

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date:</b> <b>12/01/10</b>
<b>Section: Hospital Inpatient</b>	<b>Section: 25.08</b>	
<b>Subject: Newborn Child Eligibility</b>	<b>Pages: 2</b> <b>Cross Reference:</b> <b>Beneficiary Retroactive Eligibility</b> <b>3.03</b>	

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

**Newborn to a Medicaid-eligible Mother**

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

**NOTE:** Newborns adopted at birth or released for adoption at birth are automatically entitled to the one-year eligibility period. However, if parental rights are terminated, the form must indicate this fact and the form should be faxed to the regional Medicaid office serving the county where the baby will reside; not the mother. The address of the newborn is needed on the form so that DOM will be able to issue a notice of approval and a Medicaid ID card to a correct address.

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

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

Eligibility is established by submitting an application to the appropriate Medicaid Regional Office. Application forms are available at Medicaid regional offices and on the DOM website. If eligibility criteria are met and there are unpaid bills, eligibility may be established for as much as three (3) months prior to the date of application. Refer to Provider Policy Manual Section 3.03 for Beneficiary Retroactive Eligibility policy.

**APPLICATION FOR NEWBORN HEALTH BENEFITS IDENTIFICATION NUMBER**  
**(Please print or type)**

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

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

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

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

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

\_\_\_\_\_ for purposes of enrolling my child in Medicaid or  
(Name of child as it will appear on birth certificate).

the Children's Health Insurance Program (CHIP).

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

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

Newborn's Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_  
\_\_\_\_ Single Birth  
\_\_\_\_ Multiple Births How Many \_\_\_\_\_

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

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

Mother's Medicaid Number \_\_\_\_\_ Mother's SSN\* \_\_\_\_\_

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

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

Hospital Representative Furnishing Information \_\_\_\_\_

Telephone No. \_\_\_\_\_ Date \_\_\_\_\_

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

Newborn is eligible for \_\_\_\_ Medicaid \_\_\_\_ CHIP

Health Benefits ID No. \_\_\_\_\_ Effective Date \_\_\_\_\_

Div. of Medicaid Worker \_\_\_\_\_ Date \_\_\_\_\_

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<b>Section: Hospital Inpatient</b>	<b>Section: 25.25</b> <b>Pages: 2</b>	
<b>Subject: Prior Authorization of Inpatient Hospital Services</b>	<b>Cross Reference: Utilization Management/Quality Improvement Organization 1.10</b>	

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

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

Note:

- When a beneficiary has third party insurance and Medicaid, prior authorization must be obtained from Medicaid.
- Prior authorizations are not required for Medicaid beneficiaries who are also covered by both Medicare Part A & B unless inpatient Medicare benefits are exhausted. Prior authorizations are required for Medicaid beneficiaries who are also covered by Medicare Part A only or Medicare Part B only.

### **Submitting a Prior Authorization Request**

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

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

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

### **Receiving Approval or Denial of a Request**

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

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

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

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

## **Billing for Non-Approved Services**

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

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

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

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

## **Maternity-Related Services**

Hospitals must report all admissions for deliveries, both vaginal and Cesarean section, to the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO). The hospitals must report the admissions in accordance with the requirements provided by the UM/QIO. A Treatment Authorization Number (TAN) will be issued to cover up to three (3) days for a vaginal delivery or up to five (5) days for a Cesarean section delivery.

For admissions exceeding three (3) days for a vaginal delivery or five (5) days for a Cesarean section delivery, providers must submit a request for a continued stay in accordance with the policies and procedures provided by the UM/QIO.

## **Newborns**

Normal well-baby services provided in the hospital should be included on the mother's hospital claim for labor, delivery, and immediate postpartum services. Normal well-baby services provided in the hospital will not be reimbursed separately from the mother's hospital claim.

