medical necessity criteria.

For beneficiaries covered under Medicare and Medicaid (dual eligibles), chiropractic providers may file a claim with Medicaid for 72010, 72040, 72070, 72080, and 72100 ~~the following x-ray services~~ not covered by Medicare.

~~CPT CODE~~	~~DESCRIPTION~~
~~72010~~	~~Radiologic examination, spine, entire; survey study, anteroposterior and lateral~~
~~72040~~	~~Radiologic examination, spine, cervical; anteroposterior and lateral~~
~~72070~~	~~Radiologic examination, spine, thoracic; anteroposterior and lateral~~
~~72080~~	~~Radiologic examination, spine, thoracolumbar; anteroposterior and lateral~~
~~72100~~	~~Radiologic examination, spine, lumbosacral; anteroposterior and lateral~~

To file a claim with Medicaid for chiropractic services, the chiropractic provider must first file a claim with Medicare and obtain an Explanation of Benefits (EOB). The chiropractic provider may then submit a hard copy of the CMS-1500 using Medicaid specific codes and a copy of the Medicare EOB. This must be mailed to:

ACS
P.O. Box 23076
Jackson, MS 39225-3076

The six (6) month timely filing limitation for filing crossover claims is applicable with no exceptions.

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Claims billed by an ASC for CPT code 41899 do not require prior approval. Providers must submit these claims with documentation verifying coverage criteria were met and justifying the necessity of performing the procedure in an ASC rather than the dentist's office. The claims will be reviewed by the fiscal agent's Medical Review Unit to determine appropriateness to pay.

At least one of the following criteria must be met:

1) The patient's age is six (6) years old or less.

2) The patient has a physically or mentally compromising condition.

3) The patient is extremely uncooperative due to acute situational anxiety, attention deficit disorder, or emotional disorder.

4) The patient has extensive orofacial and dental trauma.

All services performed in an ASC must meet the requirements stated in section 13.03, Covered Services, of this manual, and all other state and federal regulations and guidelines.

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Eye examinations/ refractions must be performed by an Optometrist or Ophthalmologist.

~~Examination for Determination of Refractive State~~ Refraction

Refractive errors generally occur in otherwise healthy eyes. The shape of the eye does not refract light properly causing the visual image to be blurred. There are four basic types of refractive errors: Myopia, Hyperopia, Astigmatism, and Presbyopia.

DOM covers examination for refractive errors as follows:

Benefit	Limitations	Prior Authorization
CPT 92015 ~~Exam for Determination of Refractive State (CPT 92015)~~	**Beneficiary Age 21 And Over:** Allowed one (1) refraction every five (5) years.	NO
	Beneficiary Under Age 21: Allowed up to two (2) refractions every fiscal year without prior authorization. Additional refractions may be allowed with prior authorization based on medical necessity. The second refraction in the fiscal year should be billed only if it was medically necessary for the procedure to be performed again. It is expected that there are instances where eyeglasses, lenses, and/or contact lenses can be replaced due to breakage or loss without another refraction.	NO

Fiscal year is defined as July 1 through June 30.

Providers must use CPT 92015 to bill for examinations performed to determine refractive state.

Medically Necessary Diagnostic Services

Medically necessary diagnostic services that aid in the evaluation, diagnosis, and or treatment of ocular disease or injury are covered for all beneficiaries regardless of age. **Coverage is limited to the eye examination.** The exam counts toward the twelve (12) office visits. Providers must bill using the appropriate CPT codes for new and established patients.

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Screening Services for Children Under Age Twenty-One

Vision screening services for beneficiaries under age twenty-one (21) are available through the Early and Periodic, Diagnosis and Treatment (EPSDT) Program. Refer to Section 73 of the Provider Policy Manual.

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Lacrimal punctum plugs are devices inserted into the lacrimal punctum, an opening in the lacrimal canaliculi located on the upper and lower eyelid margin near the nose, to obstruct tear drainage and thereby preserve the natural tears. Insertion of punctum plugs is considered a surgical procedure and should be considered only for the treatment of moderately severe to severe dry eye syndrome when more conservative treatments, such as artificial tears and adjustment to medications that may contribute to dry eye symptoms, have proven to be ineffective.

There are two (2) types of punctum plugs:

- Temporary (dissolvable) Collagen Plugs

  Collagen plugs are used for diagnostic purposes. If these plugs are inserted on an individual with dry eye syndrome, the individual will experience relief during the period of occlusion. If the individual does not have dry eye syndrome, the individual will experience epiphora (excessive tearing). Collagen plugs usually dissolve within four (4) to ten (10) days of insertion.

- Semi-Permanent Silicone Plugs

  Silicone plugs are non-dissolvable. They are considered semi-permanent because they can fall out or may need to be replaced.

Coverage Criteria

DOM will cover medically necessary insertion of collagen and silicone punctum plugs when there is a documented diagnosis consistent with moderately severe to severe dry eye syndrome. Prior authorization is not required. **A signed treatment/surgical consent form, specific to plug insertion, is required.**

Exclusions

DOM will **not** cover the following:

- Insertion of silicone plugs **less** than ten (10) days following collagen plug insertion
- Insertion of plugs for the treatment of any condition other than dry eye syndrome (example: contact lens intolerance, refractive correction, glaucoma, sinus maladies)
- Repetitive use of temporary (dissolvable collagen) plugs when semi-permanent or permanent treatment is indicated
- Repetitive use of semi-permanent (non-dissolvable silicone) plugs when there is an absence of documentation to support the need (example: plug fell out) and/or when permanent treatment is indicated

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- Separate reimbursement for the plug itself (i.e., the cost of the plug is included in payment for the insertion)

Billing

DOM will reimburse for up to two (2) collagen or silicone plugs per office visit. In most cases, placement of one (1) plug in each lower punctum will be sufficient to alleviate symptoms. Up to two (2) additional plugs may be performed for a total of four (4), but documentation must reflect that the additional plugs were medically necessary. There must be a period of not less than ten (10) days between the insertion of collagen plugs and the insertion of silicone plugs.

~~CPT code 68761 is the correct code for "*closure of the lacrimal punctum; by plug, each.*" The word "each" refers to each plug that is placed in a punctum.~~ Providers may bill CPT 68761 for each plug that is placed into a punctum. Modifiers should be applied as follows:

- E1 – Upper lid, left eye
- E2 – Lower lid, left eye
- E3 - Upper lid, right eye
- E4 - Lower lid, right eye

~~CPT 68761 does not differentiate between silicone and collagen plugs. The same code is used for either type. Consequently,~~ There may be both a diagnostic (temporary, dissolvable collagen) occlusion of the puncta and a therapeutic (semi-permanent, non-dissolvable silicone) occlusion done on the same beneficiary within a short amount of time. DOM will **not** reimburse if the length of time between insertion of collagen and silicone plugs is less than ten (10) days.

The billing/reimbursement policies for multiple surgery and bilateral procedures policies apply. Refer to Sections 52.03 and 52.04 of this manual.

DOM will not reimburse for an evaluation and management (E&M) CPT code billed with CPT 68761 on the same date of service.

Documentation

In addition to the general documentation and medical necessity requirements found in sections 7.03 and 29.03 of this manual, providers must document the following for insertion of lacrimal punctum plugs:

- Symptoms – dryness, scratchiness, itching, redness, burning, foreign body sensation
- Comorbidities that might be related to ophthalmic disease
- Diagnostic tests and results – visual acuity exam, slit lamp exam, tear film break-up time (BUT), Schirmer's tear test, staining procedures etc.
- Signed treatment/surgical consent form(s) specific to insertion of plug insertion
- Specific treatments rendered, including conservative treatments, and the results.

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- Operative report(s)

Documentation must be sufficient to support the type (temporary/semi-permanent) and the number of plugs inserted. Documentation must reflect a minimum of ten (10) days between insertion of temporary plugs and the insertion of semi-permanent plugs.

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Pharmacy Disease Management services are those provided by specially credentialed pharmacists for Medicaid beneficiaries with specific chronic disease states of diabetes, asthma, hyperlipidemia, anti-coagulation therapy, or other disease states as defined by the Mississippi State Board of Pharmacy. It is a patient-centered concept integrating the pharmacist into the health care team with shared responsibility for disease management and therapeutic outcomes. The process provides cost-effective, high-quality health care for patients referred by their physicians. The referring physician requests pharmacy disease management services from any credentialed participating pharmacist in Mississippi. With the appropriate transfer of pharmacy care records, including a written referral from the physician to the pharmacist, the referral is considered documented. All laboratory test results must be included because the pharmacist is not allowed reimbursement for laboratory procedures. In order to be cost-effective for the Medicaid program, the pharmacy disease management services performed by the pharmacist cannot duplicate those provided by the physician.

The pharmacist must be knowledgeable about pharmaceutical products and the design of therapeutic approaches that are safe, effective, and cost-efficient for patient outcomes. The pharmacist is to evaluate the patient and consults with the physician concerning the suggested/prescribed drug therapy. After the drug therapy review with the physician, the pharmacist counsels the patient concerning such topics as compliance and provides the patient with educational and informational materials specific to the disease or drug. The pharmacist is to function in an educational capacity to ensure the patient understanding and compliance with the proper usage of all drugs prescribed by the physician. The involvement with the patient and the education of the patient about lifestyle changes and improved drug regimen compliance are aimed at improving overall health and the reduction and/or avoidance of costly hospitalizations and emergency care.

The State Pharmacy Act in its Disease Management Protocol requires communication with the referring physician. Pharmacy disease management services follow a protocol developed between the pharmacist and patient's physician.

The primary components of this service are as follows:

- Patient evaluation
- Compliance assessment
- Drug therapy review
- Disease state management according to clinical practice guidelines
- Patient/caregiver education

The pharmacist must provide a separate, distinct area conducive to privacy for a seated, face-to-face consultation with and education of the beneficiary (ex: a partitioned booth or a private room).

A copy of the pharmacy care records, including the documentation for services, is shared with the patient's physician and remains on file in the pharmacist's facility available for audit by DOM.

To provide this service, a pharmacist must be a registered pharmacist with the Mississippi Board of Pharmacy who has completed a disease specific certification program approved by the Mississippi Board of Pharmacy practicing within the scope as defined by state law. All disease management pharmacists must renew their specific disease management certifications as required by the Board of Pharmacy.

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The pharmacist applying to become a pharmacy disease management provider must complete an enrollment packet and Mississippi Medicaid provider agreement form. The enrollment application must include proof of Mississippi Pharmacist registration and National Institute for Standards in Pharmacists Credentialing certification in the pharmacy disease management areas for which reimbursement is sought. Mississippi Medicaid Pharmacy Disease Management Provider Agreements will not be initiated or maintained with any pharmacist whose place of business is physically located more than 30 miles from the borders of Mississippi. Only the individual pharmacist may enroll as a pharmacy disease management provider. Businesses such as partnerships and corporations do not qualify. Enrollment packets can be obtained from Medicaid's fiscal agent.

Pharmacists credentialed to provide pharmacy disease management services may receive reimbursement using only the individual Medicaid pharmacy disease management provider number. Pharmacies with multiple individual pharmacy disease management providers may apply for group management services under one group provider number. Each pharmacist in the group is still required to have his/her own individual provider number. This number must be entered on the claim in the servicing provider field. An enrollment packet must be completed and a group number must be received for the servicing location.

Pharmacy disease management services are reimbursed on a per encounter basis. When billing for an encounter, pharmacy disease management providers must use the CPT code 99402. ~~(Preventive Medicine Counseling, approximately 30 minutes).~~ An encounter must be at least 15 minutes and average 30 minutes. The number of encounters will be limited to twelve (12) per beneficiary per fiscal year.

Pharmacy disease management services are not covered for beneficiaries in long term care facilities or for beneficiaries receiving home health services. Neither OBRA-mandated counseling nor JCAHO-mandated institutional discharge counseling qualify as a pharmacy disease management service. Pharmacy disease management services are available to the parent or other responsible guardian when the beneficiary is a minor and/or mentally challenged and living at home. All claims will be filed to the beneficiary's Medicaid ID number. The pharmacist provider must personally render all pharmacy disease management services billed to Medicaid. A relief pharmacist employed for pharmacy disease management services must bill Mississippi Medicaid using his/her own individual Medicaid provider number.

Pharmacy Disease Management Documentation Requirements

In addition to the documentation requirements applicable to all pharmacy providers, pharmacy disease management providers must maintain additional documentation.

The disease management pharmacist must maintain at his/her place of business proof of current certification for the specific disease state for which reimbursement is sought. A pharmaceutical care record (patient record) must be maintained on each individual beneficiary for whom services are billed. These records must be retained and maintained in a manner conducive to audit, e.g., in alphabetical order, for a minimum of five years. At a minimum, the following documents must be maintained, in date order, within each individual beneficiary's pharmaceutical care record:

- A referral from the beneficiary's physician/nurse practitioner;
- A copy of the protocol in accordance with the National Clinical Practice Guidelines authorizing pharmacy disease management of the beneficiary;
- Documentation of all oral and written communication with the beneficiary's physician/nurse practitioner;

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- Copies of all laboratory data provided;
- All pharmacist notes, including progress reports, pertaining to the care of the beneficiary.

