



MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 225
Telemedicine

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Title 23: Division of Medicaid

Part 225: Telemedicine

Part 225 Chapter 1: Telehealth Services

Rule 1.1: Definitions

The Division of Medicaid defines telemedicine as a method which uses electronic information and communication equipment to supply and support health care when remoteness disconnects patients and links primary care physicians, specialists, providers, and beneficiaries which includes, but is not limited to, telehealth services, remote patient monitoring services, teleradiology services, store-and-forward and continuous glucose monitoring services.

- A. The Division of Medicaid defines telehealth services as the delivery of health care by an enrolled Mississippi Medicaid provider, through a real-time communication method, to a beneficiary who is located at a different site. The interaction must be:
1. Live,
 2. Interactive, and
 3. Audiovisual.
- B. The Division of Medicaid defines the originating site, also referred to as the spoke site, as the physical location of the beneficiary at the time the telehealth service is provided.
- C. The Division of Medicaid defines the distant site, also referred to as the hub site, as the physical location of the provider delivering the telehealth service at the time the telehealth service is provided.
- D. The Division of Medicaid defines the telepresenter as medical personnel who:
1. Is a Mississippi Medicaid provider, or employed by a Mississippi Medicaid provider and directly supervised by the provider or an appropriate employee of the provider if the medical personnel's license or certification requires supervision,
 2. Is trained to use the appropriate technology at the originating site,
 3. Is able to facilitate comprehensive exams under the direction of a distant site practitioner who is, or is employed by, a Mississippi Medicaid provider.
 4. Must remain in the exam room for the entirety of the exam unless otherwise directed by the distant site provider for the appropriate treatment of the beneficiary, and
 5. Must act within the scope of their practice, license, or certification.

E. The Division of Medicaid defines direct supervision as the provider's, or an appropriate employee of the provider, presence in the office suite and immediately available to furnish assistance and direction throughout the performance of the telehealth service but does not require the provider to be physically present in the room when the telehealth service is delivered.

Source: 42 C.F.R. § 410.78; Miss. Code Ann. § 43-13-121; SPA 15-003.

History: Revised eff. 08/01/2020; New to correspond with SPA 15-003 (eff. 01/01/2015) eff. 07/01/2015.

Rule 1.2: Provider Enrollment

A. Providers of telehealth services must comply with all requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the provider specific requirements below:

1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),
2. Copy of current licensure card or permit, and
3. Verification of social security number using a social security card, military ID or a notarized statement signed by the provider noting the social security number. The name noted on the verification must match the name noted on the W-9.

B. Providers of telehealth services must be an enrolled Mississippi Medicaid provider acting within their scope-of-practice and license or medical certification or Mississippi Department of Health (MDSH) certification and in accordance with state and federal guidelines, including but not limited to, authorization of prescription medications at both the originating and distant site.

C. The Division of Medicaid requires that providers utilize telehealth technology sufficient to provide real-time interactive communications that provide the same information as if the telehealth visit was performed in-person. Equipment must also be compliant with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA).

D. The use and delivery of telemedicine services does not alter a provider's privacy obligations under federal and/or state law and a provider or entity operating telehealth services that involve protected health information (PHI) must meet the same Health Insurance Portability and Accountability Act (HIPAA) requirements the provider or entity would for a service provided in person.

Source: 42 C.F.R. § 410.78; The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (as amended by the Genetic Information Nondiscrimination Act (GINA) of 2008)

and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act (ARRA) Of 2009) and its implementing regulations, including 45 C.F.R. Parts 160 and 164, Subparts A and E (Privacy Rule), and Subparts A and C (Security Rule); Miss. Code Ann. § 43-13-121; SPA 20-0010; SPA 15-003.

History: Revised eff. 08/01/2020; Revised eff. 07/01/2018; Added Miss. Admin. Code Part 225, Rule 1.2.C.6. eff. 05/01/2016; New to correspond with SPA 15-003 (eff. 01/01/2015) eff. 07/01/2015.

