MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 100
General Provision

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Title 23: Division of Medicaid

Part 100: General Provisions

Part 100 Chapter 1: Introduction

Rule 1.1: History and Legal Base.

A. Title XIX of the Social Security Act, enacted in 1965, provides authority for states to establish Medicaid programs to provide medical assistance to needy individuals. The program is jointly financed by federal and state governments and administered by states. Within broad federal rules, each state decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the state to the providers that furnish the services.

B. Enabling legislation for the Medicaid program in Mississippi was enacted during a special session of the legislature in 1969. Funds were appropriated and the Mississippi Medicaid Commission was designated as the single state agency to administer the program. State statutes governing Medicaid may be found in Sections 43-l3-l0l et. seq. of the Mississippi Code of 1972.

C. From 1969 to 1973, the determination of Medicaid eligibility was the responsibility of the State Department of Public Welfare (DPW). During this time period, DPW authorized money payments for the aged, blind and disabled and dependent children.

Source: Miss. Code Ann. § 43-13-101 et. seq. (Rev.1969).

Rule 1.2: SSI Program.

A. The passage of Public Law 92-603 amended Title XVI of the Social Security Act and established the Supplemental Security Income (SSI) Program for the aged, blind and disabled. State statutes were amended to specify that DPW would no longer determine eligibility for a monthly payment for the aged, blind and disabled.

B. PL 92-603 allowed States an option to either grant Medicaid to all persons receiving SSI (known as Section 1634) or to grant Medicaid to persons who met more restrictive criteria set by States (known as 209b). The Mississippi Legislature voted to limit Medicaid eligibility to persons who met more restrictive criteria and to designate the DPW as the certifying agency for Medicaid.

C. During the l980 session of the Mississippi Legislature, Senate Bill 2118 changed the Medicaid eligibility criteria to 1634 status whereby Medicaid would be granted to all individuals receiving SSI. In addition, SSI criteria would be used to determine eligibility for all aged,

blind and disabled individuals. During the 1981 Legislative Session, Senate Bill 2478 authorized the Mississippi Medicaid Commission to make its own Medicaid determinations for aged, blind and disabled individuals. Regional Medicaid offices were opened in July, 1981, for the purpose of certifying the eligibility of aged, blind and disabled individuals who did not receive SSI cash assistance.

Source: Miss. Code Ann. § 43-13-115.2 (Rev. 1980).

Rule 1.3: Current Structure.

A. Senate Bill 3050, entitled the "Mississippi Administrative Reorganization Act of 1984,"transferred the powers and responsibilities of the Mississippi Medicaid Commission to the Division of Medicaid in the Office of the Governor. The Division of Medicaid is the single state agency designed to administer the Medicaid Program.

B. The Mississippi Department of Human Services (MDHS, formerly known as DPW) continued to determine eligibility for the Medicaid Programs for children and families as authorized under Section 43-13-115 of the Mississippi Code of 1972, Annotated, and later adding determination of eligibility for Children's Health Insurance Program (CHIP) in 1999 under Section 41-86-15.

C. However, during the 2004 Session of the Mississippi Legislature, House Bill 1434 made significant changes to Section 43-13-115 of the Mississippi Code of 1972. While retaining all Medicaid coverage groups and CHIP (Section 41-86-1 and so forth), the Division of Medicaid was given the responsibility for determining initial and ongoing eligibility for all children, families, and pregnant women. The transition of the Families, Children and CHIP (FCC) programs from MDHS to Division of Medicaid was effective January 1, 2005.

D. DHS remains the certifying agency for children under Title IV-E services and other related custody and adoption assistance and those eligible for Medicaid coverage under the Refugee Assistance grant program.

E. During the 2012 Session of the Mississippi Legislature, House Bill 316 transferred the existing contract for insurance services for the Children's Health Insurance Program (CHIP) from the State and School Employees Health Insurance Management Board to the Division of Medicaid effective January 1, 2013. The Division of Medicaid has all authority set forth in 43-13-101 et seq. in administering the Children's Health Insurance Program (CHIP).

Source: Miss. Code Ann. § 43-13-115 (Rev. 2003) and Miss Code Ann § 41-86-9 (Rev.2012).

Part 100 Chapter 2: Agency Duties

Rule 2.1: Duties of the Division of Medicaid.

The duties of the Division of Medicaid Agency are set out by State and Federal legislation and the approved Mississippi State Plan include, but are not limited to:

A. Setting regulations and standards for the administration of the Medicaid programs, with approval from the Governor, and in accordance with the Administrative Procedures Law. [Refer to Miss. Admin. Code Part 100, Rule 9.3]

B. Providing Medicaid coverage to all qualified beneficiaries under the provisions of state law and within appropriated funds.

C. Establishing reasonable fees, charges and rates for medical services, drugs, equipment and supplies

D. Fair and impartial hearings.

E. Safeguards for preserving the confidentiality of records.

F. Detecting and investigating alleged violations, and processing fraudulent practices and abuses of the program.

G. Receiving and expending funds for the program.

H. Submitting a state plan for Medicaid in accordance with state and federal regulations.

I. Preparing and distribution of required reports to the state and federal government.

J. Defining and determining the scope, duration, and amount of Medicaid coverage.

K. Cooperating and contracting with other state agencies for the purpose of administrating the Medicaid program.

L. Bringing suit in its own name.

M. Recovering incorrect beneficiary or provider payments including recovery of beneficiary or provider state tax refunds of beneficiaries or providers.

N. Establishing and providing methods of administration for the operation of the Medicaid program.

O. Contracting with the federal government to provide Medicaid coverage for certain refugees.

P. Entering into an agreement with the federal health insurance marketplace as necessary to fulfill the requirements of federal healthcare laws relating to insurance affordability programs that include Medicaid, CHIP and subsidies for insurance coverage through a federal marketplace, effective January, 2014.

Source: 42 CFR § 435.1200; Miss. Code Ann. § 43-13-121 (Rev. 2012).

History: Revised eff. 09/01/2014.

Rule 2.2: Duties of the Department of Human Services (DHS).

A. The duties of DHS with regard to Medicaid include:

1. To provide the opportunity for persons to apply for Medicaid benefits through all foster care and refugee programs.

2. To determine eligibility for foster children and adoption assistance-related Medicaid applicants and certify them as eligible, notify them of eligibility and determine retroactive eligibility, when appropriate.

3. To re-determine foster care and adoption assistance Medicaid eligibility at required intervals.

4. To provide the opportunity for filing appeals and to conduct hearings for eligibility certifications that DHS certifies.

5. To provide Medicaid Quality Control for foster care and adoption assistance recipients.

6. To identify and report third party resources for foster care and adoption assistance recipients.

Source: Miss. Code Ann. § 43-13-115.6 (Rev. 2004).

Part 100 Chapter 3: Rights of Applicants and Recipients

Rule 3.1: Opportunity to Apply.

A. Any individual, who requests assistance, including those who are clearly ineligible, must be allowed to apply immediately. Medicaid Specialists must make a reasonable effort to assist the applicant in establishing eligibility.

Source: 42 CFR § 435.906 (Rev. 1994).

Rule 3.2: Civil Rights and Non-Discrimination.

A. The Division of Medicaid complies with all state and federal policies which prohibit discrimination on the basis of race, age, sex, national origin, handicap or disability as defined through the Americans with Disabilities Act of 1990, the Rehabilitation Act of 1973 and the Civil Rights Act of 1964. All complaints of discrimination will be investigated in accordance with state and federal laws and regulations.

Source: 42 CFR § 435.901 (Rev. 1994).

Rule 3.3: Access to Information.

A. The applicant, recipient or his authorized/designated representative may have access to information in the eligibility case record to either review the file or request copies of information from the file, at no charge, in the following types of situations:

   1. In connection with a request for a hearing as otherwise provided in the regulations relating to administrative hearings. Refer to Part 100 Chapter 4, Right to Appeal and Fair Hearing, for more information.

   2. Information regarding amounts of Medicaid received by a recipient when requested by a person filing a federal or state income tax return and when authorized in writing by the recipient. A signed authorization is also required to release information to the Internal Revenue Service (IRS).

   3. Information supplied by the applicant or recipient or obtained by the specialist that the applicant or recipient needs in order to be able to qualify for other benefits which he has requested. This includes medical reports, as the examining physician must release this information to his patient. It includes proof of age, documents relating to real and personal property, and other factual material that will assist an applicant or recipient in obtaining a service or a benefit.

   4. The applicant's or recipient's statement of income and resources and other forms the applicant or recipient has signed which are contained in the case record. Budgets worked to determine eligibility for programs for which the Division of Medicaid is responsible.

   5. Any case information when the applicant or recipient presents a written request which specifies the material desired and the purpose for which the material will be used. Designated Division of Medicaid staff has computer access to other agencies' records. If the client requests another agency's information which is not part of the Division of Medicaid case file, it cannot be provided. The client must obtain the information directly from the source agency.

B. When the request is made by a person other than the applicant/recipient or their representative, the information will not be made available without the applicant's or recipient's written permission prior to releasing the information. The written release will become a permanent part of the record.

Source: Miss. Code Ann. § 205.70 (Rev. 1980). Miss. Code Ann. § 43-13-121.1 (Rev. 2005).

Rule 3.4: Release of Information to Legal Representative/Attorney.

A. When legal representative/attorney requests information from the agency to assist a client, the client or his authorized/designated representative must first provide a signed statement or letter to the agency permitting information to be released to that specific individual. This statement will be made a permanent part of the case record.

B. Legal representatives/attorneys generally do not have the degree of knowledge required about a client's circumstances to enable them to act on the client's behalf in the application process. As a result, a legal representative/attorney may not be named as an authorized or designated representative.

C. Agency notices, including the DOM-307, DOM-309 and eligibility notices may not be mailed directly to a client's legal representative/attorney. However, if the client has provided their legal representative/attorney with copies of the 307, 309 and/or other notices, the information can be discussed with the legal representative/attorney, provided there is a signed consent in the case authorizing release of information to that specific individual.

D. Information may be released to any person when a valid release of information has been executed by the client for that individual.

Source: Miss. Code Ann. § 43-13-121.1 (Rev. 2005).

Rule 3.5: Confidentiality of Information.

A. All individuals have the right to a confidential relationship with the Division of Medicaid. All information maintained on recipients, former recipients and denied applicants is confidential and must be safeguarded. The Division of Medicaid will adhere to state laws and federal regulations on the protection of the confidentiality of information about applicants/recipients. Protected information may only be disclosed without the individual's authorization for purposes directly connected with the administration of the program. This includes:

1. Establishing eligibility,

2. Determining amount of medical assistance,

3. Providing services for recipients, and

4. Conducting or assisting an investigation, prosecution and civil or criminal proceeding related to the program.

B. The Division of Medicaid will also adhere to the Health Insurance Portability and Accountability Act (HIPAA) as it relates to confidentiality of information about applicants/recipients. It is the Division of Medicaid's rule that a valid authorization be obtained for all disclosures that are not for treatment, payment or healthcare operations, to the individual or their representative, to persons involved with the individual's care, to business associates in their legitimate duties or as required by law.

C. The agency has specified the agencies, persons and circumstances under which applicant or recipient information may be released without a recipient's consent. Any other exceptions are subject to prior approval of the Executive Director or Deputy Administrator of the Division of Medicaid.

Source: 42 CFR § 435.901 (Rev. 1994). Miss. Code Ann. § 43-13-121.1 (Rev. 2005).

Rule 3.6: Protected Information.

A. Protected information is of two general types: eligibility/financial and medical. It includes the following information:

1. Eligibility information

a) Name and address of applicants/recipients;

b) Social and economic conditions or circumstances;

c) Evaluation of personal information such as financial status, citizenship, residence, age and other demographic characteristics;

d) Information received in connection with the identification of legally liable third-party resources;

e) Information received for verifying income eligibility and benefit leve;, and

f) Income information verifying income eligibility and benefit level received from the Social Security Administration, the Internal Revenue Service, the Veteran's

Administration, State Retirement Board or Medicare must be safeguarded according to the requirements of the agency that furnished the data.

2. Medical information

   a) Medical data, including diagnosis and past history of disease or disability;

   b) Medical services provided;

   c) Medical status, psycho behavioral status, and functional ability;

   d) Results of laboratory tests; and

   e) Medication records.

Source: 42 CFR § 435.901 (Rev. 1994). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

Rule 3.7: Release of Information Without Client Consent.

A. The Division of Medicaid has established criteria for release and use of eligibility and financial information about applicants and recipients. Except as provided below, no information regarding applicants or recipients may be released without consent unless prior approval of the Executive Director or the Deputy Administrator of the Division of Medicaid is obtained.

   1. Disclosure to Other Agencies. Information concerning Medicaid applicants or recipients is subject to disclosure to agencies authorized under Titles IV-A (TANF), IV-B (Child and Family Services), IV-D (Child Support), XX (Social Services) XVI (SSI) of the Social Security Act and other agencies which are Federal or Federally assisted programs and provide assistance, in cash or in-kind, or services, directly to individuals on the basis of need, pursuant to appropriately executed data exchange agreements and other cooperative agreements between the Division of Medicaid and the applicable agency. Access is restricted to those persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the Division of Medicaid. Some agencies which have standards of confidentiality comparable to those of Medicaid and which provide assistance or services to applicants and recipients, and with whom information is exchanged for the purpose of administration of the Medicaid Program are listed below.

      a) Department of Human Services;

b) Social Security Administration and District Offices;

c) Mississippi State Department of Health and County Health Departments, only if they are a provider of Medicaid services for which the information is requested;

d) State Department of Mental Health and Regional Mental Health Centers, only if they are a provider of medical services for which the information is requested;

e) State Mental Hospitals and general hospitals, the Social Service Department and the reimbursement offices for providers, only as to services each provider rendered to a specific Medicaid recipient;

f) Veteran's Administration, only if they are a provider of services and then only for those recipients for whom they provided the service or to confirm benefits.

g) Medicaid program staff in other states, when a client moves or when there is a question of dual participation or to verify the status of Medicaid in MS for an applicant in the other state. The release of information is based on a request from the other agency and must relate to the function of the Division of Medicaid's programs and the function of the agency requesting the information. When an agency makes a request for information which that agency normally would be ascertaining for itself and which is not in behalf of the applicant or recipient, the request will be denied. Lists of information on applicants or recipients are not released to other agencies unless the release is specified in an interagency agreement.

2. Disclosure to Division of Medicaid's Fiscal Agent. Information concerning applicants and recipients may also be disclosed to the Division of Medicaid's fiscal agent for purposes of eligibility verification, claims processing and claims payment pursuant to the contract between the Division of Medicaid and the fiscal agent which provides that the fiscal agent shall be bound by the same standards of confidentiality as the Division of Medicaid.

