

Office of the Governor | Mississippi Division of Medicaid

# MississippiCAN

## Hospital Inpatient Transition: Newborn Edition

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# Moderator

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# MississippiCAN

## Hospital Inpatient Transition

Frequently Asked Questions (FAQ) are available on Division of Medicaid's (DOM) website: [medicaid.ms.gov](https://www.medicaid.ms.gov)

Please submit all questions to: [inpatient@medicaid.ms.gov](mailto:inpatient@medicaid.ms.gov)

# What Providers Need to Know

## MS Code Section 43-13-117(H)(1)(d)

- Coordinated Care Organizations (CCO) are required to reimburse all providers in those organizations at rates no less than what Medicaid reimburses Fee-For-Service (FFS) Providers, if in-network providers
- All claims for services covered by the CCOs for MississippiCAN members must be submitted to the CCOs
- Claims for services excluded from MississippiCAN must be submitted to Medicaid

# MississippiCAN Legislation

The Mississippi state legislature authorized the following major changes affecting the Division of Medicaid.

## Major changes include:

- 297,054 Children were enrolled in MississippiCAN during May, June and July 2015. (House Bill 1275, 2014)
- Inpatient hospital roll-in to managed care by Dec. 1, 2015 (Senate Bill 2588, 2015)
- The Upper Payment Limit (UPL) program will be replaced with the Mississippi Hospital Access Program (MHAP) (Senate Bill 2588, 2015)

# Newborns

## MississippiCAN Inpatient Coverage for Newborns

### Newborn Reporting for Medicaid Identification Number Assignment

- Hospitals will notify DOM within five (5) calendar days of an infant's birth using the Newborn Enrollment Form.
- The enrollment form will be available on the Envision web portal ([ms-medicaid.com](http://ms-medicaid.com)) for electronic submission. (effective Dec. 1, 2015)
- DOM's Office of Eligibility will determine newborn eligibility, assign the newborn's permanent Medicaid ID number, and notify the hospital within five (5) business days.

# Newborns

## MississippiCAN Inpatient Coverage for Newborns

### Is an application necessary for newborns?

- If the mother has Medicaid coverage at the time of the birth or subsequently becomes eligible for Medicaid retroactively for the birth month, the infant is deemed eligible for the first year of life and the Newborn Enrollment Form serves as the application.
- If the mother is not enrolled in Medicaid at the time of the birth, an application can be filed at any of the 30 Medicaid regional offices for an eligibility decision.

### To whom should claims for newborns be billed?

- Upon enrollment in Medicaid, newborns of a MississippiCAN mother on or after Dec. 1, 2015 will be automatically assigned to the same CCO of the mother. Therefore, the provider should bill the plan to which the mother has been assigned. For newborns of mothers who are not enrolled in MississippiCAN, the provider should bill fee-for-service Medicaid.

# NOTIFICATION



# Notification vs Prior Authorization

## What is the difference between a notification and prior authorization?

A **notification** is defined as a process to notify the health plan of urgent/emergent hospital admission. These services may or may not require authorization. In reference to inpatient services, notification alone is not sufficient to create an authorization, as clinical information proving medical necessity of services would be required.

A **prior authorization (PA)** is defined as an administrative or clinical review conducted prior to rendering a service, inpatient admission or course of treatment after appropriate medical review. The basic elements of a PA review include eligibility verification, benefit interpretation, medical necessity review and appropriateness of care for making utilization review determinations.

# Newborn Notification Requirements

## What are the newborn notification requirements?

### **Division of Medicaid**

Upon submission of the Newborn Enrollment Form on the Envision web portal, eQHS will be automatically notified for Maternity Reporting of the delivery. No other reporting of the delivery is required.

### **Magnolia Health**

The Division of Medicaid Newborn Enrollment Form serves as notification for all normal (well-baby nursery) deliveries. For all other newborns (anything other than well-baby) Magnolia must be notified within one (1) business day of admission.

### **UnitedHealthcare Community Plan**

The Division of Medicaid Newborn Enrollment Form will serve as documentation related to initial inpatient or NICU admission for newborns. All emergent/urgent admissions require notification within one (1) business day after admission.

# Maternal Notification Requirements

## What are the maternal notification requirements?

### **Division of Medicaid**

Upon submission of the Newborn Enrollment Form on the Envision web portal, eQHS will be automatically notified for Maternity Reporting of the delivery. No other reporting of the delivery is required.

### **Magnolia Health**

The Division of Medicaid Newborn Enrollment Form serves as notification of delivery unless the mother has some complication that extends a routine vaginal delivery beyond three (3) days or a C-section delivery beyond five (5) days. In that case, Magnolia must be notified within one business day of the day that the complication necessitating additional days was noted.

