



MISSISSIPPI DIVISION OF  
**MEDICAID**

## Mississippi Medicaid

### Provider Reference Guide

#### Part 200

### General Provider Information

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

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# INTRODUCTION

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In an effort to comply with the Mississippi Administrative Procedures Act, the Division of Medicaid relocated the policy information previously contained in the Provider Policy Manuals to the Mississippi Administrative Code, Title 23, effective April 1, 2012. While there were no substantive changes to the information previously contained in the Medicaid Provider Policy Manuals, all forms, tables, charts, contact information, web addresses, etc., were removed. For this reason, the Division created the Provider Reference Guide (PRG) to communicate to providers any pertinent information not included in the Mississippi Administrative Code.

The PRG is divided into the same Parts as Title 23 of the Mississippi Administrative Code and is meant to aid providers in understanding Medicaid procedures, processes and coverage criteria. The PRG is designed as an instructional tool with contact information, charts, website addresses, etc., used in administering the Medicaid program. The PRG also instructs providers where to find additional information for questions not addressed in the PRG. A brief description and location of information for a particular Medicaid program area can be found in the Table of Contents.

## **THE MISSISSIPPI ADMINISTRATIVE CODE, TITLE 23, TAKES PRECEDENCE OVER THE PROVIDER REFERENCE GUIDE IN THE CASE OF ANY DISCREPANCY.**

The PRG is not intended to be an all-inclusive interpretation of the Medicaid program. It is the provider's responsibility to become knowledgeable of the Medicaid program requirements by referring to Title 23 of the Mississippi Administrative Code, the PRG, Provider Bulletins and other information pertinent to the performance of Medicaid services. Revisions and updates to the guides will be made with changes in healthcare initiatives, legislative directives, and Medicaid procedures. Providers will be notified of changes through Medicaid bulletins, payment register messages, correspondence, and Administrative Code filings with the Secretary of State.

## **THE PRG CONTAINS THE FOLLOWING CODE SETS**

Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS)

Maintained by the American Medical Association, the CPT and HCPCS code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

International Classification of Diseases, Clinical Modification (ICD-9-CM) Code Sets

Coordinated and maintained by the National Center for Health Statistics (NCHS) and Centers for Medicare and Medicaid Services (CMS), ICD-9-CM is used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office utilization.

## GENERAL ADMINISTRATIVE RULES FOR PROVIDERS

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At the present time, there is no additional information for this section. Please refer to the Administrative Code.

## BENEFITS

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At the present time, there is no additional information for this section. Please refer to the Administrative Code.

## BENEFICIARY INFORMATION

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At the present time, there is no additional information for this section. Please refer to the Administrative Code.

## PROVIDER ENROLLMENT

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At the present time, there is no additional information for this section. Please refer to the Administrative Code.

## GENERAL

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At the present time, there is no additional information for this section. Please refer to the Administrative Code.

## INDIAN HEALTH SERVICES INTRODUCTION

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Medicaid, as authorized by Title XIX of the Social Security Act (SSA), 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 (DOM), 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. 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. DOM initiates Medicaid policy as it relates to these factors.

Governmental responsibility for the provision of health services to the American Indian/Alaskan Native (AI/NI) population evolved through numerous Supreme Court decisions, treaties, Executive Orders, and legislation. Principal legislation authorizing federal funds for health services came through the Snyder Act of 1921. The Transfer Act of 1954 transferred the responsibility for Indian health services from the Bureau of Indian Affairs to the Department of Health, Education and Welfare (HEW), now the Department of Health and Human Services (DHHS). The Indian Health Service (IHS), an agency within DHHS, was established as the agency responsible for providing federal health services to the American Indian/Alaskan Native (AI/AN) population. The Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended) gave Tribes the option of assuming the operation of health services and community programs from Indian Health Services (IHS) or remaining within the IHS administered system. Subsequently the Indian Health Care Improvement Act (Public Law 94-437) was enacted to provide the quality and quantity of health services needed to elevate the health status of American Indians/Alaska Natives and to encourage maximum participation of tribes in the planning/management of those services.

## **PROVIDER ENROLLMENT/PARTICIPATION REQUIREMENTS**

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### **INDIAN HEALTH SERVICE (IHS) FACILITIES/TRIBAL 638 HEALTH FACILITIES**

Statutes applicable to enrollment of IHS/Tribal 638 facilities as Medicaid providers include the following:

- Sec. 1911. [42 U.S.C. 1396j] (a) of the Social Security Act (SSA) provides that a facility of the Indian Health Service (IHS) (including hospitals, nursing facilities or any other type of facility that provides services that are coverable under the Medicaid state plan), whether operated by the IHS or by an Indian tribe (IT) or a tribal organization (TO) as defined in Section 4 of the Indian Health Care Improvement Act (IHCIA), is eligible for Medicaid reimbursement under the state Medicaid plan, if and for so long as it meets all of the conditions and requirements generally applicable to such facilities under Title XIX of the Social Security Act (SSA).
- Sec. 1911. [42 U.S.C. 1396j] (b) of the SSA provides that a facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) that does not meet all of the conditions and requirements of Title XIX that are applicable generally to such facility, but submits to the Secretary within six (6) months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its actual

compliance with such conditions and requirements, during the first twelve (12) months after the month in which such plan is submitted.