Rule 1.3: Covered Services

- A. The Division of Medicaid covers medically necessary telehealth services as a substitution for an in-person visit for consultations, office visits, and/or outpatient visits when all the required medically appropriate criteria is met which aligns with the description of the Current Procedural Terminology (CPT) evaluation and management (E&M) and Healthcare Common Procedure Coding System (HCPCS) guidelines.
- B. The Division of Medicaid covers telehealth services at the following locations:
 - 1. At the following originating sites:
 - a) Office of a physician or practitioner,
 - b) Outpatient Hospital (including a Critical Access Hospital (CAH)),
 - c) Rural Health Clinic (RHC),
 - d) Federally Qualified Health Center (FQHC),
 - e) Community Mental Health/Private Mental Health Centers,
 - f) Therapeutic Group Homes,
 - g) Indian Health Service Clinic,
 - h) School-based clinic,
 - i) School which employs a school nurse,
 - j) Inpatient hospital setting, or
 - k) Beneficiary's home.
 - 2. At the distant site the following provider types are allowed to render telehealth services:

- a) Physicians,
- b) Physician Assistants,
- c) Nurse Practitioners,
- d) Psychologists,
- e) Licensed Clinical Social Workers (LCSWs),
- f) Licensed Professional Counselors (LPCs),
- g) Licensed Marriage and Family Therapists (LMFTs),
- h) Board Certified Behavior Analysts (BCBAs) or Board Certified Behavior Analyst-Doctorals (BCBA-Ds),
- i) Community Mental Health Centers (CMHCs),
- j) Private Mental Health Centers,
- k) Federally Qualified Health Centers (FQHCs),
- l) Rural Health Centers (RHCs),
- m) Physical, occupational or speech therapy, or
- n) Mississippi State Department of Health (MSDH) clinics.

C. The Division of Medicaid requires a telepresenter who meets the requirements of Miss. Admin Code Part 225, Rule 1.1.D. at the originating site unless the originating site is the beneficiary's home or as determined by the Division.

Source: 42 C.F.R. § 410.78; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-003.

History: Revised eff. 02/01/2024. Revised eff. 07/01/2021; Revised eff. 08/01/2020; New to correspond with SPA 15-003 (eff. 01/01/2015) eff. 07/01/2015.

Rule 1.4: Non-Covered Services

The Division of Medicaid does not:

- A. Cover a telehealth service if that same service is not covered in an in-person setting.
- B. Cover a separate reimbursement for the installation or maintenance of telehealth hardware, software and/or equipment, videotapes, and transmissions.

- C. Cover early and periodic screening, diagnosis, and treatment (EPSDT) well child visits through telehealth.
- D. Cover physician or other practitioner visits through telehealth for:
 - 1. Non-established beneficiaries, and/or
 - 2. Evaluation and Management Level IV or V visits.
- E. Consider the following as telehealth services:
 - 1. Telephone conversations,
 - 2. Chart reviews;
 - 3. Electronic mail messages;
 - 4. Facsimile transmission;
 - 5. Internet services for online medical evaluations, or
 - 6. Communication through social media, or
 - 7. Any other communication made in the course of usual business practices including, but not limited to,
 - a) Calling in a prescription refill, or
 - b) Performing a quick virtual triage.
- F. Cover the installation or maintenance of any telecommunication devices or systems.

Source: 42 C.F.R. § 410.78; Miss. Code Ann. § 43-13-121; SPA 15-003.

History: Revised eff. 02/01/2024. Revised eff. 07/01/2021; Revised eff. 08/01/2020; New to correspond with SPA 15-003 (eff. 01/01/2015) eff. 07/01/2015.

Rule 1.5: Reimbursement

- A. The Division of Medicaid reimburses the provider at the originating site the Mississippi Medicaid telehealth originating site facility fee for telehealth services per completed transmission, in addition to a separately identifiable covered service if performed.
 - 1. The following providers are eligible to receive the originating site facility fee for telehealth services per transmission:

- a) The office of a physician or practitioner,
 - b) An outpatient hospital, including a Critical Access Hospital (CAH),
 - c) A Rural Health Clinic (RHC),
 - d) A Federally Qualified Health Center (FQHC),
 - e) A Community Mental Health/Private Mental Health Center,
 - f) A Therapeutic Group Home,
 - g) An Indian Health Service Clinic,
 - h) A School-Based Clinic, or
 - i) School which employs a nurse.
2. The originating site provider can only bill for an encounter or Evaluation and Management (E&M) visit if a separately identifiable covered service is performed.
 3. An inpatient hospital's originating site fee is included in the All Patient Refined/Diagnosis Related Group (APR-DRG) payment.
- B. The Division of Medicaid reimburses all providers delivering a medically necessary telehealth service at the distant site at the current applicable Mississippi Medicaid fee-for-service rate or encounter for the service provided. The provider must include the appropriate modifier on the claim indicating the service was provided through telehealth.
- C. Providers delivering simultaneous distant and originating site services to a beneficiary are reimbursed:
1. The current applicable Mississippi Medicaid fee-for-service rate for the medical service(s) provided, and
 2. Either the originating or distant site facility fees, not both, except for RHC, FQHC and CMHC when such services are appropriately provided by the same organization.

Source: 42 C.F.R. § 410.78; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-003.

History: Revised eff. 07/01/2021; Revised eff. 08/01/2020; Revised eff. 07/01/2018; Added Miss. Admin. Code Part 225, Rule 1.5.B.2.f) eff. 05/01/2016; New to correspond with SPA 15-003 (eff. 01/01/2015) eff. 07/01/2015.

Rule 1.6: Documentation

The provider must document the same information as for a comparable in-person service and be maintained at both the originating and distant site of the telehealth services provided including, but not limited to:

- A. Signed consent for treatment using telehealth,
- B. Medically appropriate reason telehealth was utilized to provide services,
- C. Beneficiary's presenting diagnosis and symptoms,
- D. Specific name/type of all diagnostic studies and results/findings of the studies, and
- E. Plan of Care.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2020; New to correspond with SPA 15-003 (eff. 01/01/2015) eff. 07/01/2015.

Rule 1.7: Procedures during States of Emergency

The Mississippi Division of Medicaid will allow additional coverage of telehealth services during a state of emergency as declared by either the Governor of Mississippi or the President of the United States. Details of enhanced services include the following that will terminate at the discretion of the Mississippi Division of Medicaid:

- A. A beneficiary may seek treatment utilizing telehealth services from an originating site not listed in the Mississippi Medicaid State Plan regarding Telehealth (SPA 3.1-A Introductory Pages 1 and 2). These emergency exceptions include the following:
 - 1. A beneficiary's residence may be an originating site without prior approval by the Division of Medicaid.
 - 2. Health care facilities not listed in the State Plan wishing to act as an originating site must first be granted approval by the Division of Medicaid before rendering originating site telehealth services.
- B. A beneficiary may seek treatment utilizing telehealth services from a distant site provider not listed under Miss. Admin. Code Part 223, Rule 1.3. as determined by the Division of Medicaid.
- C. Telehealth services are expanded to include use of telephonic audio that does not include video when authorized by the State of Mississippi.
- D. A beneficiary may use the beneficiary's personal telephonic land line in addition to a cellular device, computer, tablet, or other web camera-enabled device to seek and receive medical care in a synchronous format with a distant-site provider.

- E. When the beneficiary receives services in the home, the requirement for a telepresenter to be present may be waived.
- F. The Division of Medicaid requires that providers utilize telehealth technology compliant with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA) or otherwise compliant with guidance or notifications regarding the HIPAA Privacy and Security Rules issued by the Office of Civil Rights of the U.S. Department of Health and Human Services that is specific to the State of Emergency.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121; MS SPA 20-0015.

History: Revised eff. 08/01/2020; New Rule to correspond with SPA 20-0015 (eff. 03/01/2020) eff. 03/20/2020.

Part 225 Chapter 2: Remote Patient Monitoring Services

Rule 2.1: Definitions

- A. The Division of Medicaid defines telemedicine as a method which uses electronic information and communication equipment to supply and support health care when remoteness disconnects patients and links primary care physicians, specialists, providers, and beneficiaries which includes, but is not limited to, telehealth services, remote patient monitoring services, teleradiology services, store-and-forward and continuous glucose monitoring services.
- B. The Division of Medicaid defines remote patient monitoring as using digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to healthcare providers in a different location for interpretation and recommendation.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 2.2: General Provider Information

- A. Providers of remote patient monitoring services must comply with all requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the provider specific requirements below:
 1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),
 2. Copy of current licensure card or permit, and
 3. Verification of social security number using a social security card, military ID or a

notarized statement signed by the provider noting the social security number. The name noted on the verification must match the name noted on the W-9.

