



MISSISSIPPI DIVISION OF
MEDICAID

Mississippi Medicaid Provider Reference Guide

For Part 203

Physician Services

*This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.*

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SURGERY INTRODUCTION

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

A provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers and for notifications regarding billing. Medicaid Policy as it relates to these factors is initiated by DOM.

BILLING/REIMBURSEMENT

BILLING FOR MULTIPLE SURGERIES

Multiple surgical procedures performed by the same surgeon on the same patient and on the same date of service must be billed together on the same CMS-1500 claim form unless one claim form does not accommodate all of the procedures.

The primary surgical procedure must be listed first. Under Mississippi Medicaid, the primary procedure is recognized as the procedure which allows the greatest reimbursement from the Mississippi Medicaid Physician Fee Schedule. Each secondary procedure should be billed on subsequent lines following the primary procedure.

If a provider does not agree with the amount of payment on a particular surgical procedure, the claim must NOT be resubmitted. The provider must submit a written request for reconsideration to the Fiscal Agent's Medical Review Unit which includes an explanation or justification for a different payment.

If a provider receives a denial on a particular surgical procedure because the procedure is non-covered, incidental, mutually exclusive, rebundled to another procedure, investigative, or a

procedure on which the medical necessity has not been established, the claim must NOT be resubmitted.

If a provider does not agree with these determinations, the provider must submit to the Fiscal Agents' Medical Review Unit a written request for reconsideration which includes an explanation or justification for the request for payment.

The above policies are also applicable for assistant surgeon, team surgeon, or co-surgeon services.

REIMBURSEMENT FOR MULTIPLE SURGERIES

For multiple surgeries performed on the same day, the following reimbursement criteria apply:

1. Multiple surgical procedures performed at the same operative setting through a single opening are reimbursable at the Medicaid rate for the procedure with the greatest reimbursement. The additional surgeries through this same opening are not reimbursable.

Exceptions: If a second surgical procedure adds significant time, risk, or complexity to patient care:

- The surgery with the greater Medicaid allowed amount will be paid at the full amount
 - The second surgery will be paid at half the Medicaid allowance. The secondary procedure must be billed with Modifier-51.
 - No additional benefits are paid toward incidental, mutually exclusive, or unbundled procedures.
2. Multiple surgical procedures performed at the same operative setting through separate incisions are reimbursed as follows:
 - The surgery with the greater Medicaid allowance amount will be paid that amount.
 - Secondary surgeries, except incidental, mutually exclusive, and unbundled procedures, will be paid at half their Medicaid allowance. These procedures must be identified with the Modifier-51. No benefits are provided for incidental, mutually exclusive, and unbundled procedures.
 3. Secondary procedures must meet all of the following criteria:
 - The secondary procedure is to correct a separate pathological condition

- That pathological condition would have required intervention had an incision not already been present
 - The degree of difficulty, operative time and risk were significantly increased by the secondary procedure.
4. If, after a surgical procedure has been completed, it becomes necessary to return and perform a subsequent surgical procedure that same day, Medicaid will reimburse the full- allowed amount for each surgical setting in accordance with multiple surgery criteria. In such a case, the second surgical setting should be submitted on a hard copy CMS-1500 claim form with documentation that justifies the separate surgical setting and includes the operative report.
 5. In instances where more than one surgeon is involved with a procedure(s) at the same operative setting, refer to the assistant surgeon, co-surgeon, or team surgeon policies in this section, whichever is applicable.

MODIFIERS

The following modifiers must be utilized on claims for surgery:

- 50 – Bilateral Procedure
- 51 – Multiple Procedures
- 62 – Two Surgeons (Co-Surgeons)
- 66 – Surgical Team
- 80 – Assistant Surgeon

When it is necessary to report multiple modifiers, the modifiers must be listed in numerical order.

BILATERAL PROCEDURES

Bilateral surgeries are exact procedures identified by the same CPT codes which are performed on anatomically bilateral sides of the body during the same operative session.

Modifier-50 is not applicable if the CPT code description denotes a bilateral procedure. If the bilateral procedures are the only procedures performed during the operative session, and if the code denotes bilateral, report the code with no modifier and one (1) unit. If the description indicates bilateral and the procedures are secondary to a primary procedure, report the code with the modifier – 51 and one (1) unit. Reimbursement will be made in accordance with methodology for either primary and/or secondary procedures, whichever is applicable.

MULTIPLE BIRTH DELIVERIES

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 births, same setting policy. A hard copy claim must be submitted with documentation to describe the medical necessity for the separate settings.

ASSISTANT SURGEON

An assistant surgeon is a licensed physician who actively assists the physician in charge of a case in performing a surgical procedure. Payment will be made for services provided by a physician when he/she assists another physician during major surgery. With this benefit, major surgery includes all surgical cases performed under spinal or regional anesthesia if the nature of the surgery requires the assistance of a second physician or surgeon. Claims for such services will be adjudicated on the basis of the reasonableness and need for such services to accomplish the particular procedure involved. Payment can only be made for one (1) assistant for any case.

Interns, residents, fellows, physician assistants, and nurses, including nurse practitioners, will not be reimbursed as an assistant surgeon.

CO-SURGEONS

DEFINITION OF CO-SURGEONS

Co-surgery is defined as two surgeons (each usually in a different specialty) required to perform a specific procedure. Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, such as bilateral knee replacements.

Under some circumstances, the individual skills of two (2) or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery.

Instances may occur where co-surgeons may be of the same specialty. In such cases, for eligible co surgery procedures, payment may be considered for co-surgeons where the documentation justifies the medical necessity for two surgeons without regard to the two (2) specialty requirement.