If a newborn requires hospitalization beyond the mother's hospital stay, usually three (3) days for a vaginal delivery and five (5) days for a Cesarean delivery, the hospital must obtain a Treatment Authorization Number (TAN) from the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO) for the sick baby's hospital stay. When the mother is discharged and the newborn remains hospitalized, the mother's discharge date becomes the newborn's beginning date for certification purposes.

In addition to newborns remaining after the mother is discharged, newborns delivered outside the hospital and those admitted to accommodations other than well-baby must be authorized by the UM/QIO separately from the mother.

The hospital must provide the baby's name and Medicaid ID number to the UM/QIO in order to obtain a TAN; "Baby Boy" or "Baby Girl" is not acceptable for the baby's name. Upon receipt of the newborn's own Medicaid ID number, it is the responsibility of the hospital to provide that number to the UM/QIO. Once the UM/QIO has received the newborn's Medicaid ID number, the TAN will be released to the hospital and the fiscal agent, and the hospital can then submit claim(s).

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

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

### **Newborn to a Medicaid-eligible Mother**

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

**NOTE:** ~~Newborns adopted at birth are not automatically entitled to the one-year eligibility period. An application for the newborn must be filed with the appropriate certifying agency.~~  
Newborns adopted at birth or released for adoption at birth are automatically entitled to the one-year eligibility period. However, if parental rights are terminated, the form must indicate this fact and the form should be faxed to the Regional Medicaid Office serving the county where the baby will reside; not the mother. The address of the newborn is needed on the form so that DOM will be able to issue a notice of approval and a Medicaid ID card to a correct address.

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

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

Eligibility is established by submitting an application to the appropriate Medicaid Regional Office. Application forms are available ~~at some hospitals, federally qualified health centers, health departments, and other provider offices as well as~~ at Medicaid regional offices and on the DOM website. If eligibility criteria are met and there are unpaid bills, eligibility may be established for as much as three (3) months prior to the date of application. Refer to Provider Policy Manual Section 3.03 for Beneficiary Retroactive Eligibility policy.

**REQUEST FOR NEWBORN HEALTH BENEFITS IDENTIFICATION NUMBER**

(Please print or type)

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

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

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

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

to release to the Mississippi Division of Medicaid information regarding my newborn child,  
\_\_\_\_\_ for purposes of enrolling my child in Medicaid or the  
(Name of Child As It Appears on Birth Certificate)  
Children’s Health Insurance Program (CHIP).

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

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

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

Single Birth

Multiple Births

How many? \_\_\_\_\_

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

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

Were parental rights terminated? No  Yes

Hospital Representative Furnishing Information \_\_\_\_\_

Telephone # \_\_\_\_\_ Date \_\_\_\_\_

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

Newborn is eligible for  Medicaid  Children’s Health Insurance

Health Benefits ID# \_\_\_\_\_ Effective Date \_\_\_\_\_

DOM Worker \_\_\_\_\_ Date \_\_\_\_\_

Division of Medicaid – State of Mississippi – 550 High St., Suite 1000 – Jackson, MS 39201 – 1-800-421-2408

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

Note:

- When a beneficiary has third party insurance and Medicaid, prior authorization must be obtained from Medicaid.
- Prior authorizations are not required for Medicaid beneficiaries who are also covered by both Medicare Part A & B unless inpatient Medicare benefits are exhausted. Prior authorizations are required for Medicaid beneficiaries who are also covered by Medicare Part A only or Medicare Part B only.

### **Submitting a Prior Authorization Request**

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

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

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

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

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

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For admissions exceeding three (3) days for a vaginal delivery or five (5) days for a Cesarean section delivery, providers must submit a request for a continued stay in accordance with the policies and procedures provided by the UM/QIO.

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

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

~~Newborns delivered outside the hospital, those remaining after the mother is discharged, and those admitted to accommodations other than well-baby must be authorized by the UM/QIO separately from the mother.~~

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

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

## **Newborns**

Normal well-baby services provided in the hospital should be included on the mother's hospital claim for labor, delivery, and immediate postpartum services. Normal well-baby services provided in the hospital will not be reimbursed separately from the mother's hospital claim.