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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.

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Ultrasonography is a procedure used to visualize the shape of various tissues and organs in the body through the use of intermittent low-intensity sound waves directed into the tissues. Ultrasonography during pregnancy is used to assess the umbilical cord, placenta, fetal movements, internal organs, and the status of the fetus during pregnancy.

For fetal biophysical profile the physician may bill one unit for each fetus being evaluated in cases of multiple gestations.

Ultrasounds During Hospitalization

When a pregnant beneficiary is hospitalized as an inpatient and a physician submits a claim for both a visit ~~(subsequent hospital care, per day)~~ and for review of an ultrasound, on the same date of service, reimbursement will only be provided for the visit as the review of diagnostic studies is inclusive in the CPT Evaluation and Management code for the subsequent hospital visits. ~~The CPT manual states, "All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status, (ex: changes in history, physical condition and response to management) since the last assessment by the physician."~~

A physician's interpretation of the results of an ultrasound will be reimbursed as a separate service if prepared with a separate distinctly identifiable signed written report using the appropriate CPT code with the modifier 26 which indicates professional component only. This clarification of policy is effective for dates of services on and after July 1, 2001.

Routine Ultrasounds

Mississippi Medicaid benefits will **NOT** be provided for routine sonography during pregnancy. The DOM recognizes the use of ultrasonography for sex determination and to assess fetal well being, in the absence of signs or symptoms, as **NOT** medically necessary and will not be a covered service. Although a routine ultrasound is customarily performed during pregnancy, there is no scientific evidence to support the medical necessity of this practice in the absence of the criteria listed below.

Medically Necessary Ultrasounds

The DOM recognizes the use of ultrasonography during pregnancy as appropriate and consistent with good medical practice when **all** of the following criteria are met:

1. The ultrasound is consistent with the beneficiary's signs, symptoms, and/or condition.
2. Diagnosis cannot be made through clinical evaluation of the beneficiary's signs and symptoms.
3. The results of the ultrasound can reasonably be expected to influence the beneficiary's treatment plan.

Clinical conditions for which reimbursement will be allowed include the following (this list is not all inclusive and other conditions that meet all of the above medical necessity criteria may also be reimbursed):

1. To assess a discrepancy in clinical estimates of fetal size versus fetal age

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2. To assess vaginal bleeding of undetermined etiology during pregnancy

3. To confirm suspected abnormal fetal position, e.g., breech or transverse

4. To confirm suspected multiple gestation based on detection of more than one (1) fetal heartbeat pattern, or fundal height larger than expected for dates, and/or prior use of fertility drugs

5. To confirm suspected hydatidiform mole on the basis of clinical signs of hypertension, proteinuria, and/or the presence of ovarian cysts felt on pelvic examination, or failure to detect fetal heart tones with a Doppler ultrasound device after twelve (12) weeks

6. To confirm suspected fetal death

7. To confirm suspected uterine abnormality

8. To confirm suspected polyhydramnios or oligohydramnios

9. To assess placental localization associated with abnormal bleeding

10. To estimate fetal weight and/or presentation in premature rupture of membranes and/or non-vertex presentation and/or premature labor

11. To provide guidance for other testing, such as amniocentesis, chorionic villus sampling, and cordocentesis

12. History of cervical cerclage incompetence and/or cervical cerclage placement

13. To evaluate and/or re-evaluate, serially if necessary, a pelvic mass that has been detected clinically

14. To localize intrauterine contraceptive device

15. To assess suspected abruptio placentae

16. As an adjunct to external version from breech to vertex presentation

17. To assess fetus following abnormal serum alpha-fetoprotein (AFP) value for clinical gestational age

18. To provide an estimation of gestational age for beneficiaries with clinically significant uncertain delivery dates, or verification of dates no later than end of second trimester

19. To observe intrapartum events (e.g., version or extraction of second twin, manual removal of placenta, etc.)

20. History of previous congenital anomaly or as follow up observation of identified fetal anomaly

21. To provide serial evaluation of fetal growth in multiple gestation. The most relevant clinical information is obtained when serial exams are done at least three (3) weeks apart, beginning no earlier than 16 to 18 weeks gestation

22. To evaluate fetal condition in late registrants for prenatal care

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23. To evaluate fetal growth when the beneficiary has an identified etiology for uteroplacental insufficiency (chronic systemic diseases such as diabetes, chronic hypertension, cardiac disease, renal disease, pregnancy induced hypertension, etc.)

24. To confirm suspected ectopic pregnancy or when pregnancy occurs after tuboplasty or prior ectopic gestation

25. Habitual abortion

26. To evaluate post-maturity

27. To evaluate neural tube defect

28. To evaluate fetal arrhythmias

29. To perform follow-up evaluation of placenta location for identified placenta previa

30. To evaluate macrosomia or IUGR

Documentation

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 records available to representatives of DOM or Office of 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 to Medicaid beneficiaries and those paid for by Medicaid, physicians must maintain auditable records that will substantiate the claim submitted to Medicaid.

For Medicaid reimbursement for any type of obstetrical ultrasound, documentation in the beneficiary's record must justify the medical necessity. This documentation includes, but is not limited to, at least one (1) of the following:

- Fetal measurements as applicable to gestational age (such as crown-rump length, biparietal diameter (BPD), occipitofrontal diameter/head circumference (OFD or HC), abdominal circumference (AC), femur length (FL), etc.)
- Fetal position
- Placental location
- Amniotic fluid assessment or measurement
- Suspected or known fetal anomalies or conditions
- Fetal measurements relative to determination of suspected or known intrauterine growth retardation (IUGR)
- Presence of multiple gestations

A picture displaying at least one (1) or more of these findings would be acceptable. Documentation should reflect the type of obstetrical ultrasound actually performed, limited or complete. A limited

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obstetrical ultrasound can be performed in an office setting and may include any or all of the following studies:

- Pregnancy determination
- Viability of heartbeat
- Fetal age or growth rate
- Fetal position
- Placental localization
- Multiple gestations

The complete obstetrical ultrasound involves a more complex study that requires sophisticated equipment and a more experienced ultrasonographer. The complete studies can also be performed in an office setting with appropriate equipment and training of the physician. The beneficiary's record should contain information that verifies the performance of a complete ultrasound. This information should include **all** of the following:

- Fetal measurements
- Fetal position
- Placental location
- Amniotic fluid assessment or measurement

The biophysical profile combines ultrasound with a non-stress test to check fetal well being. The five fetal parameters checked are as follows:

1. Reactive non-stress test
2. Fetal breathing movement
3. Fetal body movement
4. Fetal muscle tone
5. Amniotic fluid volume

Documentation must include a report on each of the above five (5) parameters.

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

DOM and/or 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 will be deducted from any future payments that are deemed to be due to the provider.

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A 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 provider as a provider of Medicaid services.

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Effective for dates of services on and after October 1, 2003, the Division of Medicaid will reimburse delivering physicians for maternity services provided to eligible Medicaid beneficiaries according to the following guidelines:

(1) Providers may not bill Local codes W6140, W6130, and W6150 that were used to reimburse antepartum visits. In accordance with HIPAA regulations these codes are no longer valid and should not be billed.

(2) Providers must utilize CPT evaluation and management codes 99201 through 99215, 59425 and 59426 to bill antepartum visits as listed below:

(a) Providers must bill CPT Codes in the 99201 through 99215 range for antepartum visits 1 or 2 or 3. Bill one code per visit.
(b) Providers must bill CPT code 59425 for antepartum visits 4, 5, or 6. Bill one code per visit.
(c) Providers must bill CPT code 59426 for antepartum visits 7 or over. Bill one code per visit.

The number of the antepartum visit is defined as the number of visit (s) the beneficiary has made to one Physician.

For example, a beneficiary goes to Dr. A for antepartum visits 1,2, 3,and 4 and then goes to Dr. B. , Dr. A will bill the appropriate evaluation and management code for each antepartum visit 1, 2,or 3, and CPT code 59425 for antepartum visit 4. Dr. B will then bill for his antepartum visit starting with antepartum visit number (one) 1. If Dr. B is in the same group he **will not** start over using the appropriate E&M code but will continue with the antepartum code for visit 4.

For dates of service on and after October 1, 2003, CPT codes 59410, 59515, 59614 and 59622 will be used to reimburse deliveries and postpartum care. The postpartum care is inclusive of both hospital and office visits following vaginal and cesarean section deliveries.

CPT codes 59409, 59514, 59612, 59620 can be used for reimbursement of delivery only. This code should be used by a physician who only completes the delivery, and provides no other service.

DOM will accept CPT code 59430 which is used to reimburse the postpartum hospital and office visits. It should be used only when the physician did not perform the delivery and is billing only for both inpatient and office postpartum visits. In most instances DOM expects this code to be used in rare circumstances. This code cannot be utilized by physicians in the same group as the delivery physician.

Physicians may bill the appropriate CPT E & M code for reimbursement when the postpartum office visit is the only service provided by the physician.

Modifier TH identifies "obstetrical treatment/services, prenatal and postpartum" and must be reported with each code for antepartum visits and deliveries and postpartum care. The Division of Medicaid will utilize this modifier to track data and to bypass the physician visit limitation of twelve (12) visits per fiscal year. Antepartum office visits will not be subject to this limitation.

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The following chart is being provided as a reference for providers:

CPT CODE	DESCRIPTION	BILLING INSTRUCTIONS
99201-TH	~~Office or other outpatient visit for the evaluation and management of a new patient which requires these three components:~~ ~~(1) A problem focused history,~~ ~~(2) A problem focused examination, and/or~~ ~~(3) Straightforward medical decision-making.~~	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99202-TH	~~Office or other outpatient visit for the evaluation and management of a new patient, which requires these three components:~~ ~~(1) an expanded problem focused history,~~ ~~(2) an expanded problem focused examination, and~~ ~~(3) straightforward medical decision-making.~~	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99203-TH	~~Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:~~ ~~(1) A detailed history,~~ ~~(2) A detailed examination, and/or~~ ~~(3) Medical decision making of low complexity.~~	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99204-TH	~~Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:~~ ~~(1) A comprehensive history,~~ ~~(2) A comprehensive examination, and/or~~ ~~(3) Medical decision making of moderate complexity.~~	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99205-TH	~~Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components:~~ ~~(1) A comprehensive history,~~ ~~(2) A comprehensive examination, and/or~~ ~~(3) Medical decision making of high complexity.~~	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99211-TH	~~Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.~~	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.

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99212-TH	~~Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:~~ ~~(1) A problem focused history,~~ ~~(2) A problem focused examination, and/or~~ ~~(3) Straightforward medical decision-making.~~	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99213-TH	~~Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:~~ ~~(1) An expanded problem focused history,~~ ~~(2) An expanded problem focused examination, and/or~~ ~~(3) Medical decision making of low complexity.~~	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99214-TH	~~Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:~~ ~~(1) A detailed history,~~ ~~(2) A detailed examination, and/or~~ ~~(3) Medical decision making of moderate complexity.~~	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
99215-TH	~~Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:~~ ~~(1) A comprehensive history,~~ ~~(2) A comprehensive examination, and/or~~ ~~(3) Medical decision making of high complexity.~~	Bill for dates of service on and after 10/01/03 only if appropriate to bill antepartum visit 1 or 2 or 3. Bill one code per visit.
59400-TH	~~Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care~~	Closed
59409-TH	~~Vaginal delivery only (with or without episiotomy and/or forceps)~~	Bill for dates of service on and after 10/01/03 only if physician performs the delivery with no other services.
59410-TH	~~Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care~~	Bill for dates of service on and after 10/01/03.
59425-TH	~~Antepartum care only: 4 - 6 visits~~	Bill for dates of service on and after 10/01/03 for each antepartum visit 4, 5 or 6.
59426-TH	~~Antepartum care only: 7 or more visits~~	Bill for dates of service on and after 10/01/03 for each antepartum visit 7 and over.

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59430-TH	~~Postpartum care only (separate procedure)~~	Bill for dates of service on and after 10/01/03 when the physician did not perform the delivery and is billing only for inpatient and office postpartum visits.
59510-TH	~~Routine obstetric care including antepartum care, cesarean delivery, and postpartum care~~	Closed.
59514-TH	~~Cesarean delivery only~~	Bill for dates of service on and after 10/01/03 only if physician performs the delivery with no other services.
59515-TH	~~Cesarean delivery only; including postpartum care~~	Bill for dates of service on and after 10/01/03.
59610-TH	~~Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery~~	Closed.
59612-TH	~~Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps~~	Bill for dates of service on and after 10/01/03 only if physician performs the delivery with no other services.
59614-TH	~~Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care~~	Bill for dates of service on and after 10/01/03.
59618-TH	~~Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery~~	Closed.
59620-TH	~~Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery~~	Bill for dates of service on and after 10/01/03 only if physician performs the delivery with no other services.
59622-TH	~~Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care~~	Bill for dates of service on and after 10/01/03.

Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), and Mississippi State Department of Health (MSDH) will be reimbursed according to the reimbursement methodology that applies to the clinic, with encounter rate or fee for service, whichever is applicable.