3. Disclosure Related to Third Party Liability. Information necessary to identify third party liability (TPL) and to pursue reimbursement of Medicaid lien amounts from legally liable third parties may be made available to the recipient upon written request, to the recipient's insurance carrier upon a release of information signed by the recipient or to providers of medical services for the recipient. Any other release for TPL purposes should be cleared through the Legal Unit of the Division of Medicaid.

4. Disclosure to Prosecuting Attorneys. Information shall be provided to county and district attorneys, the US prosecuting attorney, the Office of Inspector General (OIG), Medicaid Fraud Control Unit of the Attorney General's Office or other investigative boards and agencies duly authorized by state and federal law related to abuse, suspected fraud or fraudulent receipt of Medicaid and to obtaining or enforcing medical support. Before releasing any case record information to a county, district or US prosecuting attorney, clearance will be obtained from the Legal Unit of the Division of Medicaid on the release.

5. Disclosure of Subpoenaed Information. Subpoenas for recipient or applicant information may be answered as directed by the Legal Unit of the Division of Medicaid only if the recipient or applicant gives written permission for the information to be released or upon court order. The regional office will notify the Bureau of Enrollment immediately upon receipt of a subpoena and a manager will contact the Legal Unit for clearance on answering the subpoena.

6. Disclosure to Providers. Eligibility and availability of benefits may be verified for Medicaid or CHIP providers.

7. Release of Information in an Emergency Situation. If release of information is deemed necessary by the agency due to an emergency situation and time does not permit obtaining written consent before the release, the agency must notify the family or individual immediately after supplying the information.

8. Requests for Information from Non-Custodial Parents or Relatives. Information must not be released to a child's non-custodial parent or other relative without a court order that has been cleared by state office. When a non-custodial parent/relative is seeking information and presents a court order, the regional office will notify the Bureau of Enrollment. A manager will contact Legal for clearance.

Source: MS Code Ann. § 43-13-121.1 (Rev. 2005).

Rule 3.8: Release of Program Information.

A. No Medicaid data regarding recipients, providers or services may be released without prior approval of the Executive Director, unless an established exception applies. The following program information constitutes the only established exceptions which do not require prior approval of the Executive Director:

1. The annual report of the Division of Medicaid, published pursuant to state law, containing the total number of recipients, the total amount paid for medical assistance and care, the total number of applications, the total number of applications approved and denied, and similar data.

2. Pamphlets, brochures and other documents prepared for distribution to the public.

3. Information exchanged with other state or federal agencies pursuant to a contract or written agreement. If requests for information are received, including requests for large quantities of pamphlets, brochures and other public information, the regional office should forward them to the Bureau of Enrollment for further action. Requests will be considered pursuant to the Access to Public records Act, as applicable.

Source: Miss. Code Ann. § 43-13-121.1 (Rev. 2005).

Rule 3.9: Safeguarding Confidential Information.

A. The privacy rule protects electronic records, paper records and oral communication. Therefore, employees of the agency are responsible for safeguarding the confidentiality of recipient information in all forms to prevent unauthorized disclosure.

B. Failure to abide by the policies and procedures regarding confidentiality of recipient and applicant information, either intentionally or unintentionally, can result in disciplinary action. Group offenses are discussed in the Division of Medicaid Employee Manual under Discipline and Grievance Policies. In addition, any violation of privacy and security policies and procedures may be referred to state or federal agencies for prosecution.

Source: 42 CFR § 435.901 (Rev. 1994).

Rule 3.10: Safeguard Awareness Training.

A. Training on the security standards for data provided by the Internal Revenue Service (IRS) and Social Security Administration (SSA) must be conducted annually for eligibility staff in each regional office.

B. During the training employees are instructed in office security procedures to ensure security of the data and are issued a copy of the federal penalties for unauthorized disclosure of IRS and SSA information.

C. A confidentiality statement for each type of data is signed by employees.

Source: 42 CFR § 435.901 (Rev. 1994). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

Part 100 Chapter 4: Right to Appeal and Fair Hearing

Rule 4.1: Appeal Rights.

A. At the time of any action affecting an applicant or recipient's claim for assistance, the applicant or recipient must be:

   1. Informed of his right to a fair hearing;

   2. Notified of the method by which he may obtain a hearing, and

   3. Informed of his right to represent himself at the hearing or to be represented by an authorized person such as an attorney, relative, friend, or other spokesperson.

B. The agency must grant the opportunity for a fair hearing to any applicant or recipient who requests it because his claim for medical assistance is denied or not acted upon with reasonable promptness or because he believes that the agency has taken an action erroneously. A hearing request made in connection with a rebuttal prior to any adverse action being taken will not be accepted. The agency need not grant a hearing when the sole issue is a federal or state law requiring an automatic change which adversely affects some or all recipients.

Source: 42 CFR § 431.205(a) (Rev. 1993).

Rule 4.2: Notification Regarding Appeal Rights.

A. If an interview is conducted, the right to appeal must be discussed with the applicant/recipient. In addition, individuals are notified of appeal rights by statements included on the ABD and FCC application forms and on all notices. A hearings pamphlet is included with adverse action notices informing clients of the right to appeal and providing other information about the hearings process. These pamphlets are also available for distribution in regional offices.

Source: 42 CFR § 431.210 (Rev. 1992). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

Part 100 Chapter 5: The Hearing Process

Rule 5.1: Hearings Defined.

A. A fair hearing is an orderly, but informal meeting in which a client or his representative is afforded an opportunity to address an impartial hearing officer for the purpose of presenting oral testimony and/or evidence of his entitlement to medical assistance and services.

B. The applicant or recipient has the right of confrontation and cross-examination as described further in this section.

C. A fair hearing is a *de novo hearing* which means it starts over from the beginning. A new determination of the client's eligibility is made based on all the evidence that can be secured, without regard to whether the evidence was available at the time the regional office took action. Thus, the process is not essentially different from a determination of eligibility.

Source: 42 CFR § 431.201 (Rev. 2002).

Rule 5.2: Types of Hearings.

A. The client or his representative may request to present an appeal through a local-level hearing, a state-level hearing, or both. In an attempt to resolve issues at the lowest level possible, offices should encourage clients to request a local hearing first. The only exception to requesting a local hearing is when the issue under appeal involves disability, blindness or level of care. Therefore, the actions below which involve medical decisions cannot be addressed in a local hearing. A state hearing must be requested for:

    1. A disability or blindness denial, or termination, or

    2. A level of care denial or termination for a Disabled Child Living at Home.

B. Local and/or state level hearings will be held by telephone unless, at the discretion of the hearing officer, it is determined that an in-person hearing is necessary.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.3: Handling Local Hearing Requests.

A. An appeal will ordinarily be filed in the regional office responsible for the adverse decision or delay in action. If the client has moved to another regional office's jurisdiction at the time the appeal is made, it is possible for the regional office serving the client's current county of residence to act for the former regional office. However, the hearing officer may request the participation of staff in the regional office where the action was originally taken if necessary or advisable.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.4: Representation.

A. The request for a state or local hearing must be made in writing by the client or his legal representative.

B. "*Legal representative*" includes the client's authorized representative, an attorney retained to represent the client, a paralegal representative with a legal aid service, the parent of a minor child (if the client is a child), a legal guardian or conservator or an individual with power of attorney for the client.

C. The client may be represented by anyone he designates. If the client elects to be represented by someone other than a legal representative, he must designate the person in writing. If a person, other than a legal representative, states that the client has designated him as the client's representative and the client has not provided written verification to this effect, the regional office will ask the person to obtain written designation from the client.

Source: 42 CFR § 431.206(b) (Rev. 1993).

Rule 5.5: Oral Hearing Requests.

A. An oral request for a hearing must be put in written form. When an oral request is made, the specialist will inform the client that the request must be put in a letter or signed statement and mailed to the regional office ***or*** the specialist will mail the appropriate hearing request form, i.e., DOM 350, Request for Local Hearing, or DOM 352, Request for State Hearing, to the client for signature and return.

B. A hearing will not be scheduled until a written request is received by either the regional or state office.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.6: Written Hearing Requests.

A. A simple statement requesting a hearing that is signed by the client or his legal representative is sufficient; however, if possible, the client should state the reason for the request.

B. The written request may be mailed to the regional office or state office. If the letter does not specify the type of hearing desired, the specialist will contact the person making the request to determine whether a local or a state hearing is being requested. If contact cannot be made within three (3) days of receipt of the hearing request, the regional office will assume a local hearing is requested and schedule accordingly.

C. If the hearing involves a medical decision, which requires that a state hearing be held or if a state hearing is requested, the request will be forward to the Bureau of Appeals.

Source: 42 CFR § 431.201 (Rev. 2002).

Rule 5.7: Hearing Requests Made In Person.

A. The client may come to the regional office or meet with a specialist in person to request a hearing. The specialist must first determine what level of hearing, local or state, is desired.

B. If a state level hearing is *required* because the hearing request is based on a medical decision, this will be explained to the client. Otherwise, if the client is unsure of the type hearing desired, the specialist will explain the difference between the two levels of appeal and explain a state hearing may still be available if the local hearing decision is not favorable. The specialist will assist the client in completing the appropriate form, DOM-350 or DOM 352, whichever is applicable. If a state hearing is required or requested, the specialist can assist in mailing the request to state office or the client may choose to mail it himself.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.8: Appeal By Both Members Of A Couple.

A. When both members of an eligible couple wish to dispute the action or inaction of the regional office that affects both applications and cases similarly and arose from the same issue, one or both members may file the request for a hearing. The couple will be assured that both may present evidence at the hearing and that the agency's decision will be applicable to both.

B. If both file a hearing request, two hearings will be registered, but they will be conducted on the same day and in the same place, either consecutively or jointly, according to the wishes of the couple. If it is their wish for only one of them to attend the hearing, this is permissible.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.9: Time Limit For Filing A Hearing Request.

A. The client has thirty (30) days from the date the appropriate notice is mailed to request either a local or state hearing. This thirty (30) day filing period may be extended if the client can show good cause for not filing within thirty (30) days.

B. Good cause includes, but may not be limited to, illness, failure to receive the notice, being out of state, or some other reasonable explanation. If good cause can be shown, a late hearing request may be accepted, provided the facts in the case remain the same. However, if a client's circumstances have changed or if good cause for filing a request beyond thirty (30) days does not exist, a hearing request will not be accepted. If the client wishes to have his eligibility reconsidered, he may reapply.

Source; Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.10: Timeframe for Holding Local or State Hearings.

A. The Division of Medicaid must take final administrative action on a hearing, whether state and/or local, within ninety (90) days of the date of the initial request for a hearing. Although regulations allow ninety (90) days, the agency will make every effort to hold hearings promptly and render decisions in a shorter timeframe.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.11: Scheduling the Hearing.

A. If a local hearing is requested the regional office will notify the client or representative in writing of the time and date of the local hearing. If a state hearing is requested, the hearing facilitator assigned to the case will notify the appropriate person in writing of the time and date of the state hearing. The notice scheduling the time and date of a state or local hearing must be mailed to the client at least five (5) days before the day the hearing is scheduled. A hearing pamphlet will be included with the letter scheduling either a local or state hearing.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.12: Attendance at the Hearing.

A. A state or local hearing is not open to the public. All persons attending the hearing will attend for the purpose of giving information on behalf of the claimant or rendering him assistance in some other way, or for the purpose of representing the Division of Medicaid. All persons attending the hearing will be asked to give information pertinent to the issues under consideration.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.13: Withdrawn or Abandoned Hearings.

A. The hearing process is initiated by a written request and can be terminated only by a written statement in which the client or representative withdraws the request for a hearing.

B. A state or local hearing request may be withdrawn at any time prior to the scheduled hearing or after the hearing is held, but before a decision is rendered. As indicated, the withdrawal must be in writing and signed by the client or representative.

C. A hearing request will be considered abandoned if the client or representative fails to appear or is unavailable for a scheduled hearing without good cause. If no one is available for a hearing, the appropriate office will notify the client in writing that the hearing is dismissed

unless good cause is shown for not attending. Following failure to appear for a hearing, the proposed adverse action will be taken on the case if the action is not already in effect.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.14: Rights of the Client.

A. The client or his representative has the following rights in connection with a local or state hearing:

   1. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or recipient's case record. the right to have legal representation at the hearing and to bring witnesses.

   2. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.

   3. The right to present an argument without undue interference and to question or refute testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.15: Group Hearings.

A. A group hearing can be held for a number of clients under the following circumstances:

   1. The Division of Medicaid may consolidate the cases and conduct a single group hearing when the only issue involved is one of a single law or agency rule.

   2. The clients may request a group hearing when there is one issue of agency rule common to all of them.

B. In all group hearings, whether initiated by the Division of Medicaid or by the clients, the policies governing fair hearings must be followed.

   1. Each individual client in a group hearing must be permitted to present his own case and be represented by his own lawyer or withdraw from the group hearing and have his appeal heard individually.

2. As in individual hearings, the hearing will be conducted on the issue being appealed, and each client is expected to keep his testimony within a reasonable time as a matter of consideration to the other clients involved.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.16: SSI Recipients.

A. In Mississippi, persons who are eligible for SSI are automatically eligible for Medicaid. If an SSI applicant or recipient disagrees with the decision to deny or terminate SSI benefits, the individual must contact the Social Security Office which issued the adverse action.

B. Social Security handles appeals when the issue is SSI benefits and automatic Medicaid eligibility.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.17: Continuation of Benefits.

A. If a client or representative requests a hearing within the advance notice period, benefits must be continued or reinstated to the benefit level in effect prior to the planned adverse action.

1. Timely Request for Continuation of Benefits. To determine if the request for continuation of benefits is timely, the request must be received by the regional office within twelve (12) days from the notice date. This twelve (12) day period includes the ten (10) day adverse action period plus two (2) days mailing time. If a hearing is requested by telephone, the client must be advised to put the request in writing prior to the end of the specified period. Any hearing requested or dated after this period will not be accepted as a timely request for continuation of benefits.

2. Continuation of Benefits When Local Decision is Adverse. The client may request a state hearing if the local hearing is adverse. If benefits have been continued pending the local hearing, then benefits will continue pending a state hearing decision provided the request for the state hearing is made within fifteen (15) days of the date on the Notice of Local Hearing Decision.

3. Agency Action Upheld in Final Hearing Decision. When the final hearing decision is adverse to the client, the specialist will terminate or reduce the continued benefits using the original reason for the adverse action. A second (2nd) Notice of Adverse Action is not required.

4. The Division of Medicaid has the right to initiate recovery procedures against the client to recoup the cost of any medical services furnished the client under Medicaid and CHIP premiums paid by the Division of Medicaid on behalf of CHIP children, to the extent they were furnished solely based on the provision for continuation of benefits.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.18: Local Hearings.

