

OVERVIEW OF PROGRAM

This section contains general information about HealthSystems of Mississippi's (HSM's) review program. For more details regarding how and when review is performed, we strongly encourage you to read through the sections in this manual which contain HSM's policies and procedures for all review.

HSM has been authorized by the Division of Medicaid (DOM) to carry out the Utilization Management and Quality Improvement Services for the State of Mississippi. In this role, HSM conducts utilization and quality review as outlined in general below, and in more detail throughout this manual. Our offices are located in downtown Jackson at the following address: **175 East Capitol Street, Suite 250, Lockbox 13, Jackson, MS, 39201.**

HSM's OPERATIONS

HSM's business offices are open from 8:00 a.m. to 5:00 p.m., Monday through Friday. Our direct office telephone number is (601) 352-6353. Our direct fax number is (601) 352-6358.

HSM provides a **help-line** through which DME providers can check the status of a review or call for more information on the review process. This help-line can be accessed from the hours of 8:00 a.m. through 5:00 p.m., Monday through Friday. The help-line number is **(601) 360-4888.**

HSM also provides a toll-free **hot-line** through which beneficiaries and providers can report quality concerns and/or complaints. This hot-line can be accessed from the hours of 8:00 a.m. through 5:00 p.m., Monday through Friday. The hot-line number is **1-888-204-0221.**

HSM provides a **fax number** through which providers can request certification for all Durable Medical Equipment, Orthotics, Prosthetics, and Medical Supplies. **The fax number for requesting certification is 1-888-204-0159.** You can mail your reviews to

Health Systems of Mississippi
Attn: DME Department
175 East Capitol, Suite 250, Lockbox 13
Jackson, Mississippi 39201

PROGRAM NOTES

Durable Medical Equipment, Orthotics, Prosthetics and Medical Supplies, other than items exempt from certification as specified by the Division of Medicaid (DOM), must be certified through HSM. Please refer to the following guidelines:

- HSM applies DOM's Medical Review Policy in the evaluation of the medical necessity and appropriateness of DME, Orthotics, Prosthetics and Medical Supplies. DOM's Medical Review Policy (criteria) is available on DOM's web site (www.dom.state.ms.us).

- HSM issues a Treatment Authorization Number (TAN) to be used when filing claims for services certified by HSM. The TAN replaces the (prior authorization) DM number.
- HSM performs retrospective (after the fact) certification review in instances where the patient was not eligible for Medicaid at the time of delivery of the DME, Orthotics, Prosthetics, and/or Medical Supplies, and has since become **retroactively eligible** for Medicaid.
- An HSM certification determination does not guarantee Medicaid payment for services or the amount of payment for Medicaid services. Eligibility for payment of Medicaid services is subject to all terms, conditions, and limitations of the Medicaid Program.

SUMMARY OF REVIEW ACTIVITIES

General Information

For first level reviews, HSM uses only licensed professional registered nurses, Utilization Review Coordinators (URC), in all of its review activities. URCs use pre-determined medical review criteria to verify medical necessity. If the URC cannot make a determination regarding medical necessity, the case must be referred to a Physician Advisor (PA). Only physicians can make adverse determinations (denials). If an item is denied, written notification is sent to the beneficiary/representative, the DME provider, and the ordering physician/physician assistant/nurse practitioner.

HSM provides written notification through use of a computer assisted fax system referred to as “auto-fax” or by conventional mail. The auto-fax system affords rapid (real time) transmission of review decisions (notification letters) to the DME provider. Providers, who do not request auto-fax, are notified by mail and telephone.

Providers with multiple offices of operations may choose to have their notifications sent to the location submitting the certification review request. HSM issues a “HSM Assigned Identification Number” that is to be used ONLY for requesting HSM certification. HSM Assigned Identification Numbers are not to be used for billing purposes.

Please contact our help-line if you have questions regarding the above information.

CERTIFICATION

Certification is a condition for reimbursement and is not a guarantee of payment. Durable Medical Equipment, Orthotics, Prosthetics, and Medical Supplies, other than items exempt from certification as specified by DOM policy, must be certified. Certification requests may be submitted prior to or within thirty (30) calendar days of delivery on the appropriate HSM certification forms with the appropriate documentation. Forms are available on the Division of Medicaid’s web site (www.dom.state.ms.us). The beneficiary cannot be billed if the DME provider chooses to deliver the item/service prior to submitting a certification request and approval is not given. The appropriate physician/physician assistant/nurse practitioner must order the item. Documentation must be clear, legible and complete.

HSM makes the determination of medical necessity using the criteria set forth by DOM and assigns a Treatment Authorization Number (TAN) unless the item is exempt from review as specified by DOM policy. HSM review staff applies DOM's Medical Review Policy in the process of certifying requests, and DOM's reimbursement policy and methodology in assignment of reimbursement. DOM's Medical Review Policy (criteria) is available on DOM's web site (www.dom.state.ms.us). HSM completes the review of requests within two (2) business days following receipt of all needed information. For example, a complete request that is submitted on Monday will be completed by close of business on Wednesday. If a claim is submitted to the fiscal agent without a TAN for an item not exempt from review, the claim may not be paid. All review requests must be submitted by mail or fax. No certifications are given via the telephone.