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Injections

For injections into a foot joint or bursae, the provider may bill CPT codes 20600 or 20605. Do not use CPT code 64450 for injections into a foot joint or bursae.

For injections into a tendon sheath, ligament, neuroma, or ganglion cyst, the provider may bill the CPT code 20550. Do not use CPT code 64450 for injections into a tendon sheath, ligament, neuroma, or ganglion cyst.

For Medicaid covered injectable drugs, the provider must use the HCPCS procedure codes. The amount entered in the "charge" column must reflect the physician's actual cost for the drug.

Local infiltration, digital blocks, or topical anesthesia are covered in the allowance for the specific surgical procedure. The provider must not bill separately for these type anesthesia procedures.

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CPT Codes 97010 through 97139 identify Physical Therapy Modalities. Only those that are medically necessary and appropriate for treatment of a foot condition are covered. Pre-certification is required by the Division of Medicaid for certain physical therapy procedures. Providers must pre-certify the therapy services through the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid. All procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid.

Services performed for conditions "above the ankle" are not covered unless within the scope of the provider's licensure.

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When medically necessary, radiology services are provided in an office setting. It is understood that the provider is providing both the technical and professional components of the service. Medicaid will reimburse the provider the appropriate Medicaid fee or the submitted charge, whichever is the lesser. Reimbursement will be a fee that includes both technical and professional components.

If the provider does not provide the technical component and is billing for the professional component only, **MODIFIER -26 MUST BE USED TO IDENTIFY THE PROFESSIONAL COMPONENT.**

Example: 73620-26

The provider must file for the radiology service under the appropriate CPT code. The most common codes used for diagnostic radiology for the foot are within the CPT code range 73600 through 73660.

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Avulsion/Excision of Nail/Nail Matrix for Ingrown Toenails

The big toe is the most commonly affected toenail and the 5th or the little toe hardly ever develops ingrown toenails. Others may be affected but the condition is not common. Ingrown toenails can be associated with, and may actually cause, Daronvchia of the toenails.

Recommended treatments may vary from trimming of the toenail, partial or complete avulsion or wedge excision of the skin of the nail fold, to excision of nail and nail matrix, partial or complete for permanent removal.

~~The following~~ CPT codes 11730 and 11732 apply to surgical treatment of ingrown toenails~~:~~ .

~~11730 Avulsion of nail plate, partial or complete, simple; single~~

~~11732 Each additional nail plate (List separately in addition to code for primary procedure)~~

An avulsion can consist of total nail plate removal or merely removing the ingrown strip of nail. The nail bed and matrix are not involved. A new nail will grow back.

Before treatment of an ingrown or embedded toenail (onychocryptosis) can be approved by Medicaid, localized pathology of the soft tissue surrounding the nail must demonstrate that it is severe enough to require professional intervention. Documentation in the records of the use of a local anesthetic is required for codes 11730 and 11732 such as local infiltration or nerve blocks with Lidocaine, Marcaine, etc. This documentation should include the name of the medicine, route of administration, and dosage.

Avulsing small chips after trimming of the thickened/elongated nails that may have been painful under the diagnosis of ingrown toenail is considered equivalent to routine foot care and is not covered under Medicaid.

~~11750 Excision of nail and nail matrix, partial or complete, (e.g., ingrown or deformed nail) for permanent removal;~~

CPT 11750 represents all excisions of all borders carried out on a nail. The provider must report a single 11750 and must not report a separate 11750 for each border. Partial/total matrixectomies can be performed either with surgical or chemocautery techniques with anesthesia.

Avulsion/Excision of Nail/Nail Matrix for Other Conditions

For other conditions of the nails, such as trauma or conditions other than ingrown toenails, requiring avulsion or excision of the nails, apply the same guidelines indicated above for 11730, 11732 and 11750.

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CPT codes 11000 through 11044 are considered to be part of the essential treatment of the surgery codes and are not separate procedures, unless gross contamination requires prolonged cleansing.

For ulcers, the provider must document in the medical record the size, appearance, location, and any treatments or procedures on the foot.

Ulcer care is limited to ten (10) days of care after which a treatment plan must be submitted with the claim. It is important that the type of treatment be specifically identified. The treatment plan should include information such as the cause and stage of the ulcer, location and size, specific treatment, frequency of treatment, expected results, etc.

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Fungal disease of the toenails is a comparatively benign condition but difficult to eradicate due to the high recurrence rate. The only definitive treatment is a prolonged course of oral antifungal drugs or initial debridement followed by a meticulous program of self-care by the patient with topical exfoliates and antifungal drugs.

Surgical debridement of mycotic nails with a manual or electric grinder method is considered routine foot care and not covered unless both of the following conditions exist:

1. There must be clinical evidence of mycosis of the toenail contained in the physician's medical record.

AND

2. The medical records must document the severity of the condition and there must be compelling medical evidence documenting either:

   A. Ambulatory patient: The patient has marked limitation of ambulation, pain, or secondary infection resulting from the thickening and dystrophy of the infected toenail plate;

   OR

   B. Non-ambulatory patient: The patient suffers from pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

If both of the conditions are met, the provider may file for surgical debridement of mycotic nails.

Surgical debridement of nails must be reported ~~under the following codes:~~ with CPT code 11720 or 11721.

~~11720 Debridement of nail(s) by any method(s); one to five~~

~~11721 Six or more~~

Medical necessity must be documented by the use of the proper ICD-9 code on the CMS-1500 claim form.

Mycotic nails submitted without additional substantiating medical evidence will result in the service being denied as routine foot care. The provider must also document the complicating condition of the nail which limits ambulation.

The Mississippi Medicaid program limits benefits for debridement of mycotic nails to once every 60 days. The provider must not submit claims for services above and beyond this limit. It is the responsibility of the provider to monitor the frequency for submitting claims for this service.

The provider must not routinely file for visits with ~~the debridement of nails~~ CPT codes 11720 and/or 11721. If the provider provides additional treatment that justifies use of a visit, the provider may bill the appropriate level of service. If the provider bills for the debridement of nail code with a visit, the provider is responsible for maintaining appropriate documentation in the medical record that justifies the charge for a visit.

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The provider must be aware of the limitations of Medicaid benefits for visits and should work with the beneficiary in utilizing their visits wisely.

The provider may not bill a routine foot care code with the debridement of nails code for the same nail on the same date of service. Routine foot care may not be substituted for debridement of nails codes when the once every 60 day limit has been utilized.

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The Mississippi Medicaid allowance for hammertoe surgery (CPT 28285) includes all procedures necessary to correct the toe.

~~28285 Correction, hammertoe (e.g., interphalangeal fusion, partial or total phangectomy)~~

Procedures such as CPT 28153 or 28160 should not be billed in conjunction with hammertoe surgery performed on the same date of service.

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In the case of toes, paronychia is associated with deformed toenails or ingrown toenails, combined with poorly fitted shoes. The first toenail is the most commonly affected member. Depending upon the duration for which the causative problem has been present, the paronychia may result in:

Stage A: Inflammation and pain only

Stage B: Infection, pain and abscess formation

During the stage of inflammation, most of the authorities agree that a mere change of shoes and/or cutting/debridement of the offending nail or inserting lamb's wool between the nail fold and the affected nail are the treatments of choice. When infection has set in, the common treatment is partial avulsion of the offending toenail, or excision of the ingrown wing with removal of the pus.

If evaluation and advice for proper care of feet (e.g., placement of lamb's wool, suggestions for changing shoes, etc.) is the only service rendered for management of Stage A of paronychia, the appropriate E & M code should be claimed.

For management of Stage B of paronychia in which incision and drainage (I&D) is performed, use CPT codes 10060 and 10061.

~~10060 Incision and drainage of abscess (eg, carbuncle suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single~~

~~10061 Complicated or multiple~~

If partial or complete avulsion was required, use CPT codes 11730 through 11732.

For the surgical treatment of paronychia, the provider may use either the I & D code or the avulsion codes. Both procedures cannot be claimed on the same nail.

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Definitive treatment of viral or plantar warts is not considered routine foot care. As a result, services provided for the definitive treatment of viral or plantar warts on the foot are covered to the same extent as services provided for the treatment of warts located elsewhere on the body.

~~Definitive treatment of viral or plantar warts may be identified by the following CPT code examples:~~

1. ~~Destruction with cautery and curettement (e.g., CPT codes 11055, 11056, and 11057 or 17000, 17003, and 17004 or 11200 and 11201)~~

2. ~~Excision of Lesion (e.g., CPT codes 11420 - 11426)~~

The specific ICD-9 code for viral warts is 078.10 and for plantar warts 078.19. Providers must not label other conditions like calluses, etc. under this diagnosis code.

If warts are removed by cautery, the medical records should show the number of lesions removed, their location and size, and the type of cautery used, i.e., chemical or electric.

If warts are removed by surgical excision, a brief operative note and pathology report on the excised tissue should include the number of specimens, their location and size, and any/all microscopic findings should be included in the medical record.

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A nerve block is the injection of a local anesthetic or a neurolytic agent into or near a peripheral nerve, a sympathetic nerve plexus, or a local pain-sensitive trigger point. Nerve blocks may be used intraoperatively to prevent pain of the procedure, diagnostically to ascertain cause of pain, or therapeutically to relieve chronic pain.

Local infiltration, metacarpal/metatarsal/digital blocks, or topical anesthesia are covered in the allowance for specific surgical procedures. The provider must not bill separately for these anesthesia procedures.

For direct injections into joints, etc. do not use CPT code 64450. ~~This code is used only for diagnostic or therapeutic injection into a peripheral nerve.~~

When a nerve block is billed alone and is for the treatment of a non-surgical condition, such as Morton's neuroma, it should be billed under the appropriate injection/block code.

Documentation for Nerve Block Injections

Physician documentation in the patient's medical record must support the reasonableness and medical necessity of the service and must indicate that more conservative therapy has not been effective. The documentation must adequately describe the patient's clinical state (history, physical findings, laboratory and other tests), e.g., identification of the problem including diagnosis, precipitating events, quantity and quality of pain, test results, response to previous therapy, the procedure performed including the area injected, the substance(s) injected and the dosage of the substance (s).

All coverage criteria must be clearly documented in the patient's medical record and made available to the Division of Medicaid, and its authorized agents, upon request.

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Visits by beneficiaries are limited to a total of twelve (12) per fiscal year in any office, nursing facility, or clinic setting. When a beneficiary has exhausted these visits, payment will no longer be made for services provided in the office or clinic setting. The encounter codes subject to the limitation are:

99201 – 99205

99212 - 99215

The procedure code 99211 ~~(Established Patient - Minimal Office Medical Service)~~ may be used to allow a visit to the center when a patient is seen for follow-up care, such as blood pressure check, injections, etc. This procedure does not accumulate toward the 12-visit limit. However, once the limit has been reached, the procedure is no longer reimbursable.

All service limits of the Mississippi Medicaid Program are applicable.

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Encounter Services

An encounter rate is paid for services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers. A clinic's encounter rate covers the beneficiary's visit to the clinic, including all services and supplies (drugs and biologicals that are not usually self-administered by the patient) furnished as an incident to a professional service. When services, supplies, drugs or biologicals are included in the clinic's encounter rates, the clinic cannot send the beneficiary to another provider that will bill Medicaid for the covered service, supply, drug or biological.

When a beneficiary sees more than one provider type (medical, dental, optometry, or mental health) at the same Federally Qualified Health Center on the same date the clinic will be reimbursed as charted below. The exception is a case in which the patient, subsequent to the first encounter, suffers illness or injury requiring an additional diagnosis or treatment. For example, a beneficiary has a visit in the morning with a physician for a medical illness and has to return in the afternoon due to an injury which resulted in a lacerated hand. In such case, a medical encounter is paid for both visits. If the beneficiary receives an EPSDT screening only or an EPSDT screening with a medical visit on the same date, only one (1) medical encounter is paid to the clinic.

Provider Type	Encounter Allowance
Physician, Nurse Practitioner, and/or Nurse Midwife	Only one medical encounter per day
Dentist	Only one dental encounter per day
Optometrist	Only one optometry encounter per day
Clinical Psychologist and/or Clinical Social Worker	Only one mental health encounter per day

Examples are:

Service	Maximum Daily Encounter Allowance
EPSDT screening in the morning, child later becomes ill on same date, and is examined by physician in the afternoon	Two (2) medical encounters
EPSDT screening and covered dental services on same date	One (1) medical encounter and one (1) dental encounter
Physician examination for an illness and EPSDT screening during same visit	One (1) medical encounter
Exam by optometrist and dentist on same date	One(1) optometry encounter and one (1) dental encounter
Physician visit and clinical psychologist visit on same date	One (1) medical encounter and one (1) mental health encounter

The maximum number of encounters that can be paid to the same FQHC for the same beneficiary on the same date is four (4). The only exception is an instance where the beneficiary has visits with all the core service types on the same day, and in addition, the beneficiary has to return to the clinic for an injury or illness requiring additional diagnosis or treatment. In such case, the FQHC may be paid another medical encounter.