TEAM SURGEONS

REIMBURSEMENT FOR TEAM SURGEONS

If surgeons of different specialties are each performing a different procedure (with specific CPT codes), co-surgery and multiple surgery rules do not apply (even if the procedures are performed through the same incision).

If one of the surgeons performs multiple procedures, the multiple surgery reimbursement rules apply to that surgeon's service. Each surgeon must submit a separate claim and report the procedure he/she performed.

Providers must utilize modifier - 66 to identify team surgeon services. Modifier – 66 may be used in addition to other appropriate surgical modifiers.

MODIFIERS

MODIFIERS

The following modifiers must be utilized on claims for surgery:

- 50 – Bilateral Procedure
- 51 – Multiple Procedures
- 62 – Two Surgeons (Co-Surgeons)
- 66 – Surgical Team
- 80 – Assistant Surgeon

When it is necessary to report multiple modifiers, the modifiers must be listed in numerical order.

CPT CODES EXEMPT FROM MULTIPLE SURGERY RULES

Procedures designated in CPT as add-on code or otherwise exempt from multiple surgery are recognized by Mississippi Medicaid. Mississippi Medicaid will not apply multiple surgery rules to those procedures.

MODIFIER -54, -55 AND MODIFIER -56

The Division of Medicaid requires that modifiers -54 and -55 be reported with the CPT surgery codes when appropriate. The modifiers will be acceptable on the CPT surgery code range 10000 – 69999.

Modifier	Description	Mississippi Medicaid Allowable
-54	Surgical Care Only	85% of Medicaid Allowable
-55	Postoperative Management Only	15% of Medicaid Allowable
-56	Preoperative Management Only	No separate benefits are allowed as preoperative management is inclusive in the allowance for surgical care. Surgical codes billed with modifier -56 will be denied.

SUPPLIES/SURGICAL TRAYS

Fees for supplies and/or surgical trays will not be separately reimbursed when billed by a physician or physician clinic for procedures performed in the office.

BONE ANCHORED HEARING AID (BAHA)

The Bone Anchored Hearing Aid (BAHA) system works through direct conduction of sound energy via the skull bone to a functioning cochlea in the inner ear, bypassing the outer and middle ear. It consists of three (3) parts: a tiny titanium screw implanted behind the ear, the abutment, which is the socket that is attached to the implant and sits on the surface of the scalp behind the ear, and the detachable sound processor.

COVERAGE CRITERIA

Beneficiaries must meet both the audiologic and medical condition criteria listed below.

1. Audiologic criteria - A bone anchored hearing aid may be covered when a beneficiary meets all of the following:
 - a) A pure tone average bone conduction threshold of 70 dB or less
 - b) A speech discrimination score greater than 60%
2. Medical condition criteria – must meet one (1) or more of the following criteria:
 - a) Congenital or surgically induced malformations of the external ear canal and/or middle ear (e.g., atresia)
 - b) Severe chronic infections of the middle or outer ear with persistent otorrhea/discharge and documented failure with air conducted hearing aids
 - c) Tumors of the external ear canal and/or tympanic cavity
 - d) Otosclerosis with a contraindication to stapedectomy surgery (i.e., the ear requiring stapedectomy is the beneficiary's only hearing ear)
 - e) Other anatomic or medical conditions in which an air conduction hearing aid is contraindicated
 - f) Single-sided deafness

CHIROPRACTOR INTRODUCTION

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Effective July 1, 1998, services of a chiropractor are covered under the Mississippi Medicaid program. The service covered is a chiropractor's manual manipulation of the spine to correct a subluxation. An x-ray must demonstrate that a subluxation exists and if the subluxation has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment. The fee for chiropractic manipulation shall be reimbursed per the fee schedule and shall not exceed seven hundred dollars (\$700) per fiscal year (July 1 - June 30) per beneficiary.

A chiropractor provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, he/she must accept the Medicaid payment as payment in full for those services covered by Medicaid. He/she cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers and for notifications regarding billing. Medicaid Policy as it relates to these factors is initiated by DOM.

GUIDELINES

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.

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

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.

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.

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)

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 suspect's 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 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.

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.

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

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.

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

BILLINGS PROCEDURES

Medicaid utilizes the CMS – 1500 claim form for the submission of charges for services rendered to Medicaid beneficiaries. The following instructions for the CMS–1500 claim form are to be used by chiropractors exclusively.

Field 21: Diagnosis or Nature of Illness or Injury

Field 21, diagnosis or nature of illness or injury is required for all providers; chiropractors must enter the beneficiary’s diagnosis as follows:

- Treatment Area – Use the 739.X codes from the ICD-9-CM to identify treatment area. Identify the exact level of subluxation in narrative form (i.e., C5)

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)

- Symptoms Associated With Subluxation
- Complication Factors

DOCUMENTATION REQUIREMENTS

Providers must maintain proper and complete documentation to verify the services provided and the medical necessity for the services. The provider has full responsibility for maintaining complete medical records and documentation to justify the medical necessity and services provided. The medical records must document the medical necessity for the treatment, the specific modality or procedure, and x-ray reports must be available on all x-rays (DOM does require that all x-ray films be accessible at all times for review). In addition, DOM requires that the films be of such quality that they can be clearly interpreted.

DOM, the chiropractic consultant(s), and/or the fiscal agent have the authority to request any office records and x-ray films at any time to conduct a random sampling review and/or document any services billed by the chiropractor.

If a chiropractor's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the chiropractor 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 the chiropractor.

A chiropractic 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 and monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

DUAL ELIGIBLES

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

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