- B. Remote patient monitoring services must be delivered by an enrolled Medicaid provider acting within their scope-of-practice and license and in accordance with state and federal guidelines.
- C. The use and delivery of remote patient monitoring services does not alter a covered provider's privacy obligations under federal/and or state law and a provider or entity operating telehealth services that involve protected health information ("PHI") must meet the same HIPAA requirements the provider or entity would for a service provided in person.
- D. Providers of remote patient monitoring services must have protocols in place to address all of the following:
 - 1. A mechanism for monitoring, tracking and responding to changes in a beneficiary's clinical condition, and
 - 2. A process for notifying the prescribing physician of significant changes in the beneficiary's clinical signs and symptoms.

Source: The Health Insurance Portability and Accountability Act ("HIPAA") of 1996 (as amended by the Genetic Information Nondiscrimination Act ("GINA") of 2008 and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act ("ARRA") of 2009) and its implementing regulations, including 45 C.F.R. Parts 160 and 164, Subparts A and E ("Privacy Rule"), and Subparts A and C ("Security Rule"); Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 2.3: Covered Services

- A. The Division of Medicaid covers remote patient monitoring of devices when medically necessary, ordered by a physician, physician assistant or nurse practitioner which includes, but not limited to:
 - 1. Implantable pacemakers,
 - 2. Defibrillators,
 - 3. Cardiac monitors,
 - 4. Loop recorders,
 - 5. External mobile cardiovascular telemetry, and

6. Continuous glucose monitors.

B. The Division of Medicaid covers remote patient monitoring, for disease management when medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), Division of Medicaid or designee, ordered by a physician, physician assistant, or nurse practitioner for a beneficiary who meets the following criteria:

1. Has been diagnosed with one (1) or more of the chronic conditions as defined by the Centers of Medicare and Medicaid Services (CMS) which include, but are not limited to:
 - a) Diabetes,
 - b) Congestive Heart Failure (CHF),
 - c) Chronic Obstructive Pulmonary Disease (COPD),
 - d) Heart disease,
 - e) Mental health, and
 - f) Sickle cell.
2. Is capable of using the remote patient monitoring equipment and transmitting the necessary data or has a willing and able person to assist in completing electronic transmission of data.

C. Prior Authorization must include the following:

1. An order for remote patient monitoring services, signed and dated by the prescribing physician,
2. A plan of care, signed and dated by the prescribing physician, that includes transmission frequency and duration of monitoring requested,
3. Beneficiary's diagnosis and risk factors that qualify the beneficiary for remote patient monitoring,
4. Attestation that the beneficiary is cognitively intact and able to operate the equipment or has a willing and able person to assist in completing transmission of data, and
5. Attestation that the beneficiary is not receiving duplicative services via disease management.

D. Remote patient monitoring services must be provided in the beneficiary's private residence.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121, 83-9-353.

History: Revised eff. 07/01/2021, Revised eff. 01/01/2021; New eff. 07/01/2015.

Rule 2.4: Non-Covered Services

The Division of Medicaid does not cover remote patient monitoring for disease management as outlined in Miss. Admin. Code Part 225, Rule 2.3.B. for a beneficiary who is a resident of an institution that meets the basic definition of a hospital or long-term care facility.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 2.5: Reimbursement

A. The Division of Medicaid reimburses for remote patient monitoring:

1. Of devices when billed with the appropriate code, and
2. For disease management:
 - a) A daily monitoring rate for days the beneficiary's information is reviewed.
 - b) Only one (1) unit per day is allowed, not to exceed thirty-one (31) days per month.
 - c) An initial visit to install the equipment and train the beneficiary may be billed as a set-up visit.
 - d) Only one set-up is allowed per episode even if monitoring parameters are added after the initial set-up and installation.
 - e) Only one (1) daily rate will be reimbursed regardless of the number of diseases/chronic conditions being monitored.