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For an encounter to be paid, the service must be covered in accordance with the policies of the Mississippi Medicaid Program. All limitations and exclusions are applicable. If a service requires prior authorization, the provider must satisfy the prior authorization requirements.

Claims submitted to the fiscal agent for the same beneficiary will pay one encounter rate for each date of service and provider type (medical, dental, optometry, or mental health). A separate claim must be submitted for medical, dental, optometry, or mental health services. Claims for visits requiring additional diagnosis or treatment must be submitted to the fiscal agent as a paper claim with documentation justifying the medical necessity for the additional visit on the same date. Providers may refer to the DOM website at www.medicaid.ms.gov for a list of procedure codes which generate an encounter.

Approved Places of Service

All ambulatory services performed by a center employee or contractual worker for a center patient must be billed as an FQHC claim. This includes services provided in the clinic, skilled nursing facility, nursing facility or other institution used as a patient's home. The program will pay for visits at multiple places of service for a patient. Services performed for clinic patients by an outside lab should be billed to Medicaid by the outside lab. However, claims for in-house lab services must be billed with the same place of service code as the visit. In-house lab services are covered in the visit payment.

Federally Qualified Health Center services are not covered when performed in a hospital (inpatient or outpatient). Physicians employed by an FQHC and rendering services to Medicaid beneficiaries in a hospital will be reimbursed fee-for-service. The physician must obtain a provider number from the Division of Medicaid and bill using the CMS 1500 claim form.

Fee-for-Service

No services (same or separate dates) will be reimbursed to the clinic at a fee-for-service rate. All ambulatory services provided in an FQHC will be reimbursed an encounter rate on a per visit basis.

Drugs Purchased Under a Veterans Health Care Act Discount Agreement

The Veterans Health Care Act applies to FQHCs and allows centers to sign an agreement with drug companies to purchase drugs at a discount price. DOM is not allowed to file for a rebate on drugs purchased through a discount agreement. Therefore, all drugs purchased at a discounted price through a discount agreement must not be billed through the Medicaid pharmacy program. The reimbursement for the drugs is included in the encounter rate.

Obstetrical

Providers must utilize CPT evaluation and management codes 99201 through 99215, 59425, and 59426 to bill antepartum visits as listed below.

(A) Providers must bill CPT codes in the 99201 through 99215 range for antepartum visits 1 or 2 or 3. Bill one code per visit.

(B) Providers must bill CPT code 59425 for antepartum visits 4, 5, or 6. Bill one code per visit.

(C) Providers must bill CPT code 59426 for antepartum visits 7 or over. Bill one code per visit.

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The number of the antepartum visit is defined as to the number of the visit(s) that the beneficiary has been to one physician. For example, if a beneficiary goes to Dr. A for antepartum visit 1, 2, 3, and 4 and then moves and goes to Dr. B, Dr. A will bill the appropriate evaluation and management code for each antepartum visit 1 or 2 or 3 and CPT code 59425 for antepartum visit 4. Dr. B will then bill for his antepartum visits starting with antepartum visit number 1, etc.

CPT codes 59410, 59515, 59614, and 59622 will be used to reimburse deliveries and postpartum care as of October 1, 2003. The postpartum care is inclusive of both hospital and office visits following vaginal or cesarean section deliveries. These codes must be billed under the individual physician's Medicaid provider number.

CPT code 59430 can only be billed for postpartum visits when the clinic physician was not the delivering physician.

Modifier TH identifies "obstetrical treatment/services, prenatal and postpartum" and must be reported with each code for antepartum visits and deliveries and postpartum care. The Division of Medicaid will utilize this modifier to track data and to bypass the physician visit limitation of twelve (12). Antepartum office visits will not be applied to this limitation.

Refer to the Maternity, Section 38.0 of the Provider Policy Manual.

Subdermal Implant

The cost of a subdermal implant is included in the encounter rate and will not be reimbursed separately.

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Visits by beneficiaries are limited to a total of twelve (12) per fiscal year in any office, nursing facility, or clinic setting. When a beneficiary has exhausted these visits, payment will no longer be made for services provided in the office or clinic setting. The encounter codes subject to the limitation are:

99201 – 99205

99212 - 99215

The procedure code 99211 ~~(Established Patient - Minimal Office Medical Service)~~ may be used to allow a visit to the center when a patient is seen for follow-up care, such as blood pressure check, injections, etc. This procedure does not accumulate toward the 12-visit limit. However, once the limit has been reached, the procedure is no longer reimbursable.

All service limits of the Mississippi Medicaid Program are applicable.

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Encounter Services

An encounter rate is paid for services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers. A clinic's encounter rate covers the beneficiary's visit to the clinic, including all services, supplies (drugs and biologicals that are not usually self-administered by the patient) furnished as an incident to a professional service. When services, supplies, drugs, or biologicals are included in the clinic's encounter rate, the clinic cannot send the beneficiary to another provider that will bill Medicaid for the covered service, supply, drug, or biological.

When a beneficiary sees more than one provider type (medical, dental, optometry, or mental health) at the same Rural Health Clinic on the same date, the clinic will be reimbursed as charted below. The exception is a case in which the patient, subsequent to the first encounter, suffers illness or injury requiring an additional diagnosis or treatment. For example, a beneficiary has a visit in the morning with a physician for a medical illness and has to return in the afternoon due to an injury which resulted in a lacerated hand. In such case, a medical encounter is paid for both visits. If the beneficiary receives an EPSDT screening only or an EPSDT screening with a medical visit on the same date, only one(1) medical encounter is paid to the clinic.

Provider Type	Encounter Allowance
Physician, Nurse Practitioner, and/or Nurse Midwife	Only one medical encounter per day
Dentist	Only one dental encounter per day
Optometrist	Only one optometry encounter per day
Clinical Psychologist and/or Clinical Social Worker	Only one mental health encounter per day

Examples are:

Service	Maximum Daily Encounter Allowance
EPSDT screening in the morning, child later becomes ill on same date, and is examined by a physician in the afternoon	Two (2) medical encounters
EPSDT screening and covered dental services on same date	One (1) medical encounter and one (1) dental encounter
Physician examination for an illness and EPSDT screening during same visit	One (1) medical encounter
Exam by optometrist and dentist on same date	One (1) optometry encounter and one (1) dental encounter
Physician visit and clinical psychologist visit on same date	One (1) medical encounter and one (1) mental health encounter

The maximum number of encounters that can be paid to the same RHC for the same beneficiary on the same date is four (4). The only exception is an instance where the beneficiary has visits with all the core service types on the same day, and in addition, the beneficiary has to return to the clinic for an injury or illness requiring additional diagnosis or treatment. In such case, the RHC may be paid another medical encounter.

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For an encounter to be paid, the service must be covered in accordance with the policies of the Mississippi Medicaid Program. All limitations and exclusions are applicable. If a service requires prior authorization, the provider must satisfy the prior authorization requirements.

Claims submitted to the fiscal agent for the same beneficiary will pay one encounter rate for each date of service and provider type (medical, dental, optometry, or mental health). A separate claim must be submitted for medical, dental, optometry, or mental health services. Claims for visits requiring additional diagnosis or treatment must be submitted to the fiscal agent as a paper claim with documentation justifying the medical necessity for the additional visit on the same date. Providers may refer to the DOM website at www.medicaid.ms.gov for a list of procedure codes which generate an encounter.

Approved Places of Service

All ambulatory services performed by a center employee or contractual worker for a center patient must be billed as an RHC claim. This includes services provided in the clinic, skilled nursing facility, nursing facility or other institution used as a patient's home. The program will pay for visits at multiple places of service for a patient. Services performed for clinic patients by an outside lab should be billed to Medicaid by the outside lab. However, claims for in-house lab services must be billed with the same place of service code as the visit. In-house lab services are covered in the visit payment.

Rural Health Clinic services are not covered when performed in a hospital (inpatient or outpatient). Physicians employed by an RHC and rendering services to Medicaid beneficiaries in a hospital will be reimbursed fee-for-service. The physician must obtain a provider number from the Division of Medicaid and bill using the CMS 1500 claim form.

Fee-for-Service

No services (same or separate dates) will be reimbursed to the clinic at a fee-for-service rate. All ambulatory services provided in an RHC will be reimbursed an encounter rate on a per visit basis.

Drugs Purchased Under a Veterans Health Care Act Discount Agreement

The Veterans Health Care Act applies to RHC's and allows clinics to sign an agreement with drug companies to purchase drugs at a discount price. DOM is not allowed to file for a rebate on drugs purchased through a discount agreement. Therefore, all drugs purchased at a discounted price through a discount agreement must not be billed through the Medicaid pharmacy program. The reimbursement for the drugs is included in the encounter rate.

Obstetrical

Providers must utilize CPT evaluation and management codes 99201 through 99215, 59425, and 59426 to bill antepartum visits as listed below.

(A) Providers must bill CPT codes in the 99201 through 99215 range for antepartum visits 1 or 2 or 3. Bill one code per visit.

(B) Providers must bill CPT code 59425 for antepartum visits 4, 5, or 6. Bill one code per visit.

(C) Providers must bill CPT code 59426 for antepartum visits 7 or over. Bill one code per visit.

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The number of the antepartum visit is defined as to the number of the visit(s) that the beneficiary has been to one physician. For example, if a beneficiary goes to Dr. A for antepartum visit 1, 2, 3, and 4 and then moves and goes to Dr. B, Dr. A will bill the appropriate evaluation and management code for each antepartum visit 1 or 2 or 3 and CPT code 59425 for antepartum visit 4. Dr. B will then bill for his antepartum visits starting with antepartum visit number 1, etc.

CPT codes 59410, 59515, 59614, and 59622 will be used to reimburse deliveries and postpartum care as of October 1, 2003. The postpartum care is inclusive of both hospital and office visits following vaginal and cesarean section deliveries. These codes must be billed under the individual physician's Medicaid provider number.

CPT code 59430 can only be billed for postpartum visits when the clinic physician was not the delivering physician.

Modifier TH identifies "obstetrical treatment/services, prenatal and postpartum" and must be reported with each code for antepartum visits and deliveries and postpartum care. The Division of Medicaid will utilize this modifier to track data and to bypass the physician visit limitation of twelve (12). Antepartum office visits will not be applied to this limitation.

Refer to Maternity, Section 38.0 of the Provider Policy Manual for additional policy related to maternity services.

Subdermal Implant

The cost of a subdermal implant is included in the encounter rate and will not be reimbursed separately.

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A therapeutic radiology port film is a radiograph taken with the beneficiary interposed between the treatment machine portal and an x-ray film. The purpose of this film is to radiographically demonstrate that the treatment port, as externally set on the beneficiary, adequately encompasses the treatment volume and at the same time avoids adjacent critical structures. Thus, these "port films" or "portal films" are for quality assurance only, and help confirm the accuracy of treatment fields, field arrangements, custom blocks, and other treatment techniques.

This radiograph is usually taken with the same energy radiation as that used in the actual treatment, but for a much shorter exposure time. In most circumstances, the taking of this film, and the subsequent review by the Radiation Oncologist, is a necessary part of the overall treatment course as it verifies the accuracy of the treatment planning. However, it does not require significant additional physician resources to perform.

~~CPT procedure code 77417 identifies "therapeutic radiology port film(s)".~~ Mississippi Medicaid considers the review and interpretation of port films as part of the weekly clinical treatment management by the physician. Therefore, the professional component for CPT procedure 77417 is considered incidental and will not warrant separate reimbursement.

The technical component is covered for the provider who takes the films. The provider may bill CPT procedure 77417, one unit, for every five (5) treatment sessions.

Therapeutic radiology port film(s) are imaged on a weekly basis for each beneficiary undergoing radiation treatments. An example is a port film done after every five (5) treatment sessions. A week, for the purpose of making payments under this code, is comprised of five treatments, regardless of the actual time period in which the services are furnished. Multiple treatments representing two (2) or more treatment sessions furnished on the same day may be counted as long as there has been a distinct break in therapy sessions, and the treatments are of the character usually furnished on different days.

If, at the final billing of the treatment course, there are three (3) or four (4) treatments beyond a multiple of five (5), and a port film is done, then the treatments and the port film are paid. If there are one (1) or two (2) treatments beyond a multiple of five (5), and a port film is done, then the treatments are paid and the port film is considered as having been paid through prior payments.

EXAMPLE: 12 treatments - reimburse twelve (12) treatments and two (2) port films

18 treatments - reimburse eighteen (18) treatments and four (4) port films

33 treatments - reimburse thirty three (33) treatments and seven (7) port films

62 treatments - reimburse sixty two (62) treatments and twelve (12) port films

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Mississippi Medicaid covers medically necessary teleradiology services for all eligible beneficiaries in accordance with the below policies.

Definitions

Consulting provider means a licensed physician who provides the interpretation of the radiological image (professional component) at the distant site (hub). The consulting provider must be licensed in the state within the United States in which he/she practices.

Hub site means the location of the teleradiology consulting provider, also referred to as the distant site. The hub site provides the professional component of the service.

Modifier 26 identifies "professional component".