A. The regional office is responsible for completing a supervisory review of the action under appeal and for preparing the state hearing record. The office is responsible for all activities involved in the local hearing process and for taking appropriate action on the case at the end of the hearing process. The purpose of a local hearing is to provide an informal proceeding to allow the client or representative to:

   1. Present new or additional information;

   2. Question the action taken on the client's case, and

   3. Hear an explanation of eligibility requirements as they pertain to the client's situation.

B. When a request for a local hearing is received, the local hearing will be scheduled no later than twenty (20) days after receipt of the request. The client will be allowed time to obtain additional information or request an attorney, relative or friend to attend the hearing and give evidence. A local hearing must not be scheduled without giving five (5) days advance notice to the client unless the client waives advance notice time.

C. The regional office staff member who conducts the hearing must be one who has not participated in determining eligibility or directed the decision.

D. After a local hearing is held, the person who conducted the hearing will prepare a summary of the hearing procedure. The summary serves the same purpose as a transcript and is filed in the case record. The summary of the local hearing must be included as part of the state hearing record when the client requests a state hearing after an adverse local hearing decision. The local hearing summary must contain sufficient information to enable the state hearing officer to have a clear understanding of what transpired during the local hearing.

E. When a decision has been reached, the client must be notified of the decision and advised of the right to request a state hearing.

F. If the local hearing decision is unfavorable to the clients, the new effective date of closure or reduced benefits must be included on the notification if continuation of benefits applied during the hearing process. The new effective date of closure or reduced benefits must include an effective date at the end of the fifteen (15) day advance notice period. A second (2nd) Notice of Adverse Action is not required;

G. However, if a state hearing is subsequently requested within the fifteen (15) day advance notice period and continuation of benefits is applicable, the state office will notify the client of the new effective date of closure, reduced benefits or other revised eligibility dates in the state hearing decision letter.

H. Any corrective action that is required must be taken as a result of a local or state hearing decision rendered in the client's favor or for processing the originally-planned action on the case that was the basis for the appeal and continuation of benefits applied pending the hearing decision.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.19: State Hearing After Adverse Local Decision.

A. The client has the right to appeal a local hearing decision by requesting a state hearing; however, the state hearing request must be made in writing within fifteen (15) days of the mailing date of the local hearing decision. This means the state hearing request must be received by the regional office or state office on or before the fifteenth ($15^{th)}$ day after the local hearing notice is mailed.

B. If the state hearing request is made orally, then the claimant must be informed that the request must be put into writing and received within the allotted fifteen (15) day time period. If benefits have been continued pending the local hearing decision, then benefits will continue throughout the fifteen (15) day advance notice period when the local hearing decision is adverse.

C. If a state hearing is requested timely within the fifteen (15) day period, then benefits will continue pending the outcome of the state hearing. State hearings requested after the fifteen (15) day advance notice period for the local hearing will not be accepted unless the thirty (30) day period for filing a hearing request has not expired because the local hearing was held early in the thirty (30) day period and there is time remaining.

Source: Miss. Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.20: State Hearings.

A. A state hearing is assigned to an impartial hearing officer. Impartial means the hearing officer has not been involved in any way with the action or decision under appeal who

1. Reviews the local office's action;

2. Schedules the hearing;

3. Holds the hearing and provides the following explanations to those in attendance:

   a) The hearing will be recorded and a copy of the recording made available to the client upon request.

   b) The reason for the hearing, i.e., the action taken by the regional office which prompted the appeal.

   c) The client's rights and the purpose of the hearing.

B. The actual case record must be available for review by the client or representative before, during or after the state hearing.

C. The final hearing decision will be rendered by the Executive Director of the Mississippi Division of Medicaid on the basis of the facts discussed at the hearing and the claimant will be notified in writing of this decision.

D. All persons representing the claimant and those representing the regional office will have the opportunity to state all facts pertinent to the appeal.

E. If additional information is determined to be needed during the state hearing, the hearing officer may recess or continue the hearing as follows:

1. Recessing the Hearing. If additional information is needed and this information is readily available, the hearing officer will recess the hearing for the time required to obtain the facts.

2. Continuing the Hearing. If the information needed is not readily available, the hearing officer will continue the hearing to a suitable later date. If the time at which the information will be obtained is known, the hearing officer, before adjourning the original hearing, will set the time and place for the continued hearing at the earliest possible date, notifying the principals that there will be no further notice. The hearing officer will reach an agreement with the client and any persons attending on his behalf about bringing the needed information to the continued hearing. The hearing cannot be extended beyond the time limit for completion of a hearing.

F. If the regional office becomes aware of a change in the client's circumstances which will result in an adverse action other than the issue currently under appeal, the client must be notified in writing. Adverse action notice requirements, i.e., ten (10) day notice plus two (2) days mailing time, must be met and action taken as follows:

1. Change Discovered Prior to State Hearing. If the state hearing has not yet been held, the client may choose to have the new adverse action issue incorporated into the current appeal; however, the client must first request an appeal in the usual manner. If the new hearing request is filed in time for the issue to be considered in the current hearing process, the regional office will notify the hearing officer of the additional issue under appeal. In this instance, the hearing may have to be rescheduled to allow the client time to prepare for the hearing.

2. Change Discovered During the State Hearing. If the change in circumstances is discovered during the actual hearing, the hearing officer will recess the hearing and notify the regional office to send the appropriate ten (10) day notice. The hearing will be reconvened after the adverse action notice is mailed and the advance notice period has expired. The client may choose to include the new issue in the hearing when it is reconvened. The hearing will be reconvened following the usual procedure for setting the time and place.

G. When the issue under appeal is disability or blindness, a review by DDS is required. After the hearing, the hearing officer will forward all medical information to the Disability Determination Service for reconsideration. A review team consisting of medical staff who were not involved in any way with the original decision will review the medical information and hearing transcript and give a decision on the disability or blindness factor. The DDS decision is final and binding on the agency.

H. After the hearing, the final decision of the hearing officer must be based on oral and written evidence, testimony, exhibits and other supporting documents which were discussed at the hearing. The decision cannot be based on any material, oral or written, not available to and discussed with the claimant. Following the hearing, the hearing officer will make a written recommendation of the decision to be rendered as a result of the hearing. The recommendation, which becomes part of the state hearing record, will cite the appropriate rule which governs the recommendation.

I. The Executive Director of the Division of Medicaid, upon review of the recommendation, proceedings and the record may sustain the recommendation of the hearing officer, reject the recommendation or remand the matter to the hearing officer for additional testimony and evidence, in which case the hearing officer will submit a new recommendation to the Executive Director after the additional action has been taken.

J. The decision letter will specify any action to be taken by the agency and any revised eligibility dates. If the decision is adverse and continuation of benefits is applicable, the

claimant will be notified of the new effective date of reduction or termination of benefits or services, which will be fifteen (15) days from the date of the notice of decision.

K. The decision of the Executive Director of the Division of Medicaid is final and binding. The client is entitled to seek judicial review in a court of appropriate jurisdiction. Should the client file an appeal the second time without a change in circumstances or agency rule, the client will be notified in writing by the appropriate office explaining that the appeal cannot be honored. If the client's circumstances or agency rule have changed, the client will be advised to file a new application.

Source: MS Code Ann. § 43-13-116.3 (Rev. 2000).

Rule 5.21: CHIP Agency Errors.

A. The Division of Medicaid is responsible for ensuring payment for eligible beneficiaries. Providing timely CHIP benefits is a special concern because, unlike Medicaid, the CHIP effective dates are determined relative to monthly processing deadlines which do not allow the regional office to take retroactive or corrective action when an error is discovered for a prior month.

B. When CHIP agency errors occur, resolution comes through a local or state hearing request.

C. If a fair hearing is requested on a CHIP termination or denial and agency error was not involved, the procedures described previously in this section will be followed based on the type of hearing requested, i.e., local or state.

Source: MS Code Ann. § 41-86-3.4 (Rev. 2002).

Part 100 Chapter 6: Improper Payments [Refer to Part 305]

Part 100 Chapter 7: Quality Control [Refer to Part 305]

Part 100 Chapter 8: Coverage of the Categorically Needy in Mississippi

Rule 8.1: Coverage of Mandatory and Optional Categorically Needy Individuals

A. The federal government, through passage of federal laws, defines and describes categorically needy groups that either must be covered by individual state Medicaid programs or that may be covered by individual state Medicaid programs at their option.

B. All individual state Medicaid programs must provide coverage to specified categories of needy individuals that include: children, pregnant women, parents or caretaker relatives of

dependent children, aged individuals and disabled or blind individuals. Within these broad categories of coverage, the specific groups covered are either mandatory or optional.

C. Coverage of optional categorically needy groups is authorized by the passage of state laws.

Source: 42 CFR § 435.2; Miss. Code Ann. § 43-13-115.

Rule 8.2: Application of Modified Adjusted Gross Income (MAGI) to Specified Categories of Coverage

A. The Affordable Care Act (ACA) requires that certain mandatory and optional categorically needy groups are subject to the application of Modified Adjusted Gross Income (MAGI) standards, which are financial methodologies used to determine eligibility. Generally, the groups subject to MAGI rules are those that cover children, pregnant women and parents and caretaker relatives. Groups that are not subject to MAGI requirements are groups that cover the aged, blind and disabled.

B. MAGI affects income eligibility standards that are used for MAGI-related coverage groups in that net income eligibility thresholds in effect prior to the implementation of the ACA must be converted to equivalent MAGI levels to account for any income disregards used prior to the ACA. Income standards for these programs are expressed as MAGI-equivalent standards after the required conversion.

Source: 42 CFR § 435.603.

Rule 8.3: Mandatory Coverage of Parents and Other Caretaker Relatives

A. Coverage is mandatory for parents and other caretaker relatives who have a dependent child or children under the age of eighteen (18) living in the home whose household income is below the applicable limit established by the state for coverage. The limit established by the state is required by the Affordable Care Act (ACA) to convert to a Modified Adjusted Gross Income (MAGI)-equivalent standard. The Division of Medicaid certifies eligibility for this group.

B. Extended Medicaid coverage for twelve (12) months is mandatory for a family whose eligibility is based on family coverage if the family loses Medicaid coverage solely due to increased income from employment or increased hours of employment provided the family received Medicaid in any three (3) or more months during the six (6) month period prior to becoming ineligible, as determined by the Division of Medicaid.

C. Extended Medicaid for a maximum of four (4) months is required if a new collection or increased collection of child support (prior to January, 2014) or spousal support under title IV-D of the Social Security Act results in the termination of Medicaid for a family whose eligibility is based on family coverage described above, as determined by the Division of Medicaid. Effective with the implementation of the ACA, child support no longer counts as income.

Source: 42 CFR § 435.110-115.

History: Revised eff. 04/01/2016.

Rule 8.4: Mandatory Coverage of Pregnant Women

A. Coverage is mandatory for pregnant woman whose household income is at or below the income standard established by the state, not to exceed one hundred eighty-five percent (185%) of the federal poverty level converted to a Modified Adjusted Gross Income (MAGI)-equivalent standard. The Division of Medicaid certifies eligibility for this group.

B. The agency must provide categorically needy Medicaid eligibility for an extended period following termination of pregnancy to women who, while pregnant, applied for, were eligible for, and received Medicaid services on the day that their pregnancy ends. This period extends from the last day of pregnancy through the end of the month in which a sixty (60)-day period, beginning on the last day of the pregnancy, ends. Eligibility must be provided regardless of changes in the woman's financial circumstances that may occur within this extended period.

Source: 42 CFR §§ 435.116, 435.170.

History: Revised eff. 04/01/2016.

Rule 8.5: Mandatory Coverage of Newborns

A. Coverage is mandatory for infants born to Medicaid eligible mothers. The infant is deemed eligible for one (1) year from the date of birth. This provision applies in instances where the labor and delivery services were furnished prior to the date of application and covered by Medicaid based on retroactive eligibility. The Division of Medicaid is responsible for certifying eligibility for deemed eligible newborns.

B. Coverage is mandatory for infants born to qualified or non-qualified alien mothers who qualify for Medicaid on all factors other than alien status who receive Medicaid on the basis of emergency medical services, provided an application for emergency services is timely filed with the Division of Medicaid.

Source: 42 USC § 1396a; 42 CFR § 435.117; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2016.

Rule 8.6: Mandatory Coverage of Infants and Children under Age Nineteen (19)

A. Coverage is mandatory for infants to age one (1) in households whose income is at or below one hundred eighty-five percent (185%) of the federal poverty level converted to a Modified Adjusted Gross Income (MAGI)-equivalent standard.

B. Coverage is mandatory for children age one (1) to age six (6) whose household income is at or below one hundred thirty-three percent (133%) of the federal poverty level converted to a MAGI-equivalent standard. Children age six (6) to age nineteen (19) are eligible for Medicaid if household income is at or below one hundred thirty-three percent (133%) of the federal poverty level, as required by the Affordable Care Act (ACA).

C. The Division of Medicaid certifies eligibility for these age-specific groups of children.

Source: 42 CFR § 435.118.

History: Revised eff. 04/01/2016.

Rule 8.7: Mandatory Coverage of Adoption Assistance and Foster Care Children

A. Coverage is mandatory for children for whom adoption assistance or foster care maintenance payments are made under title IV-E of the Social Security Act, as determined by the Department of Human Services (DHS) who certifies eligibility for this group of children.

B. Coverage is mandatory for former foster care children who are under age twenty-six (26) if the child was in foster care and enrolled in Medicaid upon reaching the age of eighteen (18) or prior to age twenty-one (21) when released from foster care by DHS. Continued Medicaid coverage is certified by the Division of Medicaid in coordination with DHS.

Source: 42 USC 1396a; 42 CFR § 435.145.

History: Revised eff. 04/01/2016.

Rule 8.8: Mandatory Coverage of the Aged, Blind and Disabled

A. Coverage is mandatory for individuals receiving Supplemental Security Income (SSI). This includes individuals receiving SSI pending a final determination of blindness or disability, those receiving SSI under an agreement to dispose of resources that exceed the SSI resource limit, and those receiving benefits under section 1619(a) or considered to be receiving SSI under 1619(b) of the Social Security Act. Coverage also includes those who would be eligible for SSI except for an eligibility requirement used in the SSI program that is specifically prohibited under title XIX. Eligibility for SSI is determined by the Social Security Administration. No separate application for Medicaid is required unless the individual needs to apply for retroactive Medicaid for up to three (3) months prior to the month of the SSI application, in which case the individual must apply with the Division of Medicaid for the retroactive period of eligibility.

