Administrative Code

Title 23: Medicaid
Part 302
Beneficiary Health Management

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Title 23: Division of Medicaid

Part 302: Beneficiary Health Management

Part 302 Chapter 1: Beneficiary Health Management

Rule 1.1: Authority and Purpose

A. In accordance with 42 CFR 431.54 (3)(e), a state has the authority to lock-in beneficiaries who over utilize Medicaid services. If a Medicaid agency finds that a beneficiary has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that beneficiary for a reasonable period of time to obtain Medicaid services from designated providers only.

B. Beneficiary Health Management is the program implemented by the Division of Medicaid to closely monitor program usage and to identify beneficiaries who may be potentially over utilizing or misusing their Medicaid services and benefits. The purpose of Beneficiary Health Management (BHM) is to:

1. Promote quality health care,

2. Prevent harmful practices such as duplication of medical services, drug interaction, and possible drug abuse,

3. Identify beneficiaries for review who may misuse or over utilize their Medicaid benefits,

4. Analyze beneficiary pattern of utilization of health services,

5. Modify the beneficiary's improper utilization of Medicaid services through educational contacts and monitoring,

6. Prevent fragmentation of services and improve the continuity of care and coordination of services, and

7. Assure beneficiaries are receiving only health care services which are medically necessary and justified, thereby curtailing unnecessary costs to the program. "Medical Necessity" is defined as the determination by the Medical Assistance Program that a service is reasonably necessary to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap or cause physical deformity or malfunction. There must also be no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service.

Source: Miss. Code Ann. § 43-13-121

Rule 1.2: Program Oversight

The Division of Medicaid's Bureau of Program Integrity has the responsibility of initiating and coordinating BHM.

Source: Miss. Code Ann. § 43-13-121

Rule 1.3: Provider Participation

This program may include physician only, pharmacy only or physician and pharmacy type beneficiary health management.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Covered Services

A. Beneficiaries will be placed in the Beneficiary Health Management program for a period of eighteen (18) months with ongoing reviews to monitor pattern of care.

B. Beneficiaries in the BHM program are allowed two (2) counseling sessions per month per lock-in provider - physician and/or pharmacy during the eighteen (18) month lock-in.

C. Beneficiaries in BHM will continue to have access to emergency room, inpatient and outpatient hospitalizations, dental, optical, psychiatric, home health, hospice, Medicaid Waiver and DME services. All service limits are applicable.

D. The Division of Medicaid will reimburse for inpatient hospitalization for treatment of alcohol and/or drug abuse when the primary diagnosis is a mental health diagnosis (DSM diagnosis) and the inpatient hospital stay is approved by the Division of Medicaid Utilization Management and Quality Improvement Organization (UM/QIO). In addition, the Division will pay for mental health services up to twelve (12) visits per fiscal year, where counseling can be received for addiction problems.

Source: Miss. Code Ann. § 43-13-121

Rule 1.5: Exclusions

A. Beneficiaries who have received a utilization review completed within the past year are not eligible for re-review of benefits in BHM until after twelve (12) months.

B. Beneficiaries no longer eligible for Medicaid benefits.

Source: Miss. Code Ann. § 43-13-121

Rule 1.6: Provider Selection

A. Beneficiaries are required to specify one (1) physician and/or one (1) pharmacy and up to five (5) physician specialists, if requested, for his/her medical/pharmaceutical services while in the BHM program.

B. The beneficiary has thirty (30) days to choose his/her provider(s). When the beneficiary does not specify within the thirty (30) day time frame, the Division of Medicaid may designate a provider or providers for him/her.

C. Change of Provider: The beneficiary may request a change in his/her specified physician and/or pharmacy if any of the following occurs:

   1. Change in geographical location of the beneficiary or the provider(s),

   2. Death, retirement, or closing of the specified physician, pharmacy or specialist,

   3. Irreconcilable differences between the beneficiary and the provider(s) that may affect the quality of medical care the beneficiary receives,

   4. Primary diagnosis changes and therefore requires different specialist,

   5. Specified provider(s) stop(s) participating in the Mississippi Medicaid Program, or

   6. Specified provider(s) lose(s) eligibility to participate in the Mississippi Medicaid Program.

D. Referrals

   1. Beneficiaries in BMH may be referred to another provider for consultation by the specified physician or specialists by using the BHM Referral Form. Prior approval is required before the beneficiary can be seen by the referral physician. Emergency situations are excluded from this requirement.

   2. The referral may cover one (1) visit or may cover multiple visits as long as those visits are a part of the referral physician's plan of care and are medically necessary. No referral can last for more than one (1) year.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Reimbursement

A. 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.

B. Payment will be made to provider(s) other than the specified provider(s) in the following instances:

   1. Emergency care is required and the specified provider is not available, or

   2. The specified provider requires consultation with another provider.

C. Billing Guidelines - Providers of BHM services are required to bill specified procedure codes for the two (2) 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 the specified procedure codes by the physician and/or pharmacy. The specified codes must be billed two (2) times per month for each provider.

Source: Miss. Code Ann. § 43-13-12