B. The Division of Medicaid does not reimburse for the duplicate transmission or interpretation of remote patient monitoring data.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 2.6: Documentation

The provider must document the remote patient monitoring service the same as for a comparable in person service which includes, but is not limited to:

A. The monitoring equipment meets all of the following requirements:

1. Capable of monitoring any data parameters included in the plan of care,
 2. Food and Drug Administration (FDA) Class II hospital-grade medical device, and
 3. Capable of accurately measuring and transmitting beneficiary glucose and/or blood pressure data.
- B. Qualified staff installed the remote patient monitoring equipment necessary to monitor and transmit the data according to the beneficiary's care plan.
- C. Clinical data was provided to the beneficiary's primary care physician or his/her designee.
- D. Monitoring of the beneficiary's clinical data was not duplicated by any other provider.
- E. Beneficiary's home environment has the necessary space and connections for installation and transmission of data.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Part 225 Chapter 3: Teleradiology Services

Rule 3.1: Definitions

The Division of Medicaid defines telemedicine as a method which uses electronic information and communication equipment to supply and support health care when remoteness disconnects patients and links primary care physicians, specialists, providers, and beneficiaries which includes, but is not limited to, telehealth services remote patient monitoring services, teleradiology services, store-and-forward and continuous glucose monitoring services.

- A. The Division of Medicaid defines store-and-forward as telecommunication technology for the transfer of medical data from one (1) site to another through the use of a camera or similar device that records or stores an image which is transmitted or forwarded via telecommunication to another site for teleconsultation and includes, but is not limited to, teleradiology services.
- B. The Division of Medicaid defines a:
1. Teleradiology service as the electronic transmission of radiological images, known as store-and-forward images, from one (1) location to another for the purposes of interpretation.
 2. Consulting provider as a licensed physician who interprets the radiological image, at the distant site and who must be licensed in the state within the United States in which he/she practices.

3. Distant site, also referred to as a hub site, as the location of the teleradiology consulting provider.
4. Referring provider as a licensed physician, physician assistant, or nurse practitioner who orders the radiological service and who must be licensed in the state within the United States in which he/she practices.
5. Originating site, also referred to as the spoke site, as the location where the beneficiary is receiving the teleradiology service.
6. Store-and-forward as telecommunication technology for the transfer of medical data from one (1) site to another through the use of a camera or similar device that records or stores an image which is transmitted or forwarded via telecommunication to another site for teleconsultation and includes, but is not limited to, teleradiology.
7. The transmission cost as the cost of the line charge incurred during the time of the transmission of a telehealth service.

Source: Miss. Code Ann. § 43-13-121.

History: Moved from Miss. Admin. Code Part 220, Rule 1.4. eff. 07/01/2015.

Rule 3.2: General Provider Information

- A. Providers of teleradiology services must comply with all requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the provider specific requirements below:
 1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),
 2. Copy of current licensure card or permit, and
 3. Verification of social security number using a social security card, military ID or a notarized statement signed by the provider noting the social security number. The name noted on the verification must match the name noted on the W-9.
- B. Teleradiology services must be delivered by an enrolled Medicaid provider acting within their scope-of-practice and license and in accordance with state and federal guidelines.
- C. The use and delivery of teleradiology services does not alter a covered provider's privacy obligations under federal/and or state law and a provider or entity operating telehealth services that involve protected health information ("PHI") must meet the same HIPAA requirements the provider or entity would for a service provided in person.

D. The teleradiology service provider must ensure:

1. Images are provided without clinically significant loss of data from image acquisition through transmission to final image display to enable the consulting provider to accurately interpret the image,
2. Equipment used provides image quality appropriate to the clinical need.
3. The radiologic examination at the originating site be performed at the originating site by qualified personnel:
 - a) Trained in the performance of the specified radiological service,
 - b) Operating within the licensure requirements of the state in which the service is being performed, and
 - c) Under the supervision of a qualified licensed physician.
4. Teleradiology systems provide network and software security protocols to protect the confidentiality of a beneficiary's identification and imaging data with measures implemented to safeguard the data and to ensure data integrity against intentional or unintentional corruption of the data.

Source: The Health Insurance Portability and Accountability Act ("HIPAA") of 1996 (as amended by the Genetic Information Nondiscrimination Act ("GINA") of 2008 and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act ("ARRA") of 2009) and its implementing regulations, including 45 C.F.R. Parts 160 and 164, Subparts A and E ("Privacy Rule"), and Subparts A and C ("Security Rule"); Miss. Code Ann. § 43-13-121.

History: Moved with Revisions from Miss. Admin. Code Part 220, Rule 1.4. eff. 07/01/2015.