B. Individuals who become ineligible for SSI cash assistance as a result of a cost-of-living increase in title II benefits received after April, 1977, must be granted Medicaid coverage if the sole reason for the loss of SSI was an increase in Retirement, Survivor, Disability Insurance (RSDI) benefits received by the individual and/or his or her financially responsible spouse. The Division of Medicaid certifies eligibility for this group.

C. Coverage is mandatory for certain disabled widows and widowers and certain disabled adult children who would be eligible for SSI except for receipt of title II benefits. Specified conditions apply in order to have Medicaid coverage continued as a former SSI cash assistance recipient under these protected groups, as determined by the Division of Medicaid.

Source: 42 CFR § 435.120 – 138.

History: Revised eff. 04/01/2016.

Rule 8.9: Mandatory Coverage of Certain Medicare Cost-Sharing Groups

A. Qualified Medicare Beneficiaries (QMB) must be entitled to Medicare Part A and have income that does not exceed one hundred percent (100%) of the federal poverty level. Medical assistance is limited to payment of Medicare cost-sharing expenses that includes premiums, co-insurance and deductible charges.

B. Specified Low-Income Medicare Beneficiaries (SLMB) must be entitled to Medicare Part A and have income greater than one hundred percent (100%) of the federal poverty level but less than one hundred twenty percent (120%) of the federal poverty level. Medical assistance for this group is limited to payment of Medicare Part B premiums.

C. Qualifying Individuals (QI) must be entitled to Medicare Part A and have income that is at least one hundred twenty percent (120%) of the federal poverty level but less than one hundred thirty-five percent (135%) of the federal poverty level. Medical assistance for this group is limited to payment of Medicare Part B premiums under a federal allotment of funds. Eligibility for coverage as a QI is dependent on the availability of federal funds.

D. Qualified Disabled and Working Individuals must be entitled to Medicare Part A and have income that does not exceed two hundred percent (200%) of the federal poverty level whose return to work results in the loss of coverage for Medicare. Medical assistance is limited to payment of the Part A premium.

E. The Division of Medicaid certifies eligibility for all of the Medicare cost-sharing groups.

Source: 42 USC §§ 1395w-114, 1396a, 1396d.

History: Revised eff. 04/01/2016.

Rule 8.10: Mandatory Coverage of Certain Aliens for Emergency Services

A. Emergency services, including labor and delivery services, must be provided to aliens who meet all eligibility requirements for Medicaid coverage except for their alien status who are in need of treatment of an emergency medical condition.

B. Coverage is limited to treatment of the emergency condition only. Transplant services are

prohibited.

C. The Division of Medicaid certifies Medicaid coverage for Emergency Services.

Source: 42 CFR § 435.139.

History: Revised eff. 04/01/2016.

Rule 8.11: Mandatory Presumptive Eligibility Determined by Qualified Hospitals

A. As required by the Affordable Care Act (ACA), qualified hospitals must be allowed to determine presumptive eligibility for individuals eligible for Medicaid in certain Medicaid coverage groups, referred to as Hospital Presumptive Eligibility (HPE).

B. HPE affords qualified hospitals the opportunity to immediately enroll patients in Medicaid who are determined eligible for Medicaid by authorized hospital staff.

C. HPE provides temporary Medicaid eligibility but also allows access to continuing Medicaid coverage provided the HPE decision includes filing a full Medicaid application.

D. Medicaid populations eligible for HPE decisions include children up to age nineteen (19), pregnant women, low income parents or caretaker relative(s), former foster children and certain women with breast or cervical cancer.

E. The Division of Medicaid certifies HPE Medicaid eligibility.

Source: 42 CFR § 435.1110.

History: New Rule eff. 04/01/2016.

Rule 8.12: Optional Coverage of Children Elected to be Covered by Mississippi

A. Children under the age of twenty-one (21) for whom the Department of Human Services (DHS) assumes full or partial financial responsibility who are in foster homes or private institutions are certified for Medicaid coverage by DHS if the child's income is within state established standards, converted to a Modified Adjusted Gross Income (MAGI)-equivalent standard. Children under age twenty-one (21) in adoptions subsidized in full or part by DHS and children in adoption assistance who cannot be placed for adoption without medical assistance due to special needs of the child are eligible for Medicaid regardless of the child's income, as determined by DHS.

B. Independent foster care adolescents who are in foster care under the responsibility of DHS on their eighteenth (18th) birthday have Medicaid coverage continued until age twenty-one (21) without regard to any change in circumstances such as income or resources. As required by the Affordable Care Act (ACA), former foster children receive Medicaid on a mandatory basis to age twenty-six (26); however, the optional coverage of former foster children to age

twenty-one (21) was in place prior to the ACA. The Division of Medicaid, in coordination with DHS, certifies Medicaid coverage for this group.

C. Uninsured children under age nineteen (19) whose household income is at or below two hundred percent (200%) of the federal poverty level converted to a MAGI-equivalent standard are covered by the Children's Health Insurance Program (CHIP), which is a separate health plan. Covered children include: infants to age one (1) whose household income is above the MAGI-equivalent standard of one hundred eighty-five percent (185%) but does not exceed the MAGI-equivalent standard of two hundred percent (200%) of the federal poverty level; children age one (1) to age six (6) whose household income is above the MAGI-equivalent standard of one hundred thirty-three percent (133%) but does not exceed the MAGI-equivalent standard of two hundred percent (200%) of the federal poverty level and children age six (6) to age nineteen (19) whose household income is above one hundred thirty-three percent (133%) of the federal poverty level but does not exceed the MAGI-equivalent standard of two hundred percent (200%).

Source: 42 USC § 1396a; 42 CFR § 435.201; Miss. Code Ann. § 41-86-15.

History: Revised eff. 04/01/2016.

Rule 8.13: Optional Coverage of the Aged, Blind and Disabled Considered to be in an Institution Elected to be Covered by Mississippi

A. Individuals who would be eligible for cash assistance if not institutionalized. The individual must be in a title XIX nursing facility or hospital and meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.

B. Individuals in institutions who are eligible under a special income test. The individual must be in a title XIX nursing facility or hospital and meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.

C. Individuals receiving home and community-based services who would be Medicaid eligible if institutionalized who are eligible under an approved waiver and receive waivered services. The individual must meet income, resource and other non-financial factors of eligibility, as determined by the Division of Medicaid.

D. Certain disabled children age eighteen (18) or under who are living at home, who would be eligible for Medicaid if in a medical institution and for whom the Division of Medicaid has made a determination as required under section 1902(e)(3)(B) of the Social Security Act. The cost-effectiveness of care at home compared to care provided in a medical institution must be considered, as determined by the Division of Medicaid.

Source: 42 USC § 1396a; 42 CFR §§ 435.211, 435.217, 435.236.

History: Revised eff. 04/01/2016.

Rule 8.14: Optional Coverage of the Aged, Blind and Disabled Living At-Home Elected to be Covered by Mississippi

A. Disabled individuals who work in excess of an established number of hours each month whose net family earned income is at or below two hundred fifty percent (250%) of the federal poverty level and whose unearned income is at or below one hundred thirty-five percent (135%) of the federal poverty level. Resource limits and other non-financial factors of eligibility are required. Premiums are payable for households with earnings that exceed one hundred fifty percent (150%) of the poverty level. The Division of Medicaid certifies eligibility and premiums payable for this group.

B. Women who have been screened for breast or cervical cancer under the Centers for Disease Control (CDC) and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a precancerous condition of the breast or cervix. Coverage is limited to women who are otherwise uninsured and are not eligible for Medicaid under any other mandatory coverage group and have not attained age sixty-five (65). The MS State Department of Health (MSDH) is responsible for the screening, diagnosis and financial eligibility decisions. The Division of Medicaid is responsible for the non-financial eligibility decisions and for certifying Medicaid eligibility during the course of the woman's active treatment.

Source: 42 USC § 1396a.

History: Revised eff. 04/01/2016.

Rule 8.15: Optional Waiver Coverage of Non-Medicare Aged, Blind and Disabled Individuals

Section 1115(a) waiver coverage is granted to certain non-Medicare entitled individuals who are aged, blind or disabled and have income at or below one hundred thirty-five percent (135%) of the federal poverty level. Coverage under the waiver is subject to an enrollment cap. Resource limits and other factors of eligibility apply, as determined by the Division of Medicaid.

Source: 42 USC § 1315; Healthier Mississippi Waiver (HMW).

History: Revised eff. 04/01/2016.

Rule 8.16: Optional Waiver Coverage- Family Planning

Section 1115(a) waiver coverage provides family planning and family planning related services to women of child bearing age who have family incomes at or below one hundred eighty-five percent (185%) of the federal poverty level converted to a Modified Adjusted Gross Income (MAGI)-equivalent standard who are not otherwise eligible for Medicare, Medicaid, Children's Health Insurance Program (CHIP) or other health insurance that includes coverage of family planning services. Effective January 1, 2015, the family planning waiver includes the coverage

of men. All individuals qualifying for coverage of family planning services under the waiver must be within the age and income limits, as determined by the Division of Medicaid.

Source: 42 USC § 1315; Family Planning Waiver (FPW).

History: Revised to correspond with the Family Planning Waiver (FPW) (eff. 01/01/2014) eff. 04/01/2016.

Rule 8.17: Optional Waiver Coverage – 1915(c) Home and Community-Based Waivers

Section 1915(c) Home and Community-Based Services (HCBS) waiver coverage includes the following:

A. Elderly and Disabled (E&D) Waiver [Refer to Miss. Admin. Code Part 208, Chapter 1],

B. Independent Living (IL) Waiver [Refer to Miss. Admin. Code Part 208, Chapter 2],

C. Assisted Living (AL) Waiver [Refer to Miss. Admin. Code Part 208, Chapter 3],

D. Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver [Refer to Miss. Admin. Code Part 208, Chapter 4], and

E. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver [Refer to Miss. Admin. Code Part 208, Chapter 5].

Source: 42 USC § 1315; Miss. Code Ann. 43-13-117.

History: New Rule eff. 04/01/2016.

Part 100 Chapter 9: Administrative Rules

Rule 9.1: Public Notice

The Division of Medicaid provides public notice of any:

A. Significant proposed change in methods and standards for setting payment rates for State Plan services, except when a change is:

    1. Being made to conform to Medicare methods or levels of reimbursement,

    2. Required by a court order, or

    3. Based on changes in wholesalers' or manufactures' prices of drugs or materials, if the Division of Medicaid's reimbursement system is based on material cost plus a professional fee.

B. Significant proposed change in methods and standards for setting payment rates and an opportunity for public input on substantive changes to services and operations of a 1915 Waiver.

C. Submission of an application or extension of an 1115 Demonstration Waiver.

D. Proposed change to eligibility or benefits for the Children's Health Insurance Program (CHIP).

E. Proposed significant modifications to existing premiums or cost sharing, including any change in the consequences for non-payment.

F. Requests for bids or proposals as required by state law.

G. Proposed changes to the MississippiCAN program.

Source: 42 CFR §§ 431.400, 431.404, 431.408, 438.50, 438.202, 441.301, 441.304, 447.57, 447.205, 447.253, 457.65; Miss. Code Ann. §§ 25-9-120, 31-7-13, 43-13-121.

History: New Rule eff. 07/01/2015.

Rule 9.2: Public Records

A. The Division of Medicaid defines "public records" as all books, records, papers, accounts, letters, maps, photographs, films, cards, tapes, recordings or reproductions thereof, and any other documentary materials, regardless of physical form or characteristics, having been used, being in use, or prepared, possessed or retained for use in the conduct, transaction or performance of any business, transaction, work, duty or function of the Division of Medicaid or required to be maintained by the Division of Medicaid.

B. The Division of Medicaid allows any person the right to inspect, copy, mechanically reproduce or obtain a reproduction of any public record of the Division of Medicaid, unless the record is exempt from public inspection as specified by federal and/or state law, during the Division of Medicaid's normal business hours, Monday through Friday, 8:00 a.m. to 5:00 p.m., excluding legal holidays.

    1. Public records must be inspected or reproduced at the central or regional office(s) of the Division of Medicaid, depending on the type of public records requested.

    2. The Division of Medicaid may have a staff member observe the inspection or reproduction of public records by the requestor.

    3. The Division of Medicaid will provide reasonable space for the inspection and/or reproduction of public records.

    4. Requested public records and/or information will be provided by a Division of Medicaid

staff member.

5. Public records subject to inspection and/or reproduction may not be destroyed, altered, marked upon, or disassembled in any manner by the requestor.

6. The time, place and manner of inspection and/or reproduction of public records cannot interfere with other essential duties or unreasonably disrupt operations of the Division of Medicaid.

7. The time, place and manner of inspection and/or reproduction of public records must be mutually agreed upon by the Division of Medicaid and the requestor.

C. The requestor must claim or review the assembled records within thirty (30) days of the Division of Medicaid's notification to him or her that the records are available for inspection or reproduction.

1. The Division of Medicaid will notify the requestor in writing of this requirement and inform the requestor that he or she should contact the Division of Medicaid to make arrangements to claim or review the records.

2. If the requestor or a representative of the requestor fails to claim or review the records within the thirty (30) day period or make other arrangements, the Division of Medicaid may close the request and refile the assembled records.

D. Any person requesting to inspect, copy, mechanically reproduce or obtain a reproduction of public records of the Division of Medicaid must make the request in writing by email, fax or letter addressed to the Division of Medicaid's public records officer and must include the following information:

1. Name of requestor,

2. Address of requestor,

3. Other requestor contact information, including telephone number and an email address,

4. Identification of the requested public records, by individual item or by category with reasonable particularity, so that the public records officer or designee can locate the public records, and

5. Date of request.

E. Within seven (7) business days of receipt of the request, the public records officer will:

1. Make the public records available for inspection and/or reproduction,

2. Deliver requested copies to the requestor if terms of payment are agreed upon,

3. Request clarification from the requestor via telephone, letter or email, or

4. Deny the request and give the specific exemption or other authority and/or provide a brief explanation.

F. If the Division of Medicaid cannot produce the requested public records within seven (7) business days of the request, the public records officer will:

1. Provide the requestor with notification specifying the reason why the requested public records cannot be produced within seven (7) business days, and

2. Obtain a mutually agreed upon delivery date for the public records to be released.

G. The Division of Medicaid may charge for the processing, retrieval/searching, reviewing and duplicating of information and/or public records not readily available, unless the information and/or public records are requested by a federal agency, institution of higher learning, or a Medicaid beneficiary, as follows:

1. The actual cost of searching for, reviewing and redacting exempt information from public records, which is based on the hourly rate of compensation for the lowest paid agency employee qualified to perform the tasks multiplied by the actual time to complete the task according to the Division of Medicaid's fee schedule,

2. The cost of any associated computer run time or database processing time related to the retrieval of data according to the Division of Medicaid's fee schedule,

3. The cost of electronic copies of public records being placed on a data storage device. There is no charge for e-mailing electronic public records to a requestor, unless another cost applies such as a scanning fee or system costs according to the Division of Medicaid's fee schedule,

4. Fifty Cents ($0.50) per page for standard black and white and/or color copies of any public record made on a Division of Medicaid copier, and

5. The actual cost of mailing, including the cost of the shipping container.

H. The Division of Medicaid requires payment, by check or money order, to the Division of Medicaid in the amount of the estimated cost of processing or retrieval of public records and/or information prior to the completion of the request.