Modifier TC identifies "technical component".

Modifier GT identifies "interactive telecommunication".

Referring provider means a licensed physician, physician assistant, or nurse practitioner who orders the radiological service. The referring provider must be licensed in the state within the United States in which he/she practices.

Spoke site means the location where the beneficiary is receiving the teleradiology service, also referred to as the originating site. The spoke site provides the technical component of the service.

Store and forward means telecommunication technology for the transfer of medical data from one site to another through the use of a camera, or similar device that records (stores) an image which is then sent (forwarded) via telecommunication to another site for teleconsultation.

Teleradiology is the electronic transmission of radiological images, such as x-rays, CTs, or MRIs (store-and-forward images), from one location to another for the purposes of interpretation.

Transmission Cost means the cost of the line charge incurred during the time of the transmission of a telehealth service.

Criteria for Reimbursement

Mississippi Medicaid will reimburse for one technical and one professional component for teleradiology services.

Medically necessary teleradiology is covered only when the originating site (spoke) documents that there are no local radiologists to interpret the images.

The provider at the originating site (spoke) must be enrolled as a Mississippi Medicaid provider in order to bill for the technical component of the radiological service. The spoke site provider must bill using the appropriate CPT radiological code with the TC and GT modifier.

Example: 70460 – TC – GT

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The provider at the distant site (hub) must be enrolled as a Mississippi Medicaid provider in order to bill for the professional component of the radiological service. The hub site provider must bill using the appropriate CPT radiological code with the 26 and GT modifier.

Example: 70460 – 26 - GT

Hospitals, independent radiological clinics, or physician clinics may not bill Mississippi Medicaid for both the technical and professional component of teleradiology services under their own provider number. Providers may not bill for services performed by other providers. Each provider must qualify for a Mississippi Medicaid provider number and must bill for their own services. This also applies to teleradiology services through a purchase or contract arrangement.

If a hospital chooses to bill for purchased or contractual teleradiology services, the services must be billed on a CMS-1500 claim form under a physician group provider number.

No transmission cost or any other associated cost will be reimbursed.

Quality of Service

The available teleradiology system must provide images of sufficient quality to perform the indicated task. When a teleradiology system is used to render the official interpretation, there must not be a clinically significant loss of data from image acquisition through transmission to final image display. For transmission of images for display use only, the image quality should be sufficient to satisfy the needs to the clinical circumstance.

Equipment used in teleradiology will vary; however, in all cases, the equipment must provide image quality and availability appropriate to the clinical need.

The radiologic examination at the originating site (spoke) must be performed by qualified personnel trained in the performance of the specified radiological service and operating within the licensure and/or certification requirements of the state in which the service is being performed. Technicians must be working under the supervision of a qualified licensed physician.

Documentation

Services delivered via teleradiology are held to the same standard of documentation as non-teleradiology services. All professional and institutional providers participating in the Medicaid program are required to maintain records that disclose the services rendered and billed under the program. Upon request, records should be made available to DOM, the DOM's fiscal agent, the Medicaid Fraud Control Unit, and any other designated representative of the DOM to substantiate any or all claims.

In each instance, the provider file at the spoke location must include at a minimum:

- Documentation of the reason that teleradiology was utilized to deliver the service
- Date(s) of service
- Beneficiary demographic information, i.e., name, Medicaid ID number, age sex, etc.
- Signed consent for treatment, if applicable
- Medical history
- Patient's presenting complaint
- Diagnosis
- Specific name/type of all diagnostic studies and results/findings of the studies

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In each instance, the provider file at the hub location must include at a minimum:

- Date(s) of service
- Beneficiary demographic information, i.e., name, Medicaid ID number, age, sex, etc.
- Medical history
- Patient's presenting complaint
- Diagnosis
- Specific name/type of all diagnostic studies and results/findings of the studies
- Radiological images

Refer to Section 7.03 for additional documentation requirements.

Security

Teleradiology systems should provide network and software security protocols to protect the confidentiality of beneficiaries' identification and imaging data. There must be measures to safeguard the data and to ensure data integrity against intentional or unintentional corruption of the data. All providers are responsible for ensuring confidentiality in accordance with HIPAA privacy regulations.

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Mississippi Medicaid requires that all anesthesia providers assign one of the following modifiers to each CPT anesthesia code (00100-01999) submitted on the CMS 1500 claim form.

AA ANESTHESIA SERVICE PERFORMED PERSONALLY BY ANESTHESIOLOGIST

GC THIS SERVICE HAS BEEN PERFORMED IN PART BY A RESIDENT UNDER THE DIRECTION OF A TEACHING PHYSICIAN

QX CRNA SERVICE: WITH MEDICAL DIRECTION BY A PHYSICIAN

QZ CRNA SERVICE: WITHOUT MEDICAL DIRECTION BY A PHYSICIAN

For anesthesia services performed in conjunction with surgical procedures, anesthesiologists and CRNA's must bill the appropriate code from the CPT code range 00100 through 01999.

Mississippi Medicaid will allow reimbursement for medically directed CRNA cases by paying 50% of the physician's allowable to the anesthesiologist and 50% of the physician's allowable to the CRNA.

For medical direction of residents by a teaching physician, all medical direction criteria, as stated in Section 51.04 of this manual, must be satisfied. The purpose of this criteria is to ensure quality anesthesia care.

For Mississippi Medicaid purposes, anesthesiologists and CRNA's must report time units in one minute increments. **One minute of anesthesia time will equal one unit.**

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QUICK REFERENCE FOR ANESTHESIA MODIFIERS

AA ANESTHESIA SERVICES PERSONALLY PERFORMED BY ANESTHESIOLOGIST

1. AA CAN BE USED BY ANESTHESIOLOGISTS ONLY.
2. DO NOT USE AA FOR MEDICAL DIRECTION OF CRNA'S - USE QX.

GC THIS SERVICE HAS BEEN PERFORMED IN PART BY A RESIDENT UNDER THE DIRECTION OF A TEACHING PHYSICIAN

1. GC CAN BE USED ONLY BY ANESTHESIOLOGISTS IN A TEACHING FACILITY.
2. MEDICAL DIRECTION CRITERIA MUST BE SATISFIED.
3. ANESTHESIOLOGIST MUST ASSUME FULL RESPONSIBILITY FOR THE PATIENT.

QX CRNA SERVICE WITH MEDICAL DIRECTION BY A PHYSICIAN

1. QX MUST BE USED BY BOTH THE CRNA AND THE ANESTHESIOLOGIST.
2. THERE MUST BE DOCUMENTATION IN THE ANESTHESIA REPORT THAT THE MISSISSIPPI MEDICAID MEDICAL DIRECTION CRITERIA WAS SATISFIED AND THE REPORT MUST BE SIGNED BY BOTH THE ANESTHESIOLOGIST AND THE CRNA.
3. ANESTHESIOLOGIST MAY NOT BILL FOR MEDICAL DIRECTION OF MORE THAN FOUR CRNA'S AT ANY ONE TIME.

QZ CRNA SERVICE: WITHOUT MEDICAL DIRECTION BY A PHYSICIAN

QZ CAN ONLY BE USED BY THE CRNA.

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Anesthesia providers billing for maternity procedures should follow the following directions:

DELIVERING PHYSICIAN

~~62311 Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance (s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) (file 1 unit)~~

~~62319 Injection, including catheter placement, continous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance (s) including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnold; lumbar, sacral (caudal) (file 1 unit)~~

The delivering physician must report CPT 62311 or 62319 and report modifier – TH with 62311 ~~and~~/or 62319 to identify the service as maternity related.

Pudendal and/or paracervical blocks performed in conjunction with a delivery are inclusive in the obstetrical fee paid to the delivering physician and are not covered as a separate anesthesia service to either the delivering physician or the anesthesia provider.

ANESTHESIOLOGIST/ CRNA: VAGINAL DELIVERY OR CESAREAN SECTION

Anesthesiologists and CRNA's must bill the appropriate CPT codes from the CPT range 01958 through 01969 for maternity anesthesia.

General anesthesia for a vaginal delivery is not considered an acceptable standard of medical practice. If the anesthesiologist utilizes this method of anesthesia for a vaginal delivery, a hard copy of the claim must be submitted with anesthesia records which document the medical necessity for general anesthesia.

In maternity cases in which the delivering physician inserts the epidural and later the services of an anesthesiologist or CRNA are required because the patient has a cesarean section and/or tubal ligation, Medicaid will reimburse both the delivering physician and the anesthesiologist or CRNA for their services. In filing claims for reimbursement in this type case, the anesthesiologist or CRNA must bill the same as he/she does for any other maternity anesthesia services.

A maternity epidural has always been covered under Mississippi Medicaid and is **not considered an elective procedure**. It is the intent of the Division of Medicaid to ensure that all pregnant Medicaid beneficiaries have access to this anesthesia service.

MATERNITY CPT CODES 01961, 01967, 01968 AND 01969

The Division of Medicaid has authorized modifications to the methodology for reimbursing maternity anesthesia on certain codes. Effective for dates of service on and after October 1, 2003, the reimbursement for CPT Codes 01961, 01967, 01968 and 01969 will be fee for services (flat fee). Providers must note that

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CPT Codes 01968 and 01969 are add-on codes and must be billed with CPT 01967. When billing for these codes, the provider must always report one (1) unit in field 24 G of the CMS-1500 claim form.

CODING GUIDELINES FOR BILATERAL TUBAL LIGATION OR URGENT HYSTERECTOMY FOLLOWING DELIVERY

CASE SCENARIO	REIMBURSEMENT
A bilateral tubal ligation (BTL) is performed at a distinct separate surgical setting from the delivery.	Provider will bill CPT 00851. Reimbursement methodology will be "base units x base conversion factor plus time units x time conversion factor = total".
A bilateral tubal ligation (BTL) is performed under regional or general anesthesia following natural childbirth (no anesthesia utilized for labor).	Provider will bill CPT 00851. Reimbursement methodology will be "base units x base conversion factor plus time units x time conversion factor = total".
A bilateral tubal ligation (BTL) is performed at the time of a Cesarean Section.	No additional reimbursement.
A bilateral tubal ligation (BTL) is performed following vaginal delivery where regional anesthesia was utilized for the labor and delivery. OR An urgent hysterectomy is performed following delivery.	Provider will bill for both the labor epidural/delivery (CPT 01967) and the BTL (CPT 00851) or urgent hysterectomy (CPT 01962). The first (labor epidural/delivery – flat fee) will end and the second procedure (BTL or urgent hysterectomy – base plus time reimbursement) will begin utilizing the following criteria. (A) If the delivery occurs in a different room and table than where the BTL procedure or urgent hysterectomy will be performed, the anesthesia start time on the second procedure begins when the patient is moved on to the operation table for the BTL procedure or urgent hysterectomy. (B) If the delivery occurs in the same room and table where the BTL procedure or urgent hysterectomy will be performed, the anesthesia start time will begin when the surgical nurse begins to prepare the patient for the BTL procedure or urgent hysterectomy.

Modifiers

In addition to reporting modifiers AA, GC, QX, or QZ for maternity anesthesia, providers must also bill modifier -TH with the procedure. Modifier -TH replaces maternity type of service "B" formerly used in the legacy MMIS system. HIPPA requirements eliminated type of service codes. In order for providers to have an identifier to bypass the Utilization Management/ Quality Improvement Organization (UM/QIO) certification requirements on two (2) day vaginal delivery or four (4) day cesarean section admissions, the Division of Medicaid is utilizing modifier -TH. Modifier -TH should be reported after the modifier AA, GC, QX, or QZ for two (2) day vaginal delivery or four (4) day cesarean section admissions. The utilization of modifier -TH is applicable to all codes in the CPT 01958 through 01969 range.

In addition, modifier -TH should be reported with the code for bilateral tubal ligation (CPT 00851) when performed during two (2) day vaginal delivery or four (4) day cesarean section admissions.

ALL OTHER CODES IN THE CPT 00100 through 01999 RANGE

Providers will continue to bill for all other covered anesthesia services in the CPT 00100 through 01999 range by reporting the appropriate CPT code and time units. One minute of anesthesia time will equal one (1) unit.

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A basic value is listed for anesthetic management of most surgical procedures. The Basic Value includes the value of all usual anesthesia services except the time actually spent in anesthesia care and any modifiers. The usual anesthesia services included in the Basic Value include the usual pre-operative and post-operative visits, the administration of fluids and/or blood products incident to the anesthesia care and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). The Basic Value for anesthesia when multiple surgical procedures are performed during a single anesthetic administration is the Basic Value for the procedure with the highest unit value.

The Basic Value must **not** be reported on the CMS-1500 claim form as these units are assigned for each procedure by the DOM's processing system.

Mississippi Medicaid defines one anesthesia time unit as one (1) minute. Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision.

Mississippi Medicaid will not reimburse for additional modifying units for physical status, extreme age, utilization of total body hypothermia or controlled hypotension, or emergency conditions.

Mississippi Medicaid will allow additional reimbursement for the insertion of an arterial line, CVP line, or the insertion/placement of a flow directed catheter (ex: Swan-Ganz) when the procedures are personally performed by the anesthesiologist/CRNA in conjunction with anesthesia services for a surgical procedure.