Rule 3.3: Covered Services

The Division of Medicaid covers:

- A. One (1) technical and one (1) professional component for each teleradiology procedure only for providers enrolled as a Mississippi Medicaid provider and when there are no geographically local radiologist providers to interpret the images.
- B. The technical component of the radiological service is covered at the originating site.
- C. The professional component of the radiological service is covered at the distant site.

Source: Miss. Code Ann. § 43-13-121.

History: Moved with Revisions from Miss. Admin. Code Part 220, Rule 1.4. eff. 07/01/2015.

Rule 3.4: Non-Covered Services

The Division of Medicaid does not cover:

- A. The transmission cost or any other associated cost of teleradiology,
- B. Both the technical and professional component of teleradiology services for one (1) provider,
or
- C. One (1) provider billing for services performed by another provider.

Source: Miss. Code Ann. § 43-13-121.

History: Moved from Miss. Admin. Code Part 220, Rule 1.4. eff. 07/01/2015.

Rule 3.5: Reimbursement

- A. The Division of Medicaid reimburses for:
 - 1. The technical component of the radiological service at the originating site for only providers enrolled as a Mississippi Medicaid provider.
 - 2. The professional component of the radiological service at the distant site only for providers enrolled as a Mississippi Medicaid provider.
- B. If a hospital chooses to bill for purchased or contractual teleradiology services, the service must be billed under a physician group provider number only.

Source: Miss. Code Ann. § 43-13-121.

History: Moved from Miss. Admin. Code Part 220, Rule 1.4. eff. 07/01/2015.

Rule 3.6: Documentation

- A. Teleradiology documentation must include, but not limited to:
 - 1. At the originating site:
 - a) The reason teleradiology was utilized to deliver the service including there was no local radiologists to interpret the images,
 - b) Date(s) of service,

- c) Beneficiary demographic information,
- d) Signed consent for treatment, if applicable,
- e) Medical history,
- f) Beneficiary's presenting complaint,
- g) Diagnosis, and
- h) Specific name/type of all diagnostic studies and results/findings of the studies.

2. At the distant site:

- a) Date(s) of service,
- b) Beneficiary demographic information,
- c) Medical history,
- d) Beneficiary's presenting complaint,
- e) Diagnosis,
- f) Specific name/type of all diagnostic studies and results/findings of the studies, and
- g) Radiological images.

Source: Miss. Code Ann. § 43-13-121.

History: Moved from Miss. Admin. Code Part 220, Rule 1.4. eff. 07/01/2015.

Part 225 Chapter 4: Continuous Glucose Monitoring Services

Rule 4.1: Definitions

- A. The Division of Medicaid defines telemedicine as a method which uses electronic information and communication equipment to supply and support health care when remoteness disconnects patients and links primary care physicians, specialists, providers, and beneficiaries which includes, but is not limited to, telehealth services remote patient monitoring services, teleradiology services, store-and-forward, and continuous glucose monitoring services.
- B. The Division of Medicaid defines a continuous glucose monitoring service as:
 - 1. The download, retrospective review and interpretation of blood glucose values by a physician, physician's assistant or nurse practitioner when captured for more than seventy-

two (72) hours on a continuous glucose monitor system, and

2. Adjunct monitoring, not an alternative, to traditional self-monitoring of blood glucose levels, supplying additional information on glucose trends that are not available from self-monitoring.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 4.2: General Provider Information

- A. Providers of continuous glucose monitoring services must comply with all requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the provider specific requirements below:
 1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),
 2. Copy of current licensure card or permit, and
 3. Verification of social security number using a social security card, military ID or a notarized statement signed by the provider noting the social security number. The name noted on the verification must match the name noted on the W-9.
- B. Continuous glucose monitoring services must be delivered by an enrolled Medicaid provider acting within their scope-of-practice and license and in accordance with state and federal guidelines.
- C. The use and delivery of continuous glucose monitoring services does not alter a covered provider's privacy obligations under federal/and or state law and a provider or entity operating telehealth services that involve protected health information ("PHI") must meet the same HIPAA requirements the provider or entity would for a service provided in person.