Source: Miss. Code Ann. §§ 25-61-1, et seq., 43-13-121.

History: New Rule eff. 07/01/2015.

Rule 9.3: Declaratory Opinions

A. This rule sets forth the Mississippi Division of Medicaid's rules governing the form, content, and filing of requests for declaratory opinions, the procedural rights of persons in relation to the written requests, and the Mississippi Division of Medicaid's procedures regarding the disposition of requests as required by Miss. Code Ann. § 25-43-2.103.

B. The Mississippi Division of Medicaid will issue declaratory opinions regarding the applicability to specified facts of:

   1. A statute administered or enforceable by the Mississippi Division of Medicaid;

   2. A rule promulgated by the Mississippi Division of Medicaid; or

   3. An order issued by the Mississippi Division of Medicaid.

C. A request must be limited to a single transaction or occurrence.

D. When a person with substantial interest, as required by Miss. Code Ann. § 25-43-2.103, requests a declaratory opinion, the requestor must submit a printed, typewritten, or legibly handwritten request.

   1. Each request must be submitted on 8-1/2" x 11" white paper.

   2. The request may be in the form of a letter addressed to the Executive Director of the Mississippi Division of Medicaid or in the form of a pleading as if filed with a court.

   3. Each request must include the full name, telephone numbers, and mailing address of the requestor(s).

   4. All requests shall be signed by the person filing the request, unless represented by an attorney, in which case the attorney may sign the request.

   5. Each request must clearly state that it is a request for a declaratory opinion.

E. Any party who signs the request shall attest that the request complies with the requirements set forth in these rules, including but not limited to a full, complete, and accurate statement of relevant facts and that there are no related proceedings pending before any agency, administrative, or judicial tribunal.

F. Each request must contain the following:

   1. A clear identification of the statute, rule, or order at issue;

   2. The question for the declaratory opinion;

   3. A clear and concise statement of all facts relevant to the question presented;

4. The identity of all other known persons involved in or impacted by the facts giving rise to the request including their relationship to the facts, and their name, mailing address, and telephone number; and

5. A statement sufficient to show that the requestor has a substantial interest in the subject matter of the request.

G. The Mississippi Division of Medicaid may, for good cause, refuse to issue a declaratory opinion. The circumstances in which declaratory opinions will not be issued include, but are not necessarily limited to the following:

1. The matter is outside the primary jurisdiction of the Mississippi Division of Medicaid;

2. There is a lack of clarity concerning the question presented;

3. There is pending or anticipated litigation, administrative action or anticipated administrative action, or other adjudication which may either answer the question presented by the request or otherwise make an answer unnecessary;

4. The statute, rule, or order on which a declaratory opinion is sought is clear and not in need of interpretation to answer the question presented by the request;

5. The facts presented in the request are not sufficient to answer the question presented;

6. The request fails to contain information required by these rules or the requestor failed to follow the procedure set forth in these rules;

7. The request seeks to resolve issues which have become moot or are abstract or hypothetical such that the requestor is not substantially affected by the rule, statute, or order on which a declaratory opinion is sought;

8. No controversy exists or is certain to arise which raises a question concerning the application of the statute, rule, or order;

9. The question presented by the request concerns the legal validity of a statute, rule, or order;

10. The request is not based upon facts calculated to aid in the planning of future conduct, but is, instead, based on past conduct in an effort to establish the effect of that conduct;

11. No clear answer is determinable;

12. The question presented by the request involves the application of a criminal statute or sets forth facts which may constitute a crime;

13. The answer to the question presented would require the disclosure of information which is privileged or otherwise protected by law from disclosure;

14. The question is currently the subject of an Attorney General's opinion request;

15. The question has been answered by an Attorney General's opinion;

16. One or more requestors have standing to seek an Attorney General's opinion on the proffered question;

17. A similar request is pending before this agency, or any other agency, or a proceeding is pending on the same subject matter before any agency, administrative or judicial tribunal, or where such an opinion would constitute the unauthorized practice of law; or

18. The question involves eligibility for a license, permit, certificate, or other approval by the Mississippi Division of Medicaid or some other agency and there is a statutory or regulatory application process by which eligibility for said license, permit, or certificate or other approval may be determined.

H. Within forty-five (45) days after the receipt of a request for a declaratory opinion which complies with the requirements of these rules, the Mississippi Division of Medicaid shall, in writing:

1. Issue an opinion declaring the applicability of the statute, rule, or order to the specified circumstances;

2. Agree to issue a declaratory opinion by a specified time but no later than ninety (90) days after receipt of the written request; or

3. Decline to issue a declaratory opinion, stating the reasons for its action.

4. The forty-five (45) day period shall begin on the first business day after which the request is received by the Mississippi Division of Medicaid.

I. Declaratory opinions and requests for declaratory opinions shall be available for public inspection and copying at the expense of the viewer during normal business hours. All declaratory opinion and requests shall be indexed by name, subject, and date of issue. Declaratory opinions and requests which contain information which is confidential or exempt from disclosure under the Mississippi Public Records Act or other laws shall be exempt from this requirement and shall remain confidential.

Source: Miss. Code Ann. §§ 25-43-2.103; 43-13-121.

History: New eff. 09/01/2014.

Rule 9.4: Oral Proceedings

A. This rule applies to all oral proceedings held for the purpose of providing the public with an opportunity to make oral presentations or written input on proposed new rules, amendments to rules, and proposed repeal of existing rules before the Mississippi Division of Medicaid pursuant to the Administrative Procedures Act, specifically Miss. Code Ann. § 25-43-3.104.

B. When a political subdivision, an agency, or ten (10) persons request an oral proceeding in regards to a proposed rule adoption, the requestor must submit a printed, typewritten, or legibly handwritten request.

1. Each request must be submitted on 8-1/2" x 11" white paper.

2. The request may be in the form of a letter addressed to the Executive Director of the Mississippi Division of Medicaid or in the form of a pleading as if filed with a court.

3. Each request must include the full name, telephone numbers, and mailing address of the requestor(s).

4. All requests shall be signed by the person filing the request, unless represented by an attorney, in which case the attorney may sign the request.

C. Notice of the date, time, and place of all oral proceedings shall be filed with the Secretary of State's Office for publication in the Administrative Bulletin. The agency providing the notice shall provide notice of oral proceedings to all persons requesting notification of proposed rule adoptions. The oral proceedings will be scheduled no earlier than twenty (20) days from the filing of the notice with the Secretary of State. The Executive Director of the Mississippi Division of Medicaid or designee who is familiar with the substance of the proposed rule shall preside at the oral proceeding on a proposed rule.

D. Public participation shall be permitted at oral proceedings, as follows:

1. At an oral proceeding on a proposed rule, persons may make statements and present documentary and physical submissions concerning the proposed rule.

2. Persons wishing to make oral presentations at such a proceeding shall notify the Executive Director of the Mississippi Division of Medicaid at least three (3) business days prior to the proceeding and indicate the general subject of their presentations. The presiding officer in his or her discretion may allow individuals to participate that have not contacted the Mississippi Division of Medicaid prior to the proceeding.

3. At the proceeding, those who participate shall indicate their names and addresses, identify any persons or organizations they may represent, and provide any other information relating to their participation deemed appropriate by the presiding officer.

4. The presiding officer may place time limitations on individual presentations when necessary to assure the orderly and expeditious conduct of the oral proceeding. To

encourage joint presentations and to avoid repetition, additional time may be provided for persons whose presentations represent the views of other individuals as well as their own views.

5. Persons making presentations are encouraged to avoid restating matters that have already been submitted in writing. Written materials may be submitted at the oral proceeding.

6. Where time permits and to facilitate the exchange of information, the presiding officer may open the floor to questions or general discussion. The presiding officer may question participants and permit the questioning of participants by other participants about any matter relating to that rule-making proceeding, including any prior written submissions made by those participants in that proceeding. No participant shall be required to answer any question.

E. Physical and documentary submissions presented by participants in an oral proceeding shall be submitted to the presiding officer. Such submissions become the property of the Mississippi Division of Medicaid, part of the rulemaking record, and are subject to the Mississippi Division of Medicaid's public records request procedure. The Mississippi Division of Medicaid may record oral proceedings by stenographic or electronic means.

Source: Miss. Code Ann. §§ 25-43-2.103; 43-13-121.

History: New eff. 09/01/2014.

Rule 9.5: Public Hearings

A. This rule applies to all public hearings held for the purpose of providing the public with an opportunity for input on the Division of Medicaid's submissions to the Centers for Medicare and Medicaid Services (CMS).

B. The date, time, and place of a public hearing will be published as part of a public notice.

C. Public hearings held by the Division of Medicaid will allow for a reasonable time for the public to provide input.

D. The presiding officer may place time limitations on individual presentations when necessary to assure the orderly and expeditious administration of the public hearing.

E. The Division of Medicaid is not required to respond to public comments or questions during a public hearing.

F. Physical and documentary submissions presented by participants of a public hearing are to be submitted to the presiding officer and become property of the Division of Medicaid, subject to the public records request procedure.

G. The Division of Medicaid may record public hearings by stenographic or electronic means.

Source: 42 CFR § 447.205; Miss. Code Ann. § 43-13-121.

History: New Rule eff. 07/01/2015.

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 101 Application and Redetermination Process

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Title 23: Division of Medicaid

Part 101: Application and Redetermination Processes

Part 101 Chapter 1: Introduction

Rule 1.1: General Information.

A. The application process consists of all activities completed during the timely processing period from the time a signed application form is received by the regional office until a notice of approval or denial is mailed to the applicant.

B. A redetermination or renewal of eligibility is a review of all variable eligibility factors, conducted at specific intervals not to exceed 12 months for each recipient, to determine whether or not eligibility continues. Basic information that is not subject to change, such as age, citizenship, Social Security Number, etc., does not have to be re-verified.

Source: 42 CFR § 435.902 (Rev. 1994) and 42 CFR § 435.916 (Rev. 2012).

Rule 1.2: Access to the Application and Renewal Process.

A. Access to the regional office should not be a barrier for individuals wishing to apply or renew eligibility in person. Each office where Medicaid Specialists are located should be accessible for handicapped persons.

B. As required by the ACA, effective 01/01/2014, there is no requirement for an in-person interview as part of the application or renewal process. Individuals who are unable to enter a Medicaid office or out stationed site should be encouraged to apply or renew through an alternate allowable method.

Source: 42 CFR § 435.901 (Rev. 1994) and 42 CFR § 435.907.

Rule 1.3: Special Assistance.

A. Each office is required to provide services to the limited English proficient, deaf, blind and disabled applicants, who are mentally or physically impaired and/or lack someone to act for them. Services and auxiliary aids are provided at no cost to the individual requiring the service.

B. The instructions below provide guidance for communicating with any applicant or recipient, who is known to be deaf, hard of hearing, blind or visually impaired, or otherwise limited English proficient, illiterate, and/or require communication assistance.

1. Blind Applicants. Read forms to the applicant in their entirety and assist in completion of the forms. Explain the various program requirements and services offered through the agency and answer any questions the applicant may ask.

2. Deaf Applicants. When needed, secure a person proficient in sign language or communicate in writing to relate an explanation of the programs and to answer any questions, and assist in the application process.

3. Illiterate Applicants. Read forms to the applicant in their entirety and assist in the application process. Explain the various program requirements and services offered through the agency in terms and phrases which the applicant can understand.

4. Language Barrier Applicants. When interpreter services are needed, use the Language Line to secure the assistance of an interpreter capable of communicating in the applicant's language to assist in the application process and relate the services offered.

Source: 42 CFR § 435.901 (Rev. 1994) and 42 CFR § 435.907 (Rev 2012).

Rule 1.4: Assistance with Application and Renewal

A. The Division of Medicaid is required to provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and on-line in a manner that is accessible to individuals with disabilities and those who are limited English proficient. Assistance includes, but is not limited to, the following:

1. Help with forms completion.

2. Help with securing a representative, if needed, and/or allowing someone of the applicant's choice to assist in the application and renewal process.

3. Help in obtaining necessary information from third parties, and

4. Providing information that will assist the applicant in making informed decisions about Medicaid eligibility.

B. Medicaid program policies are public information. Each applicant has a right to know the policies that will impact his eligibility. Eligibility requirements, available Medicaid services and the rights and responsibilities of applicants and recipients must be furnished electronically, orally and in paper formats.

Source: CFR 42 § 435.905 (Rev. 2012) and CFR 42§ 435.908 (Rev. 2012)

Part 101 Chapter 2: Definitions

Rule 2.1: Definitions.

A. Applicant. An individual who is seeking an eligibility determination through an application received by the Division of Medicaid or transferred to the Division of Medicaid by the health insurance exchange.

B. Application. The single streamlined application developed for use for all insurance affordability programs, as required by the ACA, or the appropriate application form for use in determining Medicaid eligibility for aged, blind or disabled.

C. Affordable Care Act (ACA) means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 1110152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).

D. Recipient/Beneficiary. An applicant approved for and receiving benefits.

E. Incapacitated Individual. An individual who is unable to act on his own behalf due to a physical or mental condition.

F. Incompetent Individual. An individual adjudged to be mentally incompetent by a court.

G. Individual with Limited English Proficiency (LEP). An individual who is unable to communicate effectively in any language other than his native language.

H. Insurance Affordability Program. A program that is one of the following, required by the ACA: 1) Medicaid, 2) CHIP, 3) coverage in a qualified health plan through the health insurance marketplace with advance payments of the premium tax credit or with cost-sharing reductions.

I. Sensory Impaired Individual. An individual who has a partial, profound or complete loss of hearing or sight.

J. Legal Guardian Or Conservator. A person who has court documents which prove a legal guardianship or conservatorship has been established for the applicant. The application is filed in the name of the applicant; however, the guardian or conservator must provide eligibility information and sign the application form.

K. Authorized Representative. A person who is acting responsibly for the applicant with his knowledge and consent. The authorized representative has knowledge of the applicant's circumstances and is usually a relative or close friend. The authorized representative must be authorized in writing by the applicant to act on his behalf. The application is filed in the name of the applicant. The authorized representative can provide eligibility information and sign the application form.