It is the responsibility of the DME provider to verify Medicaid eligibility at the time service is provided. If the beneficiary continues to require services, the DME provider must verify eligibility with each review request. **Retroactive certification after the 30-day period is authorized only in cases where the beneficiary was approved for retroactive eligibility and is not applicable to any other situation.**

CASES EXEMPT FROM REVIEW

Duplicate Request – Upon receipt of a request, HSM determines what has previously been authorized. If HSM staff identifies the request as a duplicate, HSM notifies the DME provider via telephone that the request is a duplicate and does not require review. The request is then mailed back to the provider as written notification.

DME, Orthotics, Prosthetics and Medical Supplies that are furnished by home health agencies or physicians - If it is determined by HSM staff that items are being furnished by a home health agency and/or a physician, HSM cannot perform review.

Medical Eligibility Pending: If the patient has applied for Medicaid and the eligibility determination is pending, HSM cannot perform review. Once eligibility has been determined, HSM performs review based on the eligibility begin date.

PENDED CASES

HSM provides verbal and written notice (by auto-fax or mail) to the provider when additional information is required to complete the certification review. Timeframes for submission of the information is detailed in HSM's policies and procedures included in this manual. Review of the request is pended, awaiting receipt of the requested information. If the requested information is not received in the allotted timeframes, HSM stops (suspends) review of the case and notifies the DME provider that further review of the case is not possible. Review resumes once HSM receives the requested information.

RETROSPECTIVE CERTIFICATION

Retrospective certification review is initiated when a DME provider requests a retrospective review because the beneficiary was not Medicaid eligible at the time services were rendered but has since received a retroactive eligibility status. Refer to the Retrospective Review Policy and Procedure section of this manual for additional information. Under the current contract with the Mississippi

Division of Medicaid, neither HSM nor DOM reimburses providers for the cost associated with duplication of medical records for retrospective review.

RECONSIDERATIONS

If a "DME Notice of Review Outcome – Denial" letter is issued denying DME, Orthotics, Prosthetics and/or Medical Supplies, the beneficiary/representative, DME provider, and attending physician/physician assistant/nurse practitioner have the right to request a reconsideration. The request may be submitted by telephone, fax, or mail to HSM within thirty (30) calendar days of the date of the denial notice for a non-expedited reconsideration or within three (3) business days for an expedited reconsideration. Refer to the Reconsideration Policy and Procedure in this manual for additional information on this process. The form for requesting a reconsideration is located in the Review Activities Section of this manual.

5% QUARTERLY QUALITY SAMPLE REVIEW

This activity involves HSM requesting copies of medical records from DME providers for which certification has been previously obtained for review by Quality Review Nurses (QRN). The records are randomly selected from HSM's database on a quarterly basis; however, to maintain a steady and manageable workload, HSM issues requests to DME providers on a monthly basis. Please be aware that under the current contract, neither Mississippi Division of Medicaid (DOM) nor HSM reimburses providers for the cost associated with duplication of medical records for the 5% Quality Sample activity.

An inventory sheet/medical record checklist is included with each request to assist DME providers in the preparation of the medical record to submit to HSM. The completed inventory sheet must be attached to the front of the medical record copy submitted to HSM. Please refer to the 5% Quarterly Quality Sample Policy and Procedure in this manual for additional information on this activity. DME providers have a maximum of twenty (20) calendar days from HSM's request date to submit the records to HSM at the following address:

**HealthSystems of Mississippi
ATTN: 5% Quality Sample
175 East Capitol Street
Suite 250, Lock Box 13
Jackson, MS 39201**

HSM reviews the medical records to ensure that the information provided during the certification process is substantiated by the medical record. Also, HSM reviews the medical records for potential quality of care issues utilizing quality screens/indicators. If any quality screens are failed at the nurse review level, the medical record is referred for physician review where the potential issue is either confirmed or resolved. Please refer to the Quality Screens in the Quality Assurance Section of this manual for additional information. If a quality issue(s) is confirmed by the physician reviewer, written notification is issued to either the DME provider and/or attending physician/physician assistant/nurse practitioner.

QUALITY RE-REVIEW PROCESS

Any DME provider or attending physician/physician assistant/nurse practitioner who receives written notification of a confirmed quality issue has a right to request a quality re-review by HSM. The request must be submitted in writing to HSM within thirty (30) calendar days from the date of the quality issue notice. The physician who conducts the quality re-review is different from the physician who confirmed the initial quality issue. Please refer to the Quality Re-review Process Policy and Procedure in this manual for additional information. The form for requesting a Quality Re-review is located in the Quality Assurance Section of this manual.

QUALITY INTERVENTION PROCESS/ISSUE WEIGHTING AND INTERVENTION

Quarterly, HSM generates profiles identifying, by attending physician/physician assistant/nurse practitioner and by DME provider, the number of confirmed quality issues, the severity level of those issues, and the frequency of confirmed quality issues. From these profiles, the Quality Intervention Committee at HSM identifies patterns of quality problems and determines appropriate intervention to remedy the patterns. Through this process, HSM works collaboratively with DME providers and physicians/physician assistants/nurse practitioners to implement interventions to improve the quality of care Medicaid beneficiaries receive as well as monitor their effectiveness.

MISSISSIPPI DISCLAIMER STATEMENT

Health Systems of Mississippi's certification determination does not guarantee Medicaid payment for services or the amount of payment for Medicaid services. Eligibility for payment of Medicaid services is subject to all terms and conditions and limitations of the Medicaid Program.