

<b>Division of Medicaid State of Mississippi Provider Policy Manual</b>	<b>New:</b> <b>Revised: X</b> <b>Current:</b>	<b>Effective Date: 12/01/10</b>
<b>Section: Beneficiary Information</b>	<b>Section: 3.02</b>	
<b>Subject: Newborn Child Eligibility</b>	<b>Pages: 1</b> <b>Cross Reference: Beneficiary Information 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 regarding the birth to the Division of Medicaid. 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.

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

Eligibility is established by submitting an application with the appropriate Medicaid Regional Office. Application forms are available at regional Medicaid 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 as described in Section 3.03 in this manual.

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<b>Section: Beneficiary Information</b>	<b>Section: 3.04</b> <b>Pages: 2</b>	
<b>Subject: Eligibility for Medicare and Medicaid</b>	<b>Cross Reference:</b>	

Medicare provides insurance to qualified individuals who are 65 years old, are disabled or have permanent kidney failure. Medicare is the primary payor for a beneficiary who is both Medicare and Medicaid eligible. Medicare has four parts: Hospital Insurance (Part A), Medical Insurance (Part B), Medicare Advantage Plans (Part C) and Medicare Prescription Drug Coverage (Part D).

### **Medicare Part A**

Medicare Part A provides coverage of inpatient hospital services, skilled nursing facility care, hospice care, and medically-necessary home health services.

Medicaid pays for the Medicare Part A premium through a "buy-in" process for individuals who have income that does not exceed 100% of the poverty level and are classified as Qualified Medicare Beneficiaries (QMB) and QMB-dual recipients, meaning the recipient is dually eligible as both a QMB and has full Medicaid through other coverage. The Centers for Medicare and Medicaid Services (CMS) and DOM work jointly to ensure that all eligible individuals are included in the "buy-in" process for Medicare coverage. Persons who may be Medicaid-eligible should apply at the appropriate certifying agency.

### **Medicare Part B**

Medicare Part B helps cover medically-necessary services such as doctors' services, outpatient care, other medical services, and some preventive services.

DOM pays the Medicare Part B premium through a "buy-in" agreement with the Social Security Administration (SSA) for all Medicaid eligible individuals who also qualify for Medicare Part B. CMS and DOM work jointly to ensure that all eligible individuals are included in the "buy-in" process.

DOM also pays Part B premiums for specified low-income Medicare beneficiaries (SLMBs) and certain qualifying individuals (QIs). SLMBs and QIs do not receive a Medicaid ID card or any other benefits.

### **Medicare Part C (Medicare Advantage Plans)**

Medicare Advantage Plans are health plan options (like an HMO or PPO) approved by Medicare and offered by private companies. Medicare pays a fixed amount for care to the companies offering the plans and the Medicare Advantage Plan provides the Medicare health coverage.

Medicaid will pay the coinsurance and deductible for beneficiaries in applicable Categories of Eligibility (COE).

DOM does not pay co-payments.

### **Medicare Part D (Medicare Prescription Drug Plan)**

Medicare Part D helps cover the cost of prescription drugs, lower prescription drug costs and protect against higher costs in the future. Medicare offers prescription drug coverage plans run by insurance companies or other private companies approved by Medicare. Each plan can vary in cost and drugs covered.

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When Medicaid beneficiaries have both Medicare and Medicaid coverage, pharmacy providers are required to bill Medicare for drugs covered by that program. DOM considers the Medicare payment as payment in full for Part D pharmacy claims.

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<b>Section: Beneficiary Information</b>	<b>Section: 3.08</b>	
<b>Subject: Beneficiary Cost Sharing</b>	<b>Pages: 3</b>	
	<b>Cross Reference: DME Co-Payments 10.03</b>	

Section 1902 (a) (14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services, such as enrollment fee payments, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges.

**The Division of Medicaid applies co-payments to the following beneficiary group or services.**

<b>Beneficiary Group / Service</b>	<b>Co-Payment Amount</b>
Ambulance	\$ 3.00 per trip
Ambulatory Surgical Center	\$3.00 per visit
Dental	\$ 3.00 per visit
DME, Orthotics, Prosthetics (excludes medical supplies)	Up to \$ 3.00 per item (varies per State payment for each item)
FQHC	\$ 3.00 per visit
Home Health	\$ 3.00 per visit
MS State Department of Health	\$ 3.00 per visit
Hospital Inpatient	\$10.00 per day up to one-half the hospital's first day per diem per admission
Hospital Outpatient	\$ 3.00 per visit
Physician (office, home, emergency room, ophthalmological)	\$ 3.00 per visit
Prescription	\$ 3.00 per prescription, including refills
Vision	\$ 3.00 per pair of eyeglasses
Rural Health Center	\$ 3.00 per visit

In the absence of knowledge or indication to the contrary, the provider may accept the beneficiary's assertion that he/she cannot afford to pay the cost sharing co-payment amount. The provider may not deny services to any eligible Medicaid individual due to the individual's inability to pay the cost of the co-payment. However, the individual's inability to pay the co-payment amount does not alter the Medicaid reimbursement amount for the claim, unless the beneficiary or service is excluded from the co-payment policy.