L. Designated Representative. A person acting responsibly for an applicant because the physical or mental condition of the applicant is such that he cannot authorize anyone to act for him nor can he act for himself. The designated representative has knowledge of the applicant's circumstances and is usually a relative or close friend. The application must be filed in the name of the applicant with the designated representative providing the eligibility information

and signing the application form. A non-applicant caretaker, who is not the legal parent of the applicant children, is a designated representative.

M. Application Forms. All applications must be filed on the single application form designed for all insurance affordability programs or appropriate application forms for the aged, blind and disabled Medicaid Programs. These forms can be a paper version, an electronic version or an exact facsimile of the appropriate form. The application form is:

1. A legal document, completed by the applicant or a person acting on behalf of the applicant, that signifies intent to apply,

2. The official agency document used to collect information necessary to determine eligibility,

3. The applicant's formal declaration of financial and other circumstances at the time of application,

4. The applicant's certification that all information provided is true and correct, signed under penalty of perjury, regardless of whether the application is completed and submitted electronically, by telephone or in paper form.

5. Providing notice to the applicant of his rights and responsibilities, and

6. May be introduced as evidence in a court of law.

N. Request for Informal Medicaid Eligibility Opinion. An individual seeking assistance from other social service agencies may be required to obtain a statement from the Division of Medicaid that he is not eligible for Medicaid in order to obtain that agency's services. If the individual indicates through questioning that none of the categorical requirements would be met, i.e., the person is not aged, blind, disabled, pregnant, under age nineteen (19) or part of a family with dependent children, the regional office may provide the individual with a statement that he is not eligible based on the self-declared information. The statement must also explain to the individual that the decision is not an official denial and cannot be appealed.

1. If an official denial notice is required, an application must be filed and a decision rendered after all eligibility factors have been examined according to rule. In addition, the statement issued by the office cannot be used to indicate a person's ineligibility due to financial or other non-categorical eligibility criteria. If the person appears categorically eligible, an application must be filed to obtain an eligibility decision.

O. ABD Resource Assessment. When either member of a couple, the Institutional Spouse (IS) or Community Spouse (CS), or a representative acting on behalf of either the IS, CS, or the couple, requests an assessment of the couple's resources, the regional office will use the following guidelines:

1. An assessment is separate from an application for Medicaid. If the IS wishes to apply for Medicaid, an assessment is no required. Resources will be evaluated under Spousal Impoverishment rules and appropriate notice of eligibility will be issued.

2. When the couple only wants to know how Medicaid will evaluate their total resources if an application were filed, an assessment is required. In order for an assessment to be provided, one member of the couple must be institutionalized at the time of the request.

3. An assessment is a "snapshot" of the couple's total countable resources in the month of the institutionalization, i.e., what was true in the month the IS entered an institution for thirty (30) consecutive days or longer on or after 9/30/1989.

4. An assessment provides a written evaluation of resources to the couple giving the following information: Total value of countable resources; The basis for the determination; The CS' share based on the maximum standard allowed as of the month of the assessment; Whether the IS would be currently resource-eligible if an application were to be filed. A "Resource Assessment Notice" will be used to document the information specified above to the couple or their representative.

Source: MS Code Ann. § 43-13-121~~.1~~ (Rev. 2012) and 42 CFR § 435.4 (Rev. 2012)

Part 101 Chapter 3: Filing the Application

Rule 3.1: Right to Apply.

A. Individuals inquiring about program eligibility requirements should be informed of their opportunity to apply and informed about the various means of applying. If a hardcopy application is requested, it must be provided or mailed, as applicable. If another person or agency refers the name of an individual in need of medical assistance to the regional office, the individual will be contacted, if possible, and the various means of applying will be explained. Otherwise, an application will be mailed if an address is available.

B. Individuals wishing to file an application must be afforded the opportunity to do so without delay. When an individual inquires about making an application, an application form must be provided and the person offered the opportunity to file that day.

C. The application of a clearly ineligible person wishing to file must be accepted and then denied.

Source: 42 CFR § 435.906 (Rev. 1994) and 42 CFR § 435.907 (Rev. 2012).

Rule 3.2: Application.

A. Applications for insurance affordability programs or for aged, blind and disabled Medicaid programs may be filed via the internet, by telephone, by mail, in-person and through other

commonly available electronic means, such as by fax or scanned copy, as required by the ACA.

Source: 42 CFR § 435. 907 (Rev. 2012)

Rule 3.3: Application File Date.

A. The application file date is the date a valid application form is received by the agency. To be valid, the application must be the single application form for all insurance affordability programs or the appropriate application form for aged, blind and disabled Medicaid programs or an exact facsimile of the form and it must be signed by the applicant or his representative. Applications may be filed in one of the following ways:

1. In person at any regional office, official out-stationed location or other location outside the regional office where eligibility staff are on official duty, such as a nursing home, hospital or other public facility. The filing date is the date received by the office or other location;

2. By mail in any regional office;

   a) Applications received by mail which arrive after the end of the month, but which are postmarked by the last day of the month will be considered to have been received by the regional office on the last day of the month in which they are postmarked.

3. By fax or a scanned version in any regional office. The date filed is the date received by a regional office.

4. By on-line submission of the application to the Division of Medicaid or to the health insurance exchange which is then transferred to the Division of Medicaid. The date of filing is the date received or transferred to the Division of Medicaid.

Source: MS Code Ann. § 43-13-121 (Rev. 2012) and 42 CFR § 435.907 (Rev. 2012) and 42 CFR § 435.912 (Rev. 2012).

Rule 3.4: Protected Application Dates for Medicaid Applicants.

A. An applicant who applies for Medicaid on any basis is entitled to have eligibility determined under all available coverage groups. Therefore, an individual who files an application for an insurance affordability program does not also have to file a separate application to be evaluated for potential eligibility in an aged, blind and disabled Medicaid program and vice versa. Any application received by the regional office must be evaluated across program lines to determine if eligibility exists under any category of Medicaid coverage.

B. The protected date also includes applications filed through another certifying agency, such as the Social Security Administration (for SSI applicants).

1. If an individual is denied SSI, but would qualify in any available Medicaid-only coverage group, the SSI application date is the protected filing date for Medicaid benefits.

2. If the individual is eligible for Medicaid-only, eligibility must be determined using the SSI application date as the Medicaid application date even if additional information may be needed to determine eligibility

Source: Social Security Act § 1902(a) 55(b) and 42 CFR § 435.911 (Rev. 2012).

Rule 3.5: Who Can File the Application.

A. An application can be filed by one (1) of the following individuals, as applicable:

1. Adult applicants or an adult who is in the applicant's household;

2. Certain minor applicants including:

a) A pregnant minor of any age requesting coverage solely due to pregnancy,

b) A married minor living with a spouse,

c) A minor living independently, or

d) A minor living with his/her parents and applying only for the minors own children.

3. The parent who has primary physical custody of a minor child,

4. Either parent of a minor child when physical custody is equally divided between legal parents,

5. The legal guardian or conservator,

6. An authorized representative, or

7. A designated representative.

Source: MS Code Ann. § 43-13-121 (Rev. 2012) and 42 CFR § 435.907 (Rev. 2012)

Rule 3.6: Applications Received from MS Residents Out-Of-State.

A. Applications made for Mississippi residents who are temporarily out of the state may be accepted. Generally the applicant must return to the state before the application processing period ends.

B. The application of someone who is hospitalized in another state and planning to return to Mississippi when discharged may be processed in the usual manner. If the application is

approved, it must be reviewed every three (3) months to determine the individual's continued intent to reside in MS.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 3.7: Out of State Applicants.

A. Applications received from persons residing in another state will be denied and notice mailed to explain that the applicants will need to reapply upon arrival in MS with intent to reside.

B. Persons who are in MS for a temporary purpose, such as a visit, who intend to return to their home out of state are not eligible for Mississippi Medicaid or CHIP.

C. Applicants must always be given the right to make an application if they wish to do so and receive a decision on their case.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 3.8: Residence Change During the Application Process.

A. If the applicant reports moving to another location within the state during the application process, the application must be completed by the first regional office, and if approved, transferred to the new location. If the application is denied, the record is not transferred until the person reapplies in the second location.

B. If the applicant reports moving out of the state during the application process, the date of the move must be determined. If otherwise eligible, the applicant may be approved for Medicaid from any requested retroactive months through the month of the move. If the applicant will be CHIP eligible, the application will be denied when CHIP eligibility is for a future month.

C. If only some members of the applicant family are moving from the state, the remaining children and adults who remain in MS will be identified and the case will be handled on their ongoing eligibility accordingly.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 3.9: Where to File the Application.

A. Applications submitted via any acceptable method for applying should be filed with the regional office that serves the applicant's county of residence. However, applications for individuals living in another RO's service area must be accepted by any regional office. The regional office must review each application upon receipt and confirm the accuracy of the address if there is a question about the responsible office.

Source: MS Code Ann. § 43-13-121 (Rev. 2012).

Part 101 Chapter 4: Determination of Eligibility

Rule 4.1: Determination of Eligibility for Medicaid, CHIP and Other Insurance Affordability Programs.

A. For each individual who submits an application or whose eligibility is subject to an annual renewal or a renewal pursuant to a change in circumstance who meets the non-financial requirements for eligibility, the Division of Medicaid must comply with the following, as required by the ACA:

1. The agency must promptly and without undue delay furnish Medicaid or CHIP coverage to individuals whose eligibility is based on the applicable modified adjusted gross income (MAGI) standard. Coverage for these individuals includes children, parents and other caretaker relatives and pregnant women.

2. For each individual who is not eligible on the basis of MAGI who is identified as being potentially eligible as an aged, blind or disabled individual, additional information must be collected to determine if such individual is eligible for Medicaid on any basis other than MAGI and determine eligibility on such basis.

3. For individuals not eligible for Medicaid or CHIP based on MAGI or Medicaid based on non-MAGI coverage for the aged, blind or disabled but who are potentially eligible for coverage in a qualified health plan, the individual's electronic account will be transferred to the health insurance marketplace via a secure electronic interface for an evaluation of coverage in other insurance affordability programs.

4. For individuals not eligible for Medicaid or CHIP based on MAGI but who may potentially be eligible for Medicaid based on non-MAGI requirements for aged, blind or disabled Medicaid, the individual's electronic account will be transferred to the health insurance marketplace for coverage in other insurance affordability programs, if appropriate, while the non-MAGI application is pending a final decision.

Source: 42 CFR § 435.911 (Rev. 2012) and 42 CFR § 435.1200 (Rev. 2012)

Part 101 Chapter 5: Standards of Promptness

Rule 5.1: Regional Office Responsibilities.

A. Eligibility must be determined within the appropriate timeframes for the program type.

B. If there is a delay in processing, the reason must be clearly documented in the record.

C. Each regional office must have controls in place which ensure timely application processing at all staff levels, including sufficient time for supervisory review and corrections, as appropriate.

D. Applications should generally be processed in the order in which they are received, taking into consideration promptness and delay in receipt of verifications, and in some cases, urgent need.

E. Under no circumstances should an application be approved without the proper verifications, received through electronic databases and otherwise that document eligibility for each applicant.

Source: 42 CFR § 435.911 (Rev. 2012).

Rule 5.2: Exceptions to Timely Promptness.

A. The agency must determine eligibility within established standards, except in unusual circumstances when a decision cannot be reached because of:

1. Failure or delay on the part of the applicant;

2. Administrative or other emergency delay that could not be controlled by the agency such as:

a) Staff vacancies or illness of eligibility staff lasting two months or more;

b) Wholesale desk reviews on active cases mandated by court order, Federal regulations of wholesale increase in benefits, such as Social Security, VA, etc., which require extensive staff time;

c) Computer problems arising from control of systems by an outside agency.

B. Time standards may not be used in the agency as a waiting period before determining eligibility or as a reason to deny eligibility because the agency has not determined eligibility within the time standards.

Source: 42 CFR § 435.911 (Rev. 2012).

Rule 5.3: Timely Processing

A. Federal rules require that applications be approved or denied, and the applicant notified, within forty-five (45) days from the date the application was filed.

B. The processing timeframe is ninety (90) days when a disability determination is required before the eligibility determination can be completed. However, if a separate disability decision is not required, the forty-five (45) day standard applies.

C. The applicable standard of promptness, i.e., forty-five (45) or ninety (90) days, is applied to an ABD application from the date an application is filed to the date the notice of decision is mailed to the applicant. When there is a delay, the reason must be documented in the record.

Source: 42 CFR § 435.911 (Rev. 2012).

Part 101 Chapter 6: Disposition of Applications

Rule 6.1: Making an Eligibility Decision.

A. Eligibility is determined based on information contained on the application form as well as information secured during the application process. Appropriate Division of Medicaid forms, along with other legal or official documents which support the eligibility decision must be imaged for filing in the electronic case record.

B. As part of the eligibility process, information provided by the applicant and secured from electronic databases must be evaluated by the specialist prior to making the eligibility decision.

C. If information provided by or on behalf of an individual on the application or renewal form or otherwise provided is reasonably compatible with information obtained through electronic databases, eligibility must be determined or renewed based on such information.

D. An individual must not be required to provide additional information or documentation unless information needed cannot be obtained electronically or the information obtained electronically is not reasonably compatible, as described and defined in Mississippi's federally approved verification plan, as required by the ACA.

E. The Division of Medicaid is not required to use data available from an electronic source if establishing a data match would not be effective considering such factors as the administrative costs associated with establishing and using the data match as compared to relying on paper documentation.

F. Income information obtained from electronic sources such as the Internal Revenue Service, Mississippi Department of Employment Security, the Social Security Administration and other cost-effective available databases are considered reasonably compatible with information provided by the individual if both are either above or at or below the applicable income standard.

G. If information is not reasonably compatible, information must be provided by the individual to clear up any discrepancies. Information provided becomes part of the electronic case record.

H. The general rule for verification is to verify only the information which is material to the individuals' eligibility. The specialist has permission to obtain needed verifications based on the signed and dated application form.

Source: 42 CFR § 435. 940 through § 435.960 (Rev. 2012).

Rule 6.2: Application Actions.

A. All applications will be subject to one (1) of the following actions:

1. Approval.

   a) When all eligibility factors are met, the application is approved.

2. Denial.

   a) When one (1) or more eligibility factors are not met, the application is denied.

   b) Death is not an appropriate reason to deny a Medicaid application. If the applicant dies before a final eligibility determination is made, the application process must be continued to completion.

3. Withdrawal.

   a) When the applicant decides to withdraw his request for assistance during the application process, it is not necessary to complete any remaining verification and evaluation. If the applicant is present, the specialist will obtain the request for withdrawal in writing. When the request to withdraw is not made in person, the specialist will document the case to reflect the specifics of the request. The application will be denied and appropriate notice issued.