When filing for anesthesia services on the CMS-1500 claim form, apply the following guidelines:

1. The correct CPT anesthesia code from the 00100 through 01999 range must be entered in ITEM 24D. This should be listed on Line 1.

   The correct number of anesthesia time units must be entered in ITEM 24G. One minute of anesthesia time will equal one unit. **THIS FIELD (ITEM 24) IS FOR TIME UNITS ONLY. DO NOT ADD THE BASIC UNIT VALUES OR ANY OTHER ADDITIONAL MODIFYING UNITS TO THIS FIELD.**

   The exception applies to CPT codes 01961, 01967, 01968, and 10969. For these codes, the provider must report only one (1) unit. Refer to Section 51.05 of this manual.

2. If the anesthesia provider inserts an arterial line, a CVP line, and/or flow directed catheter (ex: Swan-Ganz) in conjunction with anesthesia services for a surgical procedure, select the appropriate CPT code(s) and enter it in ITEM 24D on Line 2-4.

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Multiple Birth Deliveries, Same Delivery Setting

When two or more infants from one pregnancy are delivered vaginally in the same delivery setting, one vaginal delivery fee will be paid at 100% of the Medicaid allowable rate and one additional vaginal delivery fee will be paid at 50% of the Medicaid allowable rate. Bill the appropriate CPT code, one unit, on one line and one additional appropriate CPT code with modifier -51, one unit, on a second line of the CMS-1500. For example, bill CPT code 59409, one unit, on one line, and CPT code 59409-51, one unit, on a second line.

When two or more infants from one pregnancy are delivered by Cesarean section in the same operative setting, one Cesarean section delivery fee will be paid at 100% of the Medicaid allowable rate and one additional Cesarean section delivery fee will be paid at 50% of the Medicaid allowable rate. Bill the appropriate CPT code, one unit, on one line and one additional appropriate CPT code with modifier -51, one unit, on a second line of the CMS-1500. For example, bill CPT code 59514, one unit, on one line, and CPT code 59514-51, one unit, on a second line.

When at least one infant of a multiple pregnancy is delivered vaginally followed by one or more infants delivered by Cesarean section, one Cesarean section fee will be paid at 100% of the Medicaid allowable rate and one vaginal delivery fee will be paid at 50% of the Medicaid allowable rate. Bill the appropriate CPT code, one unit, on one line and one additional appropriate CPT code with modifier -51, one unit, on a second line of the CMS-1500. For example, bill CPT code 59514, one unit, on one line and CPT code 59409-51, one unit, on a second line of the CMS-1500.

Multiple Birth Deliveries, Separate Delivery Settings

Occasionally, two or more infants from one pregnancy may be delivered at separate times, e.g., delayed interval delivery. The deliveries may be separated by hours, days, or weeks and are performed in separate, distinct settings. Examples of these situations include:

- Baby 1 is born on March 10 and Baby 2 is born on April 12;
- Baby 1 is born on March 10 at 8:00 a. m. and Baby 2 is born on March 11 at 7:00 p. m;
- Baby 1 is born on March 10 at 8:00 a. m. and Babies 2 and 3 are born on March 10 at 3:00 p. m.

In the case of twins in these situations, each delivery will be paid at 100% of the Medicaid allowable rate for the appropriate procedure. A hard copy claim must be submitted with documentation to describe the medical necessity for the separate settings. Bill the appropriate CPT code, one unit, on one line and one additional CPT code, one unit, on a second line of the CMS-1500.

In the case of multiple births of three or more infants where one infant is delivered during one setting followed by two or more infants delivered later in a separate setting, the multiple birth, same setting policy will apply to the second delivery. For example, if one infant is delivered vaginally and two additional infants are delivered hours later by Cesarean section, the first delivery will be paid at 100% of the Medicaid allowable rate for a vaginal delivery and should be billed on one CMS-1500 claim form. The second delivery will be paid at 100% of one Cesarean section delivery fee and 50% of one additional Cesarean section delivery fee at the Medicaid allowable rate and should be billed according to the multiple birth, same setting policy. A hard copy claim must be submitted with documentation to describe the medical necessity for the separate settings.

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Hyperbaric Oxygen Therapy (HBOT) involves placing a person into a special hyperbaric oxygen chamber with increased air pressure and administering 100 percent oxygen for the patient to breathe. Hyperbaric oxygen therapy is a covered service only if documentation supports the following criteria:

HBOT is covered for specific medical diagnoses only (see list below);

- The patient's entire body must be placed into the hyperbaric chamber (topical application of oxygen with portable chambers is NOT covered);
- HBOT must be performed in the hospital setting, either inpatient or outpatient;
- A physician must order HBOT treatments, document medical necessity, and establish the plan of care specifying the goals for hyperbaric oxygen therapy to accomplish and an estimated number of treatments, with revisions made as appropriate and justification for extending treatments;
- A cardiopulmonary resuscitation team and a fully equipped emergency cart must be immediately available where the hyperbaric chamber is located when a patient is receiving HBOT in the event of a complication.

For services billed under CPT code 99183, the physician must be in constant personal attendance where the hyperbaric oxygen chamber is located while the patient is receiving HBOT. If the physician delegates administration of HBOT to hospital staff, such as respiratory therapists, and is not in constant personal attendance during the entire HBOT treatment, the facility may bill for the HBOT services and the physician may not bill CPT code 99183.

Covered Medical Diagnoses for Hyperbaric Oxygen Therapy

Hyperbaric oxygen therapy is covered for the following medical diagnoses and ICD-9 codes only:

- acute carbon monoxide intoxication: 986
- decompression illness (Caisson disease) : 993.3
- air (gas) embolism: 958.0; 999.1
- gas gangrene: 040.0
- acute traumatic peripheral ischemia, as adjunctive treatment to accepted standard therapeutic measures when function, life, or limb is threatened: 902.53; 903.01; 903.1; 903.2; 903.3; 904.0; 904.1; 904.41; 904.51; 904.53
- crush injuries and suturing of severed limbs, as adjunctive treatment to accepted standard therapeutic measures when function, life, or limb is threatened: 925 - 929.9; 996.90 - 996.99
- progressive necrotizing infections - necrotizing fasciitis: 728.86; meleney ulcer (pyoderma gangrenosum): 686.01

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- acute peripheral arterial insufficiency: 444.21; 444.22; 444.81; 733.40-733.49
- preparation and preservation of compromised skin grafts: 996.52
- chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management: 730.10 - 730.19
- osteoradionecrosis as an adjunct to conventional treatment: 526.89; 909.2
- soft tissue radionecrosis as an adjunct to conventional treatment: 990
- cyanide poisoning: 987.7; 989.0
- actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment: 039.0 - 039.9

Documentation of Medical Necessity for Hyperbaric Oxygen Therapy

Documentation must be legible and available for review if requested. Documentation must include the following:

- Specific written record that HBOT was performed in a hospital setting (inpatient or outpatient) utilizing a full body hyperbaric chamber;
- A written physician order and comprehensive history and physical report detailing the condition/diagnosis(es) requiring HBOT, including prior treatments and their results and additional treatments being rendered concurrently with HBOT;
- Physician progress notes and consult reports that describe the patient's response to treatment;
- Established goals for hyperbaric oxygen therapy to accomplish and an estimated number of treatments, with revisions made as appropriate and justification for extending treatments;
- Wound description, if applicable, including wound size and appearance, for each day of service billed;
- Radiology and laboratory reports, including culture and sensitivity studies, to support the diagnosis when applicable;
- For CPT code 99183, specific written record of the physician's constant personal attendance where the hyperbaric chamber is located while the patient is undergoing HBOT;
- Specific written record of the availability of a cardiopulmonary resuscitation team and a fully equipped emergency cart where the hyperbaric chamber is located while the patient is undergoing HBOT.

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In an effort to encourage Medicaid beneficiaries to utilize appropriate services for urgent, non-emergency conditions rather than going to the emergency room, physician office visits provided during extended hours may be reimbursed with a fee in addition to an appropriate office visit charge. Extended hours fees are limited to visits for urgent situations that arise unexpectedly but are not emergencies that require the use of an emergency room as defined by the prudent layperson standard established by the Balanced Budget Act of 1997.

Extended hours office visits are defined as those that occur outside of regularly scheduled office hours. The extended hours office visit fee of $15.00 must be billed using CPT code 99050. ~~"Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg., holidays, Saturday or Sunday), in addition to basic service".~~ This code should be billed in addition to an appropriate evaluation and management (E/M) office visit procedure code and will be paid only if the associated office visit is covered. The extended hours office visit fee will not count toward the twelve (12) physician visits service limit.

The provider must maintain records that document "regularly scheduled office hours". If changes are made to the schedule, the provider must maintain records that reflect the date of change, the regularly scheduled hours prior to the change, and the new hours. These records must be maintained for audit purposes.

The extended hours office visit fee may not be billed with CPT code 99211. The fee also may not be billed for regularly scheduled, non-urgent visits or when an appointment was scheduled for regular office hours but took place at another time because the regular schedule went overtime. Documentation of the visit time and the urgent situation that arose unexpectedly must be included in the medical record, and documentation of the appointment time must be available for review if requested.

Providers that are reimbursed based on cost-based methodology, i.e., encounter rates, such as Rural Health Clinics and Federally Qualified Health Centers, may not bill the extended hours office visit fee. Their costs for extended office hours should be included in their cost reports.

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As authorized in House Bill 1434 during the 2004 Legislative Session, the Division of Medicaid will cover annual physical examinations. Through this provision, eligible Mississippi Medicaid beneficiaries will be encouraged to choose a medical home and undertake a physical examination to establish a base-line level of health.

A medical home is defined as the usual and customary source that provides both preventive and treatment or diagnosis of a specific illness, symptom, complaint, or injury. The medical home will serve as the focal point for a beneficiary's health care, providing care that is accessible, accountable, comprehensive, integrated, and patient centered.

Physical Examinations for Beneficiaries for Adults (Age 21 and over)

Coverage for the annual physical examination for adults will be effective as of February 1, 2005. To bill for the service, providers will utilize the age appropriate code from the CPT Evaluation and Management Preventive Medicine codes 99385, 99386, 99387, 99395, 99396, or 99397.

The co-payment amount of $3.00 for a physician visit will **not** be applicable to beneficiaries age 18 and over. The annual physical examination will **not** be counted toward the physician visit limit of twelve (12) per fiscal year.

Physical Examinations for Children (Under Age 21)

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, a mandatory service under Medicaid, provides preventive and comprehensive health services for Medicaid eligible children and youths up to age twenty one (21). Children will access the mandatory periodic screening services through EPSDT providers. EPSDT providers will continue to follow the Division of Medicaid's policy and procedures for the EPSDT Program.

No copayment is applicable for services to children under age 18. The provider must report the Co-payment Exception Code "C" on claims for beneficiaries under age 18. The codes for the periodic screening examinations do not apply toward the physician visit limit per fiscal year.

Dual Eligibles

Beneficiaries whose Medicare Part B coverage begins on or after January 1, 2005 will have Medicare coverage for a one time only "Welcome to Medicare" Physical Examination within the first six months of the Medicare coverage.

If the beneficiary has both Medicare and Mississippi Medicaid, the routine annual physical examination is not covered under Medicaid if the beneficiary is eligible for or has already received the "Welcome to Medicare" physical examination. The Division of Medicaid will not duplicate benefits for routine annual physical examinations covered by Medicare and will not provide an annual physical examination until twelve months (12) has elapsed from the original effective date of the Medicare Part B coverage. For these instances, it is the sole responsibility of the provider to determine whether Medicare or Mississippi Medicaid is the appropriate billing source.

Dual eligibles whose Medicare Part B effective date is prior to January 1, 2005 will be eligible for the physical examination as outlined above for adults or children.

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Diagnostic and/or Screening Procedures

Radiology and laboratory procedures which are a standard part of a routine adult annual age/gender physical examination or well child periodic screening may be billed by the provider performing the procedure, and coverage will be determined based on current Mississippi Medicaid policies for the individual procedures.

Exclusions

The purpose for providing a benefit for routine annual physical examinations and well child screenings is to assist Mississippi Medicaid beneficiaries in establishing a medical home and to assist the beneficiary in accessing preventive services. Using the examination as a tool for other purposes, such as physicals for school, sports, or employment, will not be covered and must not be billed to Medicaid.

This benefit is not covered for beneficiaries in an institutional setting (locked-in to a nursing home or intermediate care facility for the mentally retarded (ICF/MR) or those covered in Category of Eligibility 029 (Family Planning) or 088 (Pregnant Women – 185%).

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Sleep disorder studies are performed to diagnose certain conditions through the study of sleep. The studies are commonly performed in an outpatient setting such as a physician's clinic, a freestanding facility, an Independent Diagnostic Treatment Facility (IDTF), or through an outpatient hospital department.

The Mississippi Medicaid Program reimburses covered and medically necessary sleep study services performed in a physician's office or in the outpatient department of a hospital. Sleep study services are not reimbursed when performed in an IDTF or freestanding facility.