The Division of Medicaid accepts Indian Health Service Facilities/Tribal 638 Health Facilities as Medicaid providers on the same basis as other qualified providers. IHS/Tribal 638 facilities must meet all applicable standards for state licensure but need not obtain a state license.

## **ALL OTHER PROVIDERS**

All other providers must complete the enrollment requirements for their respective provider type.

## **REIMBURSEMENT**

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### **Indian Health Service (IHS) Facilities/Tribal 638 Health Facilities/Providers**

The Social Security Act, Sec. 1911. [42 U.S.C. 1396j], provides the legal statute for Medicaid reimbursement of Indian Health service facilities. The statute reads as follows:

- “Sec. 1911. [42 U.S.C. 1396j] (a) A facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan), whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act , shall be eligible for reimbursement for medical assistance provided under a State plan if and for so long as it meets all of the conditions and requirements which are applicable generally to such facilities under this title.
- Notwithstanding subsection , a facility of the Indian Health Service (including a hospital, nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan) which does not meet all of the conditions and requirements of this title which are applicable generally to such facility, but which submits to the Secretary within six months after the date of the enactment of this section an acceptable plan for achieving compliance with such conditions and requirements, shall be deemed to meet such conditions and requirements (and to be eligible for reimbursement under this title), without regard to the extent of its actual compliance with such conditions and requirements, during the first twelve months after the month in which such plan is submitted.
- The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan.
- For provisions relating to the authority of certain Indian tribes, tribal organizations, and Alaska Native health organizations to elect to directly bill for, and receive payment for, health care services provided by a hospital or clinic of such tribes or organizations and for which payment may be made under this title, see section 405 of the Indian Health Care Improvement Act (25 U.S.C. 1645).”

Section 1905 (b) of the Social Security Act provides that 100 percent Federal Medical Percentages (FMAP) is available to states for amounts spent on medical assistance received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act).

## CONTACTS

Medicaid Regional Offices

Go to [www.medicaid.ms.gov](http://www.medicaid.ms.gov)

Click on the Contact Us Tab

Click on the Medicaid Regional Offices Tab

# DIABETES SELF-MANAGEMENT TRAINING

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## DIABETES SELF-MANAGEMENT TRAINING BILLING/CODING REQUIREMENTS

Diabetes Self-Management Training will be considered for Medicaid beneficiaries with the following diabetes diagnoses which support medical necessity:

| ICD-9-CM Code   | Diagnosis | Description                                       |
|-----------------|-----------|---|
| 250.00 - 250.03 |           | Diabetes mellitus without mention of complication |
| 250.10 - 250.13 |           | Diabetes with ketoacidosis                        |
| 250.20 - 250.23 |           | Diabetes with hyperosmolarity                     |
| 250.30 - 250.33 |           | Diabetes with other coma                          |
| 250.40 - 250.43 |           | Diabetes with renal manifestations                |
| 250.50 - 250.53 |           | Diabetes with ophthalmic manifestations           |
| 250.60 - 250.63 |           | Diabetes with neurological manifestations         |
| 250.70 - 250.73 |           | Diabetes with peripheral circulatory disorders    |
| 250.80 - 250.83 |           | Diabetes with other specified manifestations      |
| 250.90 - 250.93 |           | Diabetes with unspecified complication            |
| 648.80 - 648.84 |           | Abnormal glucose tolerance                        |

| ICD-10 Codes      | Diagnoses | Description  |
|-------------------|-----------|--|
| E08.0 – E13.9     |           | Diabetes mellitus  |
| O24.001 – O24.93  |           | Diabetes mellitus in pregnancy, childbirth and the puerperium          |
| O99.810 – O99.815 |           | Abnormal glucose complicating pregnancy, childbirth and the puerperium |

Diabetes Self-Management Training will be covered under the following HCPCS codes:

| HCPCS Codes | Procedure | Description |
|-------------|-----------|-------------|
|-------------|-----------|-------------|

|       |  |
|-------|--|
| G0108 | Diabetes outpatient self-management training services, individual, per 30 minutes                |
| G0109 | Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes |

For Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), and the Mississippi State Department of Health (MSDH) providers, Diabetes Self-Management Training is covered in the encounter rate for a core service. An encounter cannot be paid solely for Diabetes Self-Management Training.

**PRIOR AUTHORIZATION**

Prior Authorization acknowledges the medical necessity and appropriateness of services. It does not guarantee payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.

Providers must use the standardized Pre-certification Review Request forms provided by a Utilization Management and Quality Improvement Organization (UM/QIO).

**REVIEW OUTCOMES**

The UM/QIO will issue a Notice of Review Outcome to the provider at the completion of the review process. Once medical necessity is determined, a Treatment Authorization Number (TAN) will be assigned for billing purposes. If the review outcome results in a denial, written notification will be sent to the beneficiary/guardian/legal representative and provider.

**REIMBURSEMENT**

Reimbursement for services are made from a statewide uniform fee schedule and paid at the lesser of the provider charge or the Medicaid allowable fee. Medicaid allowable fees are set in accordance with the Mississippi Medicaid State Plan.

Beneficiaries enrolled in Mississippi Coordinated Access Network (MSCAN) will refer to specific Diabetes Self-Management Training guidelines for coverage by each MSCAN provider.