Source: 42 CFR § 435.913 (Rev. 2012).

Part 101 Chapter 7: Eligibility Dates

Rule 7.1: Beginning Dates of Medicaid Eligibility.

A. Medicaid applicants, including an applicant who dies prior to filing an application or dies prior to completion of the application process, may qualify for Medicaid on one of the following dates:

   1. The first (1st) day of the month of the application, provided all eligibility factors are met for the first (1st) day of the month;

   2. The first (1st) day of the month after the month the application in which all eligibility factors are met;

   3. The first (1st) day of the first (1st), second (2nd) or third (3rd) month prior to the month of application when conditions are met for retroactive Medicaid.

Source: 42 CFR § 435.914 (Rev.2012).

Rule 7.2: Beginning Dates of CHIP Eligibility.

A. The benefit start date for CHIP is generally a future month. Coverage authorized by the 3rd (third) day of the current month is effective the current month. Coverage authorized after the 3rd (third) day of the current is effective on the first (1st) of the following month.

B. There is one exception for limited retroactive coverage in CHIP. The start date for a CHIP-eligible newborn may be retroactive to the date of birth if the application for the newborn is filed within thirty-one (31) days of birth (start the thirty-one (31) day count the day following the date of birth).

Source: 42 CFR § 457.340(f) (Rev. 2012).

Rule 7.3: Terminations Dates.

A. Eligibility for a Medicaid or CHIP recipient will end on one (1) of the following days of the month, unless otherwise noted:

1. The last of the month in which the recipient was eligible;

2. The death date of the recipient, or

3. The date the recipient entered a public institution.

Source: Miss. Code Ann. 43-13-121.~~1~~ (Rev. 2012).

Rule 7.4: Retroactive Medicaid Eligibility.

A. Retroactive Medicaid eligibility may be available to any Medicaid applicant who received medical care prior to applying for Medicaid.

B. Applicants may qualify for coverage for a three (3) month period prior to the month of the application.

C. Retroactive eligibility can cover all three (3) months of the prior period or any month(s) in the three (3) month period. In addition:

1. Each Applicant must be informed of the availability of retroactive Medicaid coverage.

2. The applicant's statement is accepted regarding medical expenses incurred in the retroactive period.

3. Retroactive Medicaid may also be available to an individual who is added to a case. (e.g. child returns home).

4. The applicant does not have to be eligible in the month of the application (or current month) to be eligible for one or months of retroactive Medicaid.

5. The applicant or recipient may ask for retroactive Medicaid coverage at any time.

6. The date of application, rather than the date of the eligibility determination, establishes the beginning of the three-month retroactive period.

7. There is no provision for retroactive coverage in the Qualified Medicare beneficiary (QMB) program. QMB eligibility begins the month following the month of authorization. It is not appropriate to place a QMB-only approval into an SLMB or Ql-1 category of eligibility to provide retroactive payment of Part B premiums for the retro period.

Source: 42 CFR § 435. 915 (Rev. 2012).

Rule 7.5: Deceased Applicants.

A. An application for retroactive Medicaid coverage may be made on behalf of a deceased person. Retroactive eligibility can cover all three (3) months prior to the month of application or any month(s) in the three (3) month period if the deceased person is found to be eligible.

Source: 42 CFR § 435.914(a) (Rev. 1986).

Part 101 Chapter 8: Continuous Eligibility for Children

Rule 8.1: Continuous Eligibility.

A. When a child under age nineteen (19) is approved for Medicaid or CHIP, eligibility continues for twelve (12) months, regardless of changes in family income and other household circumstances.

B. This rule must be applied when determining and re-determining eligibility for a child under age nineteen (19), regardless of category of eligibility.

C. Continuous coverage may also be referred to as a protected period because the child cannot lose eligibility in the assigned category, unless one (1) of a limited number of early termination reasons is met.

D. In addition, the child's program cannot be changed (Medicaid to CHIP or vice versa), unless the Head of Household voluntarily requests early termination or the child was approved in error in the current program.

Source: Social Security Act § 1902(e)(12). Miss. Code Ann. 43-13-115(20) (Rev. 2005).

Rule 8.2: Early Termination Reasons for Children.

A. The following reasons may shorten the twelve (12) month certification for a child in FCC or ABD programs, as applicable.

1. If a child dies, his eligibility must be terminated.

2. If a child moves out of the state, his eligibility must be terminated.

3. If a child attains the maximum age for his program and an assessment of continued eligibility indicates the child is not eligible in any other FCC or ABD program, his eligibility must be terminated. Refer to Rule 10.4 Exparte Reviews for further discussion on assessing eligibility in another program.

4. When the basis of a child's eligibility is long term care placement, eligibility must be terminated if the child is discharged from the facility.

5. If a child becomes an inmate in a public institution, his eligibility must be terminated.

6. If a child becomes eligible for Medicaid through SSI or Foster Care, coverage authorized through the Medicaid Regional Office will be terminated because the child must have only one source of eligibility.

7. If a child is approved in error, his eligibility must be terminated.

8. If a child cannot be located after reasonable efforts, his eligibility must be terminated.

9. If there is a voluntary request for closure, eligibility must be terminated.

10. In addition to the above termination reasons, CHIP eligibility will also be terminated within the twelve (12) month period if the child becomes covered by other full health insurance.

B. Other changes for children under age nineteen (19) in a child or family-related category of eligibility do not affect the child's eligibility prior to the end of the twelve (12) months of continuous eligibility.

Source: Social Security Act § 1902(e)(12).

Rule 8.3: Deemed Eligible Infants.

A. A deemed eligible infant is a child whose mother was eligible for Medicaid in the child's birth month; however, there is no requirement that the child remain with the mother.

B. The deemed eligible child has continuous Medicaid eligibility for a thirteen (13) month period from his birth month through the month of the first (1st) birthday unless one (1) of the above early termination reasons is applicable.

C. The deemed child's eligibility start date should always be his birth month, regardless of the date the agency authorizes eligibility for the child.

Source: Social Security Act § 1902(e)(4).

Rule 8.4: Eligibility of Adults.

A. Adults generally have no protected period of eligibility. Changes in income and other circumstances can impact an adult's eligibility as such changes occur.

B. However, women eligible solely due to pregnancy are provided coverage from their first eligible month through the post-partum months regardless of any subsequent changes in income, household composition, etc.

Source: Social Security Act § 1902(e)(5).

Part 101 Chapter 9: The Redetermination or Renewal Process

Rule 9.1: General Information.

A. Redetermination or renewal is the process of verifying whether a recipient continues to meet the eligibility requirements of a particular program. Redeterminations are classified as either regular or special reviews.

1. A regular review is an annual review of eligibility factors that are subject to change.

2. A special review is completed when a portion of the case must be re-worked or case information must be updated because of a change. This chapter contains information about the redetermination process.

Source: 42 CFR § 435.916 (Rev. 2012).

Rule 9.2: Regular Redeterminations.

A. Federal regulations require that the eligibility of every Medicaid and CHIP recipient be reviewed at least every twelve (12) months.

B. Mississippi state law also requires annual reviews.

C. During the regular redetermination process, the recipient's circumstances are reviewed and each eligibility factor subject to change, such as income and/or resources is re-evaluated. Recipients are not asked to provide information that is not relevant to ongoing eligibility or that has already been provided and is not subject to change. As required by the ACA, a renewal of eligibility must be processed without requiring information from the recipient if the agency is able to do so based on reliable information contained in the recipient's case

record and other more current information available to the agency, such as data secured from data matches with other state, federal and commercial databases. If a recipient's eligibility can be renewed based on available information, the recipient will be notified of the approval and the basis for the approval. It is then the recipient's responsibility to inform the agency, through any of the modes permitted for submission of applications, if any information reported in the renewal process is inaccurate. The individual is not required to sign and return the approval notice if all information on the notice is accurate.

D. If the agency cannot renew eligibility based on information available to the agency from electronic data matches, the agency must issue a pre-populated renewal form to the recipient displaying the information that is available to the agency. The recipient has 30 (thirty) days from the date the renewal form is issued to respond and provide any necessary information that is needed to renew eligibility, which includes returning the signed renewal form. The signed form and any paper verifications may be returned to the agency through any of the modes permitted for submission of applications.

E. If the recipient is determined no longer eligible at the time of the annual redetermination of eligibility, it is required that the specialist review the information in the case record for possible eligibility under any other available coverage within Medicaid, CHIP (if appropriate) and potential eligibility for advance payments of premium tax credits and cost-sharing reductions through the health insurance marketplace. Eligibility will not be terminated by the Division of Medicaid until after the prepopulated review form is issued and the recipient is allowed the opportunity to respond to the information.

F. If a renewal form is not returned within the 30 (thirty) days allowed for responding to a renewal but the recipient subsequently submits the renewal form and any necessary information needed to renew eligibility within 90 (ninety) days after the case is terminated, the case will be reinstated without requiring a new application.

Source: 42 CFR§ 435.916 (Rev. 1986). Miss. Code Ann. 43-13-115.

Rule 9.3: Adverse Action.

A. Advance notice of an adverse action is generally required, if the eligibility decision results in:

1. Termination of benefits;

2. Conversion to a reduced services coverage group;

3. Increase in the amount of patient liability; and

4. Termination of a nursing facility vendor payment.

B. During the advance notice period, the recipient is allowed at least ten days' notice before the date of the action. During this time, the recipient can fully comply with unmet redetermination

requirements, provide information or verification that will alter the decision to terminate or reduce benefits, or request a Fair Hearing with continued benefits.

Source: 42 CFR § 431.211 (Rev. 1986).

Rule 9.4: Exparte Reviews.

A. Any recipient under review who is losing eligibility in one (1) category of assistance is entitled to have eligibility reviewed and evaluated under any/all available coverage groups.

B. The term "exparte review" means to review information available to the agency to make a determination of eligibility in another coverage group without requiring the individual to come into the office or file a separate application.

1. When to Complete an Exparte Determination. For an exparte determination to be made, the specialist must be in the process of making a decision on a current application, review or reported change. If the specialist is denying or closing for failure to return information or failure to complete the interview process, an exparte determination is not applicable.

2. Basis for the Exparte Review. The decision of whether the recipient is eligible under a different coverage group must be based on information contained in the case record. This may include income, household or personal information in the physical record which indicates the ineligible adult or child has potential eligibility in another coverage group. Information received through electronic matches with other state/federal agencies such as a disability onset date or prior receipt of benefits based on disability are also considered part of the case record.

3. Obtaining Information to Make the Determination. When potential eligibility under another coverage group is indicated, but the specialist does not have sufficient information to make an eligibility determination, the recipient must be allowed a reasonable opportunity to provide necessary information.

4. Eligibility Decision. If the individual is subsequently determined to be eligible in the new category, the approval must be coordinated with termination in the current program to ensure there is no lapse or duplication in coverage. However, if requested information is not provided or if the information clearly shows that the recipient is not eligible under another category, eligibility in the current program will be terminated with advance notice. During the advance notice period, the recipient is allowed time to provide all requested information to determine eligibility in the new program, provide information which alters the decision to terminate benefits in the current program or request a hearing with continued benefits.

5. Requested Information Provided After Closure. If the recipient subsequently provides all of the information needed to assess eligibility in the new program within two (2) months of termination, the case should be handled in accordance with the redetermination procedures.

Source: Social Security Act § 1902(a)(55)(b). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

Part 101 Chapter 10: Special Reviews

Rule 10.1: Conducting a Special Review.

A. A special case review is completed when changes occur between regular reviews, which may result in adjustments to eligibility or benefit level.

B. A special case review is not a full review. Instead the case (or an individual) is evaluated to consider the impact of the changed information. Factors unrelated to the change are not re-verified as part of a special review.

C. A special review of eligibility is required when:

1. The recipient reports a change in circumstances which could affect eligibility and benefit level;

2. Information is received from any other source which could affect eligibility and benefit level; and

3. Potential changes in eligibility are indicated by information available to the agency.

D. The special review process may result in termination of benefits, benefit reduction or adjustments to Medicaid Income. It may also involve procedural changes, i.e., updating or correcting case information with no impact on eligibility or benefits.

Source: 42 CFR § 435.916 (Rev. 1986). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

Rule 10.2: Recipient Reporting Requirements.

A. Recipients must report required changes impacting eligibility within ten (10) days of the date the change becomes known. Changes may be reported in person, by telephone or by mail.

B. A change is considered reported on the date the report of change is received by the agency. If an individual fails to report timely or the agency fails to take timely action, causing the recipient to receive benefits to which he is not entitled, the specialist will take steps to report an overpayment.

Source: 42 CFR § 435.916 (Rev. 1986).

Rule 10.3: Taking Action on Reported Changes.

A. If the reported change has no effect on eligibility or benefits, the information will be considered during the next regular redetermination.

B. Action on a reportable change must be initiated no later than ten (10) working days from the date the change becomes known to the agency to determine its impact on eligibility and benefit level.

C. If verification of a reportable change is needed, it must be requested from the recipient,. If the client fails to respond to the request, eligibility will be terminated allowing advance notice.

Source: 42 CFR § 435.916 (Rev. 1986). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

Part 101 Chapter 11: Notification

Rule 11.1: Notification.

A. The recipient and, when applicable, the medical facility must be notified in writing of the action taken on an application or an active case when eligibility or benefit level is affected by a change.

Source: 42 CFR § 435.912 (Rev. 1986).

Rule 11.2: Advance Notice.

A. Federal regulations require issuance of a notice of adverse action ten (10) days before the effective date of an action to reduce or terminate benefits.

B. During the advance notice period, the recipient is allowed time to fully comply with unmet requirements, provide information or verification that will alter the decision to terminate or reduce benefits, or request a Fair Hearing with continued benefits. If this occurs, the agency must take prompt and appropriate action to reinstate benefits.

Source: 42 CFR § 435.919 (Rev. 1986).

Rule 11.3: Exceptions to Advance Notice.

A. Unless noted, the following actions require notification to the recipient; however, ten (10) day advance notice is not required.

1. Death.

a) When the agency has factual notification of death, eligibility is terminated as of the death date and no notice is issued.

2. Loss of State Residence.

a) When the agency establishes that a recipient has moved from the state through information received from the recipient or because another state reports the client has

been accepted as a resident for Medicaid in that state, eligibility is terminated. Advance notice of closure is not required.

3. Resident of a Public Institution.

a) When the agency has established that the recipient has been admitted to a public institution, such as a prison or a state hospital in a non-Title XIX facility, eligibility is terminated. Advance notice of termination is not required.