Source: The Health Insurance Portability and Accountability Act ("HIPAA") of 1996 (as amended by the Genetic Information Nondiscrimination Act ("GINA") of 2008 and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act ("ARRA") Of 2009) and its implementing regulations, including 45 C.F.R. Parts 160 and 164, Subparts A and E ("Privacy Rule"), and Subparts A and C ("Security Rule"); Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 4.3: Covered Services

A. The Division of Medicaid covers:

1. A continuous glucose monitoring (CGM) service when medically necessary, prior authorized by the UM/QIO, Division of Medicaid or designee, ordered by the physician who is actively managing the beneficiary's diabetes and the beneficiary meets all of the following criteria:
 - a) Has an established diagnosis of type I or type II diabetes mellitus that is poorly controlled as defined below:
 - 1) Unexplained hypoglycemic episodes,
 - 2) Nocturnal hypoglycemic episode(s),
 - 3) Hypoglycemic unawareness and/or frequent hypoglycemic episodes leading to impairments in activities of daily living,
 - 4) Suspected postprandial hyperglycemia,
 - 5) Recurrent diabetic ketoacidosis, or
 - 6) Unable to achieve optimum glycemic control as defined by the most current version of the American Diabetes Association (ADA).
 - b) Be able, or have a caregiver who is able, to hear and view CGM alerts and respond appropriately.
 - c) Has documented self-monitoring of blood glucose at least four (4) times per day.
 - d) Requires insulin injections three (3) or more times per day or requires the use of an insulin pump for maintenance of blood glucose control.
 - e) Requires frequent adjustment to insulin treatment regimen based on blood glucose testing results,
 - f) Had an in-person visit with the ordering physician within six (6) months prior to ordering to evaluate their diabetes control and determined that criteria (1-4) above are met,
 - g) Has an in-person visit every six (6) months following the prescription of the CGM to assess adherence to the CGM regimen and diabetes treatment plan.
2. CGM service only when the blood glucose data is obtained from a Federal Drug Administration (FDA) approved durable medical equipment (DME) medical device for home use.

- B. The Division of Medicaid does not require the provider to have a face-to-face office visit with the beneficiary to download, review and interpret the blood glucose data.

Source: 42 U.S.C. § 1395x(n); Miss. Code Ann. § 43-13-121.

History: Revised eff. 10/01/2023; Revised eff. 07/01/2021; New eff. 07/01/2015.

Rule 4.4: Non-Covered Services

- A. The Division of Medicaid does not cover non-medically necessary non-durable medical equipment (DME) CGM devices that are not approved by the Food and Drug Administration (FDA) and do not comply with the FDA and American Diabetes Association (ADA) recommendations.

- B. The Division of Medicaid does not cover non-DME devices including, but not limited to, smartphones, tablets, or personal computers.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2021; New eff. 07/01/2015.

Rule 4.5: Reimbursement

- A. The Division of Medicaid reimburses for:

1. One (1) retrospective review and interpretation of blood glucose values per month, and
2. A one (1) time device hook-up which includes beneficiary education.

- B. The Division of Medicaid does not reimburse for a separate Evaluation and Management (E&M) visit unless a separately identifiable service is performed.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 4.6: Documentation

Continuous glucose monitoring (CGM) service documentation must include, but is not limited to:

- A. The beneficiary and/or care giver is capable of operating the continuous glucose monitoring system,

- B. The beneficiary:

1. Has an established diagnosis of type I or type II diabetes mellitus that is poorly controlled

as defined in Miss. Admin. Code Part 225, Rule 4.3.A.1.a),

2. Requires three (3) insulin injections per day, or use of an insulin pump, for maintenance of blood glucose control,
 3. Requires regular self-monitoring of at least four (4) times a day,
 4. Requires frequent adjustment to insulin treatment regimen based on blood glucose testing results,
 5. Had an in-person visit with the ordering physician within six (6) months prior to ordering to evaluate their diabetes control and determined that criteria (1-4) above are met,
 6. Has an in-person visit every six (6) months following the prescription of the CGM to assess adherence to the CGM regimen and diabetes treatment plan.
- C. The CGM is a Food and Drug Administration (FDA) approved medical device and is capable of accurately measuring and transmitting beneficiary blood data.

Source: 42 U.S.C. § 1395x(n); Miss. Code Ann. §§ 43-13-117, 43-13-121, 83-9-353.

History: Revised eff. 10/01/2023; Revised eff. 07/01/2021; New eff. 07/01/2015.