Providers billing sleep disorder studies must maintain proper certification / accreditation by either the American Academy of Sleep Medicine (AASM) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Space, equipment, and staffing must be consistent with the AASM or JCAHO standards.

Criteria for Covered Services in a Sleep Disorder Clinic

Sleep studies and polysomnography are the most frequently provided services by sleep disorder clinics. These tests refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for 6 or more hours with physician review, interpretation and report.

Sleep Study

A sleep study does not include sleep staging. A sleep study may involve simultaneous recording of ventilation, respiratory effort, EKG or heart rate, and oxygen saturation.

1) **Multiple Sleep Latency Test (MSLT)**
   MSLT is usually conducted after the patient has already undergone a polysomnogram. The purpose of an MSLT is to determine the average time it takes the patient to fall asleep and to assess if REM stage sleep occurs during these short naps.

   - Measures daytime sleepiness.
   - The instruction is to try to fall asleep.
   - Involves four to five, 20-minute recordings of sleep-wake states spaced at 2-hour intervals throughout the day.

2) **Maintenance of Wakefulness Test (MWT)**
   - Measures daytime sleepiness.
   - Involves multiple trials throughout a day of low-demand activity when the instructions are to resist sleep.

Polysomnography (PSG)

Polysomnography includes sleep staging that is refined to include a 1-4 lead electroencephalogram (EEG), and electro-oculogram (EOG), and a submental electromyogram (EMG). Additional parameters of sleep that must be recorded include:

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- electrocardiogram (ECG)
- airflow
- ventilation and respiratory effort
- gas exchange by oximetry, transcutaneous monitoring, or end tidal gas analysis
- extremity muscle activity, motor activity-movement
- extended EEG monitoring
- penile tumescence
- gastroesophageal reflux
- continuous blood pressure monitoring
- snoring
- body positions, etc.

For a study to be reported as a polysomnogram:

- Studies must be performed for 6 hours
- Sleep must be recorded and staged
- An attendant must be present throughout the course of the study.

The diagnostic evaluation of sleep disorders often requires overnight examination of the sleeping patient by means of polysomnography to assess severity, effect on sleep architecture and continuity, and the effects on gas exchange, cardiac function, etc.

Polysomnography is used in conjunction with the patient's history, other laboratory tests and observations, and the physician's knowledge of sleep disorders to reach a diagnosis and to recommend appropriate treatment and follow-up.

A supervised polysomnography or sleep study performed in a facility- based sleep disorder clinic may be covered by the Mississippi Medicaid Program as a medically necessary diagnostic test in patients who present with one of the following conditions:

(a) Narcolepsy

Narcolepsy is a syndrome that is characterized by abnormal sleep tendencies (excessive daytime sleepiness, disturbed nocturnal sleep, inappropriate sleep episodes or attacks).
Polysomnography or sleep studies are covered as a diagnostic test for narcolepsy when the condition is severe enough to interfere with the patient's well-being and health. MSLT is useful in helping patients with narcolepsy adjust their medications.

(b) Hypersomnia

Hypersomnia/drowsiness refers to feeling abnormally sleepy during the day; often with a strong tendency to actually fall asleep in inappropriate situations or at inappropriate times. Excessive daytime sleepiness (without a known cause) suggests the presence of a significant sleep disorder and is different from fatigue. MSLT is useful in quantifying the degree of sleepiness in a particular patient.

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(c) Sleep Apnea

Sleep apnea is a potentially lethal condition where the patient stops breathing during sleep. The three types are central, obstructive and mixed. PSG is the most common test used to diagnose sleep apnea. MSLT is useful in determining the degree of sleepiness in patients that are currently being treated.

(d) Parasomnia

Parasomnia is a group of conditions that represent undesirable or unpleasant occurrences during sleep. These conditions may include:

- Sleepwalking
- Sleep terrors
- REM sleep behavior disorders.

(Seizure disorders that occur as the result of parasomonia are appropriately evaluated by standard or prolonged sleep EEG studies.) Parasomnias are usually diagnosed by PSG.

(e) Periodic Limb Movement Disorder (PLMD)

PLMD or restless leg syndrome is an involuntary, repetitive movement disorder during sleep, primarily in the legs that may lead to arousals, sleep disruption, and corresponding daytime sleepiness. Periodic Limb Movement Disorder is usually diagnosed by PSG.

(f) Chronic Insomnia

Chronic Insomnia is a covered indication when one of the following conditions is met:

- diagnosis is uncertain,
- sleep related breathing disorder or periodic limb movement disorder are suspected,
- a patient is refractory to treatment,
- violent behaviors are co-morbid,
- circadian dysrhythmias complicate the clinical picture.

PSG is most frequently used to diagnose this condition.

Therapeutic services may be covered by the Mississippi Medicaid Program in a sleep disorder clinic if they are standard and accepted services, are reasonable and necessary for the patient, are performed in a hospital affiliated setting, and are performed under the direct personal supervision of a physician.

The evaluation of a patient's response to therapies such as nasal Continuous Positive Airway Pressure (CPAP) is an example of a covered therapeutic service in a sleep disorder clinic.

Non-Covered Services

Actigraphy

Actigraphy testing consists of a small portable device (actigraph) that senses physical motion and stores the resulting information. Actigraphy testing has been predominantly used in research studies to evaluate rest-activity cycles in patients with sleep disorders, to determine circadian rhythm activity cycles, and to determine the effect of a treatment on sleep. The actigraph is most commonly worn on the wrist, but can also be worn on the ankle or trunk of the body. Actigraphy testing is based on the assumption that movement is reduced during sleep compared with wakefulness and that activity level can be used as a diagnostic indicator for sleep disorders.

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Studies have found that actigraphy is less useful for documenting sleep-wake in persons who have long motionless periods of wakefulness (e.g. insomnia patients) or who have disorders that involve altered motility patterns (e.g. sleep apnea). Identified pitfalls of actigraphy testing are:

a) validity has not been established for all scoring algorithms or devices, or for all clinical groups;

b) actigraphy is not sufficient for diagnosis of sleep disorders in individuals with motor disorders or high motility during sleep;

c) the use of computer scoring algorithms without controlling for potential artifacts can lead to inaccurate and misleading results.

The Mississippi Medicaid Program considers actigraphy testing experimental and investigational for the purposes of treating sleep disorders because there is insufficient scientific evidence in the medical literature to support its use in clinical practice.

Sleep studies and polysomnography are not considered medically necessary by the Mississippi Medicaid Program in any setting for the following conditions:

- the service is an unattended home study (usually billed with CPT Code 95806);
- Impotence; (Use CPT Code 54250~~- Nocturnal penile tumescence and /or rigidity test~~.)
- to preoperatively evaluate a patient undergoing a laser assisted uvulopalatopharyngoplasty without clinical evidence that obstructive sleep apnea is suspected;
- to diagnose chronic lung disease (Nocturnal hypoxemia in patients with chronic, obstructive, restrictive, or reactive lung disease is usually adequately evaluated by oximetry.);
- in cases where seizure disorders have not been ruled out;
- in cases of typical, uncomplicated, and non-injurious parasomnias when the diagnosis is clearly delineated;
- for patients with epilepsy who have no specific complaints consistent with a sleep disorder;
- for the diagnoses, shift-work sleep disorder, delayed sleep phase syndrome, advanced sleep phase syndrome, and non 24-hour sleep wake disorder.
- an overnight stay is considered an integral part of these tests. More than one overnight session may be required to complete the study. However, these multiple sessions are included in the cost of the test and may not be reported separately. Therefore, regardless of how many overnight sessions are required to complete the study, the CPT code for the diagnostic test may only be reported once, with the date that the study began reported as the date of service.
- performance of a sleep study on the same day as an Evaluation and Management (E&M) service unless significant and separately identifiable medical services were rendered and clearly documented in the patient's medical record.

Required Documentation

The billing provider must maintain and provide to the Mississippi Medicaid upon request the following documentation. In addition, providers of interpretations must be capable of demonstrating documented training and experience and maintain documentation for post-payment audit.

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- All centers billing sleep studies must maintain proper certification/ accreditation by either the American Academy of Sleep Medicine (AASM) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Space, equipment, and staffing must be consistent with the AASM's Standards of Accreditation or accredited through JCAHO.

- Medical records must document the name of the technician who attended the sleep study. Examples of appropriate personnel certification include:

  a) Registered Polysomnography Technologist (RPSGT) credentialed through the Board of Registered Polysomnographic Technologists, and

  b) Somnologist or Diplomat of the ABSM credentialed through the AASM.

- The patient is to be evaluated by a physician prior to ordering of test. When billing for a sleep disorder test, the ordering physician's UPIN must be indicated on the claim form and the order kept on record.

- A complete, legible patient medical record that describes relevant history and physical findings to support the medical necessity of the sleep study must be maintained. Documentation must indicate that the patient's condition is severe enough to interfere with the patient's well being and health.

- When significant and separately identifiable medical services are rendered in addition to the sleep study or polysomnography evidence is required to be clearly documented in the patient's medical record.

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Routine venipuncture performed for the purpose of obtaining a blood sample for laboratory testing will be reimbursed as follows:

- Routine venipuncture must be billed with CPT Code 36415. ~~ACollection of venous blood by venipuncture@.~~

- Physicians, nurse practitioners, physician assistants, hospitals, and independent laboratories may bill for routine venipuncture only if the blood sample is drawn and all of it is referred to a separate, non-affiliated laboratory. If all or part of the sample is retained for a test to be performed in the facility where the venipuncture was performed, the physicians, nurse practitioners, physician assistants, hospitals, and independent laboratories may not bill for the venipuncture.

- EPSDT Screening providers may bill Medicaid for routine venipuncture when performed for lead screening and/or RPR screening, only if the blood sample is drawn and all of it is referred to a separate, non-affiliated laboratory. If all or part of the sample is retained for a test to be performed in the facility where the venipuncture was performed, the provider may not bill for the venipuncture.

- The Mississippi State Department of Health (MSDH), rural health clinic (RHC) and federally qualified health center (FQHC) providers who are reimbursed an encounter rate will not be paid separately for performance of routine venipuncture during the same encounter.

- Finger/heel/ear sticks that are performed for the purpose of collecting blood specimens or obtaining blood specimens via a partially or completely implantable venous access device are not covered. Providers must not bill CPT code 36415 when the blood samples are obtained by these methods.

- Dialysis facilities will not be reimbursed outside the composite rate for CPT code 36415.

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Medicaid will reimburse high risk case management agencies for case management enhanced services to infants using the procedure codes and limits listed below:

CODE	DESCRIPTION	LIMITS
	EPSDT EXAMINATIONS UP TO ONE YEAR OF AGE	
99381 or 99391-EP	0-1 month	1 exam
99381 or 99391-EP	2 months	1 exam
99381 or 99391-EP	4 months	1 exam
99381 or 99391-EP	6 months	1 exam
99381 or 99391-EP	9 months	1 exam
99382 or 99392-EP	12 months	1 exam
	HIGH RISK INFANT SERVICES	
T1017-EP	High Risk Management	Monthly
S9470-EP	Nutritional Counseling	1 of 6 extra screens
H0023-EP	Psychological Counseling	1 of 6 extra screens
S9445-EP	Health Education	1 of 6 extra screens
S9123-EP	In-Home Nurse Visits	1 of 6 extra screens
S9470-EP	In-Home Nutritionist	1 of 6 extra screens
S9127-EP	In-Home Social Worker	1 of 6 extra screens
T1023	Risk Screening	2 done in the first year of life

For questions regarding this program contact:

Division of Medicaid
EPSDT
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201
Phone: 601-359-6150 Fax: 601-359-6147

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Periodic Referral

All children and adolescents under age 21 who qualify for full medical assistance benefits coverage are eligible to receive Mississippi Cool Kids (EPSDT) services.

For children whose eligibility is certified by one of the Medicaid Regional Offices, the referral process for the Mississippi Cool Kids (EPSDT) preventative health program must take place during the in-person interview process. The Medicaid Specialists are responsible for providing written and oral information pertaining to the Mississippi Cool Kids (EPSDT) program and then completing the DOM-315 Referral form. The DOM-315 form will be used for referring the beneficiary to the provider of their choice.

Parents or guardians whose children do not get referred through the process described above may select the provider of their choice to conduct their Mississippi Cool Kids (EPSDT) screenings.

Periodic Schedule

In order for Mississippi Cool Kids (EPSDT) providers to receive Medicaid reimbursement for those eligible Medicaid beneficiaries for screening services, the provider must follow the periodicity schedule. Periodicity refers to the frequency and time of the well-child check-up.

Frequency is as follows:

- 0-1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months

Yearly beginning at the age 2 years, up to age 21.

Yearly visit must be planned to occur once during the state fiscal year (July 1st- June 30th).

Time refers to appointment scheduling/re-appointing/ tracking system.

The schedule is based on the American Academy of Pediatrics "Recommendations for Preventive Pediatric Health Care."