### **UnitedHealthcare Community Plan**

Notification is required within one (1) business day of mother's admission for delivery.

# PRIOR AUTHORIZATION

# Prior Authorization Contact Information

## **eQHealth Solutions**

Fax and Web Hours: 24 hours/day, 7 days/week

Fax: 1-888-204-0504

Web: [mswebapps.eqhs.org/webportal/Login.aspx](https://mswebapps.eqhs.org/webportal/Login.aspx)

Phone Hours: 8:00AM – 5:00PM (Business Days)

Phone: 1-888-204-0502

## **Magnolia Health**

Monday – Friday, 8:00AM to 5:00PM, CST (excluding holidays)

Phone: 1-866-912-6285

Fax: 1-855-684-6746

Web: [www.magnoliahealthplan.com](http://www.magnoliahealthplan.com)

## **UnitedHealthcare Community Plan**

Monday – Friday, 8:00AM to 5:00PM, CST

Phone: 1-866-604-3267

24 hours a day for emergencies

Fax: 1-888-310-6858

Web: [UHCCommunityPlan.com](http://UHCCommunityPlan.com)

# Prior Authorization

**Will the CCOs accept eQHS PA obtained prior to December 1, 2015 for the dates of service December 1 – December 30?**

## **Magnolia Health and UnitedHealthcare Community Plan**

Yes. Magnolia Health and UnitedHealthcare Community Plan will accept PA obtained by eQHS prior to December 1, 2015 for dates of service December 1 – December 30.

# Prior Authorization

## What are the newborn PA requirements?

### **Division of Medicaid**

Newborns with a length of stay of five (5) days or less do not require a PA.

### **Magnolia Health**

If the Newborn Enrollment Form is completed and submitted timely, Magnolia Health Plan does not require any additional information for mother or newborn, unless complications develop during the stay. If complications develop with mother or baby that may necessitate additional hospital days or a non well-baby or NICU admission, a prior authorization should be submitted along with clinical information to support the stay (standard three (3) day stay for vaginal deliveries, five (5) day stay for C sections).

### **UnitedHealthcare Community Plan**

PA is not required for urgent/emergent or NICU admission. In case of newborn, Mississippi DOM's Newborn Enrollment Form will serve as initial newborn notification. Concurrent review will be performed if the newborn remains inpatient at time of notification. UnitedHealthcare will conduct a retrospective eligibility review if the newborn has been discharged prior to receipt of the Newborn Enrollment Form.

# NICU PA Process

## What is the NICU PA process including concurrent reviews?

### Division of Medicaid

For NICU stays greater than five (5) days, a PA is required. Approved PAs are issued for 19 days, concurrent review is required if not discharged on day 20.

### Magnolia Health

The NICU PA process:

1. Provider submits PA form and all supporting clinical documentation within one (1) business day of admission.
2. If all necessary supporting clinical documentation is submitted and the nurse can make a determination, notification will be sent to the provider within one (1) business day of receipt of PA.
3. Magnolia requires clinical information every five (5) days; however this may vary on a case by case basis.



# NICU PA Process (continued)

## What is the NICU PA process including concurrent reviews?

### UnitedHealthcare Community Plan

NICU admissions do not require prior authorization. Outreach will be made to the facility to obtain clinical information for review within 24 hours of receipt of notification. When initial review is completed, determination is communicated to the facility and additional concurrent reviews are done based on acuity of the infant, impending discharge, and/or other coordination needs every one (1) to seven (7) days.

# Retrospective Review Policy

## What is your retrospective review policy?

### Division of Medicaid

DOM provides retrospective reviews when the beneficiary's admission was not certified and the beneficiary was discharged, for example: the beneficiary was admitted and discharged over a weekend or the length of stay was 19 days or more. DOM provides retroactive Medicaid eligibility for a beneficiary that was eligible for Medicaid benefits at the time of hospitalization, and eligibility was later determined.

### Magnolia Health

Magnolia does not routinely retrospectively authorize services that have already been rendered. Request for retrospective reviews will only be considered in extenuating circumstances (i.e., retroactive eligibility of newborns, out of state non-Mississippi Medicaid provider) and for services when the member is still receiving the services requiring authorization delivered without prior authorization and/or without timely notification. These requests must be reviewed by the Magnolia Chief Financial Officer or the Chief Executive Officer. Medical necessity post-service decisions and subsequent written member and provider notification will occur no later than 20 days from receipt of the request.

# Retrospective Review Policy

## What is the your retrospective review policy?

### **UnitedHealthcare Community Plan**

For NICU cases in which the infant has been discharged prior to or same day of receipt of referral from provider (i.e. the newborn eligibility notification from DOM) the case would be reviewed for appropriateness for retrospective review.