Collecting the co-payment amount from the beneficiary is the responsibility of the provider. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing co-payments from the beneficiary remains the responsibility of the provider.

**The following beneficiary groups or services are exempt from payment of the above co-payments.**

When the beneficiary or service is exempt from the co-payment, the applicable co-payment exception code must be indicated on the claim in the recipient ID field as a suffix to the Medicaid number; otherwise, a co-payment will be deducted.

Example: 123456789C

Example: 999999999N

Example: 100100100P

Exception Code	Description	Applicable On CMS 1500	Applicable On UB04?
<b>K</b> (Use only on Pharmacy claims.)	<u>Infant</u>	No (Use only on Pharmacy claims)	No (Use only on Pharmacy claims)
<b>C</b>	<u>Children Under 18</u>	Yes	Yes
<b>P</b>	<u>Pregnant Women</u>  Prenatal Care  Labor and Delivery  Routine Postpartum Care (the immediate postpartum period which begins on the last day of the pregnancy and extends through the end of the month in which the 60 day period following termination of the pregnancy).  Complications of pregnancy likely to affect the pregnancy, such as hypertension, diabetes, urinary tract infection, and services furnished during the postpartum period for conditions or complications related to the pregnancy.	Yes	Yes
<b>N</b>	<u>Nursing Facility</u>  Services furnished to any individual who is a resident in a nursing facility, ICF/MR or PRTF.  This exception code is applicable to the facility charges, professional fees, and pharmaceuticals.	Yes	Yes
<b>F</b>	<u>Family Planning</u>  Family planning services and supplies.	Yes	Yes
<b>E</b>	<u>Emergency Services</u>  Services performed in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.  <u>The documentation in the medical records must justify the service as a true emergency.</u>	Yes	Yes

<p><b>O</b></p>	<p><b><u>Chemotherapy (Drug Therapy for Cancer)</u></b></p> <p>Applicable only to <u>facility</u> charges for chemotherapy services performed in the outpatient department of the hospital.</p> <ul style="list-style-type: none"> <li>• Treatment of cancer with drugs that can destroy cancer cells.</li> </ul> <p>This exception code does <u>not</u> apply to the physician charges.</p>	<p>No</p>	<p>Yes</p>
<p><b>T</b></p>	<p><b><u>Radiation Therapy</u></b></p> <p>Applicable only to <u>facility</u> charges for radiation therapy performed in the outpatient department of the hospital.</p> <ul style="list-style-type: none"> <li>• Therapeutic radiology services.</li> <li>• Nondiagnostic in nature</li> <li>• Includes therapy by injection or ingestion of radioactive substances.</li> </ul> <p>This exception code does <u>not</u> apply to physician charges.</p>	<p>No</p>	<p>Yes</p>
<p><b>L</b></p>	<p><b><u>Laboratory/ Laboratory Pathology</u></b></p> <p>Applicable only to <u>facility</u> charges when beneficiary is <b>ONLY</b> receiving laboratory services in the outpatient department of the hospital.</p> <ul style="list-style-type: none"> <li>• Diagnostic and routine clinical laboratory tests.</li> <li>• Diagnostic and routine laboratory tests on tissues and cultures.</li> </ul> <p>This exception code does <u>not</u> apply to physician charges.</p>	<p>No</p>	<p>Yes</p>
<p><b>No Exception Code Required</b></p>	<p><b><u>Dialysis Facility</u></b></p> <p>Hospital based or freestanding dialysis <u>facility</u> charges are exempt from co-payment. However, the provider is <u>not</u> required to indicate an exception code when billing the claim.</p> <p>This exception code does <u>not</u> apply to physician charges.</p>	<p>No</p>	<p>Yes</p>

For beneficiaries covered under a Home and Community Based Services Waiver, the co-payment is exempt if the service is being paid through the Waiver. If services are being paid through regular Mississippi Medicaid State Plan benefits, the co-payment is applicable unless exempt by one of the beneficiary groups or services listed above.