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EPSDT Periodic Examination Schedule

Screening Code		Modifier	Age of Child	Unit
New Patient	Established Patient			
99381	99391	EP	0 – 1 Months	1
99381	99391	EP	2 Months	1
99381	99391	EP	4 Months	1
99381	99391	EP	6 Months	1
99381	99391	EP	9 Months	1
99382	99392	EP	12 Months	1
99382	99392	EP	15 Months	1
99382	99392	EP	18 Months	1
99382	99392	EP	2 – 4 years*	1
99383	99393	EP	5 - 11 years*	1
99384	99394	EP	12 – 17 years*	1
99385	99395	EP	18 - 21 years*	1

Beginning at 2 years of age EPSDT Screenings can be done annually.

Vision and Hearing

Screening Code	EPSDT ~~Description~~ Service	Age of Child	Period Limitations	Unit
99173-EP	Vision Screen	3 – 21 Years	Annually*	1
92551-EP	Hearing Screen	3 – 21 Years	Annually*	1

Adolescent Counseling

Screening Code	EPSDT ~~Description~~ Service	Age of Child	Period Limitations	Unit
99401-EP	Adolescent Counseling	9 – 21 Years	Annually*	1

- Vision, Hearing and Adolescent counseling must be billed in conjunction with an EPSDT comprehensive age-appropriate screening.

Appointments

Health Assessments

1. **Appointments for Initial Assessments**

   The provider will make an appointment for the eligible beneficiary according to the periodicity schedule. If the family fails to keep the scheduled appointment or fails to contact the provider for a change in date and time, a second appointment letter will be sent providing the family another opportunity to participate in the EPSDT program within thirty (30) days of the initial appointment.

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Failure of the family to keep the second appointment or to contact the clinic for a change in date and time will be considered a declination of services. Further attempts to contact the patient are not required for that periodic schedule.

2. **Appointments for Periodic Assessments**

   Appointment should be made according to the periodicity schedule. The clinic will contact the family, setting forth the nature and benefit of EPSDT services and arranging an appointment for a health assessment.

3. **Appointment Failures**

   After two appointment failures, the provider shall place the child for recall for the next screening date on the periodicity schedule. It is the responsibility of the screening provider to document efforts made to ensure the family an opportunity to participate in the EPSDT program. In no circumstances should the child be deleted from the system, unless the family refuses the services.

4. **Documentation Requirements**

   - The date of the scheduled appointment for screening.
   - The date the screening service was provided.
   - The attempts to reschedule the beneficiary for services requested. If scheduled, which appointments were not kept.
   - The condition(s) found and/or the referral(s) for diagnostic treatment.
   - The offer of transportation and scheduling assistance.

Dental Assessments

At the time of the exit counseling session following the initial or periodic screen, the screening provider will give notice to a family who has requested EPSDT services that a dental assessment is due. This provides the counselor an opportunity to stress the importance of dental care by a dentist and the importance of seeing the dentist on a routine basis.

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According to the Centers for Disease Control and Prevention (CDC), the American Thoracic Society, and the American Academy of Pediatrics, the standard diagnostic test for determining if a person is infected with *Mycobaterium tuberculosis* is the Mantoux tuberculin skin test, in which 0.1 ml of 5 tuberculin units (TU) of purified protein derivative (PPD) is injected intradermally using a small gauge needle and tuberculin syringe. The test should be administered and interpreted by persons who are trained in correct intradermal injection technique and interpretation of test reactions.

Multiple puncture tests (i.e., Tine and Heaf) are not as reliable as the Mantoux method of skin testing and should not be used as a diagnostic test.

Tuberculin skin testing also should be targeted to 1) persons or groups with presumed recent *M. tuberculosis* infection, and 2) persons with clinical conditions associated with rapid progression to active tuberculosis (TB). Routine testing of persons at low risk for TB for administrative purposes, i.e., schoolteachers, food workers, school entry for children, is not recommended.

Additionally, the purpose of tuberculin testing is to identify persons at high risk for TB who would benefit by treatment of latent TB infection. Therefore, persons with a positive tuberculin skin test must be medically evaluated to rule out active TB disease and for treatment of latent TB infection. Providers are encouraged to consult with the Mississippi State Department of Health concerning tuberculin testing programs and evaluation and treatment of latent TB infection and TB disease.

Therefore, a tuberculin skin test will be a covered service only if the following conditions are met:

- The test is administered using the Mantoux intradermal method
- The test is billed using CPT code 86580 ~~"tuberculosis, intradermal test"~~
- The beneficiary has a risk for TB substantially higher than that of the general U. S. population, or has a clinical condition associated with an increased risk of progression from latent TB infection to active TB disease, based on recommendations from the CDC
- There is a plan for a beneficiary with a positive tuberculin skin test to receive a medical evaluation, including chest x-ray and clinical assessment, and to be evaluated for a course of treatment for latent TB infection

Tuberculin skin testing for routine screening of pregnant women and children in the absence of specific risk factors for TB is not a covered service. The provider must document the medical necessity for tuberculin skin testing and appropriate evaluation and treatment of persons with a positive tuberculin skin test in the medical record and must maintain auditable records that will substantiate the claim submitted to Medicaid.

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Populations at Increased Risk Who Should Be Screened for Latent Tuberculosis Infection

Condition	Examples
Increased risk of exposure to infectious TB cases	Recent contact of persons known to have clinically active TB
	Health-care workers
Increased risk of TB infection	Foreign-born persons from high-prevalence countries
	Homeless persons
	Persons living or employed in long-term care facilities
Increased risk of TB once infection has occurred	HIV infection
	Recent TB infection (e.g. children < 4 years old and TB skin test converters*)
	Injection drug users
	End-stage renal disease
	Silicosis
	Diabetes mellitus
	Immunosuppressive therapy
	Hematologic malignancies
	Malnutrition
	Gastrectomy or jejunoileal bypass

*TB skin test conversion is defined as an increase of 10 mm induration within a 2-year period.

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The Mississippi Division of Medicaid (DOM) covers immunizations for adults that are related to the treatment of injury or direct exposure to a disease such as rabies or tetanus. Influenza and pneumococcal vaccinations are covered services for Medicaid beneficiaries nineteen (19) years of age or older. Quadrivalent Human Papillomavirus (HPV) vaccinations are covered services for Medicaid beneficiaries 19 to 26 years of age. Hepatitis B vaccinations are covered services for Medicaid beneficiaries 19 years of age and older.

Influenza Vaccine

Influenza ("the flu") is a highly contagious viral infection of the nose, throat, and lungs that is one of the most severe illnesses of the winter season. Influenza viruses continually change over time, and each year the vaccine is updated. In the United States the best time to vaccinate against influenza is from October to mid-November; however, influenza vaccinations can be given at any time during the season. Providers should use the most current influenza vaccine recommendations developed and endorsed by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP).

Pneumococcal Polysaccharide Vaccine

Pneumococcal disease is an infection caused by the bacteria Streptococcus pneumoniae. The major clinical syndromes of invasive pneumococcal disease include pneumonia, bacteremia, and meningitis. Pneumococcal disease is a significant cause of morbidity and mortality in the United States. Providers should use the most current pneumococcal vaccine recommendations developed and endorsed by the CDC's ACIP.

Pneumococcal and influenza vaccinations may be given at the same time (different injection sites) without increased side effects.

Reimbursement for Influenza and Pneumococcal Vaccinations

To receive maximum reimbursement for flu and pneumonia immunizations for adults, providers should bill as follows:

- For beneficiaries who come in only for these immunizations, providers may bill E&M procedure code 99211, the vaccine code(s), and the appropriate administration code(s). This E&M procedure code does not count toward the twelve (12) office visit limit for beneficiaries.
- For beneficiaries who are seen by the provider for evaluation or treatment and receive these immunizations, the provider may bill the appropriate E&M procedure code, the vaccine code(s), and the appropriate administration code(s). The E&M procedure code billed in this instance will count toward the twelve (12) office visit limit for beneficiaries.
- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) providers will count visits under current procedures. Providers will not count or bill visits when the only service involved is the administration of influenza or pneumonia vaccine.

DOM does not allow a separate reimbursement fee for the administration of FluMist.

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Providers should refer to Section 77.06 in this manual for information on nursing facility residents.

Quadrivalent Human Papillomavirus (HPV) Vaccine

Genital human papillomavirus is a common sexually transmitted virus that can cause cervical cancer in women. Most HPV infections, however, may occur without any symptoms and go away on their own. The vaccine is proven to be effective only if given before infection with HPV.

Quadrivalent Human Pappillomavirus (Types 6, 11, 16, and 18) Recombinant Vaccine is indicated for vaccination in females 9 to 26 years of age for prevention of the following diseases caused by Human Papillomavirus (HPV) Types 6, 11, 16, and 18:

- Cervical cancer
- Genital warts (condyloma acuminate)
- The following precancerous or dysplastic lesions:
    - Cervical adenocarcinoma *in situ* (AIS)
    - Cervical intraepithelial neoplasia (CIN) grade 2 and grade 3
    - Vulvar intraepithelial neoplasia (VIN) grade 2 and grade 3
    - Vaginal intraepithelial neoplasia (ValN) grade 2 and grade 3
    - Cervical intraepithelial neoplasia (CIN) grade 1

This vaccine is not intended to be used for treatment of cervical cancer, CIN, VIN, ValN, or genital warts.

This vaccine has not been shown to protect against diseases due to non-vaccine HPV types.

If this vaccine is given to women who may already be infected with one (1) or more vaccine related HPV types prior to vaccination, they may find that the vaccine protects them from the clinical disease caused by the remaining vaccine types, but that it may not alter the course of an infection that is already present.

Reimbursement for HPV Vaccine

To receive maximum reimbursement for the HPV immunization for adults, providers should bill as follows:

- For beneficiaries who come in only for this immunization, providers may bill E&M procedure code 99211 and the vaccine code. This E&M procedure code does not count toward the twelve (12) office visit limit for beneficiaries.

- For beneficiaries who are seen by the provider for evaluation or treatment and receives this immunization, the provider may bill the appropriate E&M procedure code and the vaccine code. The E&M procedure code billed in this instance will count toward the twelve (12) office visit limit for beneficiaries.

- For Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), and the Mississippi State Department of Health (MSDH) providers, the vaccine and its administration is covered in the encounter rate for a core service. An encounter will not be paid solely for administration of the vaccine.

Dosage and Administration

This vaccine should be administered in three (3) separate intramuscular injections in the upper arm over a six-month period. The following dosage schedule is recommended: first dose at elected date, second dose two (2) months after the first dose, and the third dose six months after the first dose.

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Mississippi Medicaid will not reimburse for a vaccine administration fee.

This vaccine is not covered for beneficiaries covered through the Family Planning Waiver.

Hepatitis B Vaccine

Hepatitis B is a disease caused by the hepatitis B virus (HBV), which is transmitted through percutaneous (i.e., puncture through the skin) or mucosal (i.e., direct contact with mucous membranes) exposure to infectious blood or body fluids. Hepatitis B virus is one of several hepatitis viruses that cause a systemic infection, with a major pathology in the liver.

The Division of Medicaid will cover the Hepatitis B vaccine for adults who are at risk for contracting Hepatitis B. The following list includes, but is not limited to, examples of persons at risk for contracting the Hepatitis B virus:

- Persons with more than one sex partner in six months
- Homosexual men
- Sex contacts with prostitutes or infected persons
- HIV-positive persons
- Current or recent injection drug users
- Health care and public safety workers who might be exposed to infected blood or body fluids
- Household members and sex partners of persons with chronic HBV infection
- Hemodialysis patients and patients with early renal failure before they require hemodialysis
- Persons who received a blood transfusion or other blood products prior to 1992
- Individuals with hemophilia who received Factor VIII or IX concentrates
- Staff and residents of institution or group homes for the developmentally disabled

Reimbursement

To receive maximum reimbursement for Hepatitis B immunization for adults, providers should bill per dose and not as a series, and should bill as follows:

- For beneficiaries who come in only for this immunization, providers may bill E&M procedure code 99211 and the vaccine code. This E&M procedure code does not count toward the twelve (12) office visit limit for beneficiaries.
- For the beneficiary who is seen by the provider for evaluation or treatment and receives this immunization, the provider may bill the appropriate E&M procedure code and the vaccine code. The E&M procedure code billed in this instance will count toward the twelve (12) office visit limit for beneficiaries.
- For Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), and the Mississippi

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State Department of Health (MSDH) providers, the vaccine and its administration is covered in an encounter rate for a core service. An encounter will not be paid solely for administration of the vaccine.

Dosage and Administration

This vaccine should be administered in three (3) separate intramuscular injections in the upper arm over a six-month period. The following dosage schedule, depending upon the brand of vaccine, is recommended: first dose at elected date, second dose at least one-to-two months after the first dose, and the third dose six months after the first dose. If, after the third injection, the HBV titer is not within normal limits, DOM will cover a fourth HBV injection being administered.

Mississippi Medicaid will not reimburse for a vaccine administration fee.

Documentation

The provider's medical records must indicate the high risk factor for the adult Medicaid beneficiary receiving the vaccine. Claims must be submitted with appropriate ICD-9 diagnosis coding.

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