Please ensure that enough clinical information has been provided to the retro team to complete the review. Example: Readmission, Date of Birth, Type of Birth, Type of Delivery, Birth weight in grams (NICU), Gestational Age at birth, surgical history, phototherapy – bilirubin levels are included, NAS scores and treatment/medications/diagnostic studies, clinical details to level each inpatient day.

# Plan Changes During Stay

What is the CCOs' policy for covering an inpatient stay for a member who changes CCOs during the inpatient stay?

## **Magnolia Health and UnitedHealthcare Community Plan**

Both CCOs (Magnolia Health and UnitedHealthcare Community Plan) are working collaboratively to develop a policy for members who change CCO during an inpatient stay.

# Maternity Observation

## What is the CCOs' policy for maternity observation?

### **Magnolia Health**

Magnolia follows the APR-DRG Methodology and observation stays are recognized as 8-23 hours. The APR-DRG rule states that if a patient is admitted for less than eight (8) hours the stay should be billed for diagnostic services using the appropriate revenue codes and procedure codes. If the stay is greater than eight (8) hours and up to 23 hours the stay can be processed and billed as Observation and a request for authorization should be submitted. If the observation stay results in an inpatient admission and delivery, then the overall service type should be changed to C-section or vaginal delivery.

### **UnitedHealthcare**

Observation stays do not require prior authorization. All antepartum admissions will have clinical review for medical necessity. If cases do not meet Milliman CareGuidelines (MCG) criteria for inpatient admission, admitting facility will be notified with an offer to accept observation status. If observation status is accepted, that status is approved. If request remains for non-supported admission, a denial of admission will be administered.

# OVERSIGHT

# DOM Hospital Inpatient Oversight

## Inpatient Claims

### How will DOM monitor claims denials by MississippiCAN providers?

- DOM will monitor denials through required monthly reporting from the CCOs.
- An explanation will be required for any percentage of denial in excess of two (2) percent of total claims. Any denials for prior-authorization in excess of one (1) percent of total claims processed with prior-authorization should be specifically explained.

## Quality Improvement Organization (QIO) Oversight

- eQHealthSolutions (eQHS) will remain the Quality Improvement Organization responsible for oversight and all utilization management and reimbursement reviews, including for MississippiCAN beneficiaries. This includes the following:
  - Clinical quality review
  - Utilization Management determination review
  - APR-DRG coding validation
  - Claims Adjudication logic validation

# DOM Hospital Inpatient Oversight

## (continued)

### Inpatient Claims

### Clinical/Medical Oversight

- Specific DOM contractors are required to have the capacity and procedures to perform clinical consultations in order to assist DOM in addressing the following areas:
  - Medical necessity issues
  - Researching new technology
  - Developing medical policies
  - Addressing quality issues
- Clinical oversight is performed by a provider of equal or greater specialty or licensure for the various types of healthcare practitioners participating in the MS Medicaid program



# CLAIMS

# Newborn Inpatient Claims

## Information about Inpatient Claims

### **How will MississippiCAN payments compare to current FFS payments from DOM?**

- Both MississippiCAN and DOM pay for hospital inpatient services based on the APR-DRG payment methodology using the approved State Plan parameters.

### **How often are the APR-DRG payments updated by DOM and MississippiCAN contractors?**

- The FFS APR-DRG payments are updated at least once annually by DOM and Xerox.
- The MississippiCAN contractors will be notified by DOM of the updated APR-DRG payments and parameters and are required to implement these updates on the effective date.

# Third Party Liability

## Third Party Liability (TPL)

### Does Third Party Liability apply under managed care?

- *Yes.* Third Party Liability (TPL) refers to the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan including Medicaid CCOs.

### Does the beneficiary's third party insurance information affect the payment of inpatient hospital claims?

- *Yes.* A method of avoiding payment of Medicaid claims when other insurance resources are available to the Medicaid beneficiary is called Cost Avoidance. Whenever the Medicaid agency is billed first, claims are denied and returned to the provider who is required to bill and collect from liable third parties. CCOs will follow these same guidelines.

### Will DOM conduct a third party liability audit?

- *Yes.* An annual audit will be conducted by the Office of Recovery. The purpose of the review is to ensure CCOs are accurately cost avoiding expenditures and recovering monies from any third party sources responsible for paying claims of Medicaid beneficiaries. CCOs will receive a list of randomly selected beneficiaries with dates of service within the specific fiscal year. A report of all claim activity for the beneficiaries must be submitted for review within 30 days from the date of the listing. DOM will notify CCOs of findings.

# MississippiCAN

## Hospital Inpatient Transition

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