4. Unable to Locate.

a) When a recipient's whereabouts are unknown, the agency must take reasonable efforts to locate the recipient. When efforts to locate the recipient are unsuccessful, eligibility will be terminated. However, if the client's whereabouts subsequently become known during the time the client is eligible for services, the case must be reinstated.

5. Voluntary Request for Closure.

a) If the recipient or his designated representative voluntarily requests closure, eligibility will be terminated. Advance notice is not required.

6. Eligible for Medicaid through another Source.

a) If a recipient becomes Medicaid-eligible through SSI or foster care, eligibility in the current ABD or FCC program will be teminated. Advance notice of termination of benefits authorized through the Medicaid Regional Office is not required.

Source: 42 CFR § 431.213 (Rev. 1993). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

Part 101 Chapter 12: Reinstatements and Corrective Action

Rule 12.1: Situations Requiring a Reinstatement.

A. Certain situations require a reinstatement of services, which means either eligibility is restored or Medicaid income is corrected for a prior period. Both types of reinstatements are completed without requiring that a new application be filed on behalf of the recipient.

B. A reinstatement is in order in the following situations, as applicable:

1. Hearing Decision.

a) When a decision, granting eligibility or increased benefits is rendered as part of a state or local hearing, the regional office may be required to reinstate, or when appropriate correct Medicaid Income, retroactive to the date decided by the hearing official.

2. Action Taken During Advance Notice Period.

a) When the client makes a timely hearing request during the advance notice period, benefits will be continued at the same level through the reinstatement process until a hearing decision is reached.

b) If the recipient provides information that changes the adverse action decision or fully complies with unmet requirements during the adverse action period, benefits must be reinstated to ensure no loss of benefits, if the recipient remains eligible.

c) If advance notice of benefit reduction or termination is not issued as required, benefits must be reinstated at the time the error is discovered, regardless of whether the client is currently eligible. After benefits are reinstated, advance notice would be issued.

3. Whereabouts Become Known.

a) Eligibility must be terminated if a client's whereabouts remain unknown after the agency has made reasonable efforts to locate the recipient.

b) If the client's location subsequently becomes known during the time he is eligible, benefits will be reinstated.

c) For a child who has continuous eligibility, Medicaid benefits must be reinstated with no break in coverage.

d) For an adult, the specialist must determine eligibility for each month that the adult recipient's whereabouts were unknown and reinstate for any period he would have been eligible.

4. Temporary Case Closure.

a) When it is known that a client will be ineligible for three (3) months or less, the closure is processed in the usual manner; however, at the end of the temporary period, the case may be reinstated without completing new eligibility forms necessary for reapplication.

b) In this situation a break in eligibility correctly exists; therefore, it is necessary to adjust the eligibility begin date to reflect the most recent eligibility begin date.

5. Reapplication.

a) When an applicant has a prior application which has been in rejected status for three (3) months or less, the rejected application form can be reinstated without requiring a new application provided all information is provided to determine eligibility.

6. Agency Error.

a) When the agency has denied or terminated eligibility in error or reduced benefits in error, benefits must be reinstated retroactive to the month the error occurred.

Source: 42 CFR § 431.246 (Rev. 1992).

Rule 12.2: Corrective Action.

A. At the time the agency becomes aware of an error which affects eligibility or level of benefits, action must be initiated to correct the error and prevent further error.

B. In some instances, it may also be necessary to correct an error retroactively into prior months.

C. When corrective action into prior months adversely affects the recipient, meaning the error caused the client to be totally ineligible or eligible for fewer benefits, an improper payment has occurred.

D. When corrective action into prior months favorably affects the client, meaning the client was eligible or eligible for more benefits, the corrective action is handled through reinstatement.

Source: 42 CFR § 431.246 (Rev. 1992).

Part 101 Chapter 13: Other Changes - ABD Programs

Rule 13.1: Changes in Medicaid Income.

A. The amount of income an institutional client must pay to the nursing facility toward the cost of his care is known as Medicaid Income.

B. Changes in income, marital status or non-covered medical expenses will either increase or decrease Medicaid income. The effective dates of such changes are determined as follows:

1. Decrease in Medicaid Income. A change which results in a decrease in Medicaid Income is effective the month in which the change is reported or becomes known to the agency.

2. Increase in Medicaid Income. A change which results in an increase in Medicaid Income requires advance notice to the client advising of the increase. However, advance notice for Medicaid Income increases is based on issuing notice ten (10) days before the date Medicaid makes its payment to the facility. If a state or local hearing is requested within the advance notice period, the increase cannot be effective until the final hearing decision is rendered.

3. Temporary Decrease in Medicaid Income. When Medicaid Income is temporarily decreased due to the allowance of a deduction, i.e., health insurance premium or other non-covered medical expense, and Medicaid Income is subsequently returned to the amount previously in effect, this action is not considered an increase in Medicaid Income subject to advance notice.

4. Increase in Medicaid Income Combined with a Closure. In instances where income is counted in the month received and receipt of the income also renders the client ineligible, the excess income is included in the Medicaid Income computation provided there are ten (10) calendar days left in the month of receipt to allow for advance notice.

5. Temporary Increase in Medicaid Income. When excess resources are not an issue, but receipt of additional income results in the monthly income total being over the income limit for LTC, the case will remain open if, for whatever reason, there is not time to allow advance notice of closure. However, if there are ten (10) calendar days left in the month, Medicaid Income must still be increased to the amount of that month's income or the Medicaid reimbursement rate for the facility, whichever is less.

Source: 42 CFR § 435.725 (Rev. 1993).

Rule 13.2 Changing to a Reduced Service Coverage Group.

A. Changing from a full service coverage group to a reduced coverage group requires advance notice before the change can be effective the following month. It is not possible to change an active full service case to a reduced service coverage group such as QMB, SLMB, or QI in MEDS for the following month unless there are at least twelve (12) days remaining in the current month.

Source: 42 CFR § 431.211 (Rev. 1993).

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 102
Non-Financial Requirements

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Title 23: Division of Medicaid

Part 102: Non-Financial Requirements

Part 102 Chapter 1: Residency

Rule 1.1: State Residency.

A. Medicaid must be available to eligible residents of the state.

B. A resident is someone who voluntarily lives in Mississippi with the intention to remain permanently or for an indefinite period of time, or someone living in Mississippi, having entered with a job commitment or for the purpose of seeking employment, whether or not the individual is currently employed.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 1.2: Residency Requirements.

A. The individual must live in Mississippi and meet all other eligibility requirements in order to receive Medicaid benefits.

B. A spouse and children living in the same household with the individual are also considered Mississippi residents.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 1.3: No Permanent Mississippi Address.

A. An individual, including someone with no permanent address, is a resident of Mississippi if he lives in the state and is capable of stating and does state intent to remain here permanently or for an indefinite period of time.

1. Indefinite indicates the individual does not have a date in mind when he will no longer be a resident of the state.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 1.4: Residing in Another State.

A. An individual who claims to be a resident of Mississippi, but is residing in another state, must show an established address or place of residence in Mississippi before he can be considered temporarily absent from Mississippi for Medicaid purposes.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 1.5: Incapable of Stating Intent.

A. An individual who is incapable of stating intent to reside is a resident of the state in which he is physically located. No statement of intent is needed.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 1.6: Stating Intent to Reside.

A. A person is considered capable of stating intent to reside unless he has an IQ of forty-nine (49) or less or has a mental age of seven (7) or less based on tests acceptable to the Department of Education; or is judged legally incompetent; or is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist or other individual licensed by the state in the field of mental retardation.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 1.7: Specific Residency Prohibitions.

A. An individual cannot be denied Medicaid based on residency for the following reasons:

1. The individual has not resided in MS for a specified period of time. There is no durational requirement for residency.

2. The individual is temporarily absent from MS and intends to return when the purpose of the absence has been accomplished. However, if another state has accepted him as a resident for Medicaid purposes, the individual cannot be considered a MS resident.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 1.8: Temporary Absence From the State.

A. The recipient is responsible for reporting a temporary absence from Mississippi and for giving information on his purpose, plans and dates of departure and return. The recipient's eligibility must be reviewed every three (3) months to determine the recipient's continued intent to reside in MS.

B. No limit is place on the length of the out-of-state visit; however, if it is determined that an individual has left the state with no declared intention to return, the individual will be deemed to have given up MS residency and his eligibility will be terminated.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 1.9: Individuals Receiving a State Supplementary Payment.

A. An individual receiving a state supplementary payment (optional or mandatory), such as state adoption assistance or state foster care payment, is a resident of the state making the supplementary payment.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 1.10: Individuals Receiving a Title IV-E Payment.

A. An individual, who is receiving a Title IV-E foster care or adoption assistance payment, is a resident of the state in which the child is currently residing.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 1.11: Determination of Residency (Under Age 21).

A. Determine residency for persons under age twenty-one (21) as follows:

1. Not in an Institution or Under Parental Care and Control.

a) If a non-institutionalized individual under age twenty-one (21) is emancipated from his/her parents or is married and capable of stating intent, the state of residence is where the individual is living with the intent to remain permanently or for an indefinite period**.**

2. Blind or Disabled Not in an Institution.

a) An individual, under age twenty-one (21) and in a private living arrangement, whose eligibility is based on blindness or disability, is a resident of the state where the individual is actually living.

3. Others under twenty-one (21) Not Living in an Institution.

a) The state where the individual resides, with or without a fixed address, or

b) The state of residency of the parent, caretaker or guardian with whom the individual resides.

4. Under twenty-one (21), In an Institution and Under Parental Care and Control

a) The state of residence is:

1) The parent's state of residence at the time of placement; however, if a legal guardian has been appointed and parental rights have been terminated, the state of residence of the guardian is used instead of the parents; or

2) The current state of residence of the parent who files the application, if the individual is residing in an institution in that state. However, if a legal guardian has been appointed and parental rights have been terminated, the state of residence of the guardian is used instead of the parents, or

3) The state of residence of the individual party that files an application if the individual:

(a) Has been abandoned by his parent(s),

(b) Does not have a legal guardian and

(c) Is residing in an institution in that state.

Source: 42 CFR § 435.403 (Rev. 2012).

Rule 1.12: Determination of Residency (Age 21 and Older).

A. Determine residency for individuals age twenty-one (21) and older as follows:

1. Not in an Institution.

a) The state of residence is where the individual is living with the intent to remain there permanently or for an indefinite period, or the state where the individual is living because the individual had a job commitment or is seeking employment, either currently employed or not. If the individual is incapable of stating intent, the state of residence is where the individual is living.

2. In an Institution and Became Incapable of Stating Intent before Age Twenty-One (21)

a) The state of residence is:

1) The state of residence of the parent who is applying for Medicaid on the individual's behalf. If a legal guardian has been appointed and parental rights have been terminated, the state of residence of the legal guardian is used instead of the parents.

2) The state of residence of the parent at the time of placement. If the legal guardian has been appointed and parental rights have been terminated, the state of residence of the guardian is used instead of the parents.

3) The current state of residence of the parent or legal guardian who files the application, if the individual is residing in an institution in that state. If a legal guardian has been appointed and parental rights have been terminated, the state residence of the guardian is used instead of the parents.

4) The state of residence of the individual or party that files an application if the individual:

(a) Has been abandoned by his parent(s),

(b) Does not have a legal guardian and

(c) Is residing in an institution in that state.

3. In an Institution and Became Incapable of Stating Intent at or After Twenty-One (21).

a) The state of residence is where the individual is physically present, except in instances where another state made the placement.

4. Any Other Individual in an Institution

a) The state of residence is where the individual is living permanently or for an indefinite period of time.

b) When a competent individual leaves the facility in which he was placed, his residence becomes the state where he is physically located.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 1.13: State Placement in an Out-of-State Institution.

A. If a state agency arranges for an individual to be placed in an institution in another state, the state arranging or making the placement is the individual's state of residence.

B. For purposes of state placement, the term “institution” also includes licensed foster care homes that provide food, shelter, and supportive services for one or more individuals unrelated to the proprietor. The following actions are not considered state placement:

1. Providing basic information to individuals about another state’s Medicaid program and information about healthcare services and facilities in another state or

2. Providing information regarding institutions in another state if the individual is capable of indicating intent and decides to move.

Source: 42 CFR § 435.403 (Rev. 2006).

Rule 1.14: Out-of-State Placements.

A. There are two circumstances under which Mississippi will pay for placement in an out-of-state nursing facility.

1. If the agency has a part in the placement or otherwise approves or authorizes an out-of-state placement, regional offices will be notified on an individual case basis.

2. When a MS resident moves to a nursing facility in another state, only the partial month of the move can be paid if the facility enrolls as a Mississippi provider. The individual is considered a resident of the new state effective with the first full month of residence and has to qualify for Medicaid eligibility and vendor payment in the new state.

B. If an individual moves to Mississippi, he would apply for benefits here and meet all eligibility requirements. If he is transferred directly from one medical facility to another, the time spent in the out-of-state facility can be used to meet the thirty (30) consecutive day requirement.

Source: 42 CFR § 435.403 (Rev. 2006). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

Rule 1.15: Recipients Moving to Mississippi From Another State.

A. Termination of Benefits in the Former State of Residence.

1. An individual coming to MS from another state may be considered a resident of Mississippi in the month of the move, provided the individual intends to reside in Mississippi.

2. Individuals are not entitled to duplication of Medicaid services from both the former state and Mississippi. When a Medicaid recipient moves from one state to another, the former state initiates the change effective the first month in which it can administratively terminate the case in accordance with timely and adequate notice regulations.

B. Request for Mississippi Medicaid Prior to Termination in Former State.

1. There will be occasions when a recipient requests that eligibility in Mississippi begin prior to the effective date of closure in the former state. Neither state can deny coverage because of administrative requirements or time constraints needed to take action to terminate benefits in the former state.

2. When an individual is no longer a resident of a state, that state is not required to pay for any services incurred in Mississippi.

   a) If the former state will pay out of state claims or the partial and subsequent months for a nursing home recipient, Mississippi cannot approve eligibility until the former state has terminated services.

   b) If the former state will not pay out of state claims, duplication of services is not an issue and Medicaid eligibility in Mississippi can potentially begin with the month of the move.

C. When two (2) or more states cannot agree on residence, the state where the individual is

physically located is his residence. Coordination efforts should ensure that an eligible person does not experience a discontinuation of benefits.

Source: 42 CFR § 435.403 (Rev. 2012).

Part 102 Chapter 2: United States Citizens

Rule 2.1: Eligible Individuals.

A. An eligible individual must either be a citizen of the United States or a qualified alien.

1. Most United States citizens are natural-born citizens, meaning they were born in the United States or were born to United States citizens overseas. Individuals born in the United States, which includes the fifty (50) states, the District of Columbia, Puerto Rico, Guam, the U. S. Virgin Islands, the Northern Marinara Islands and the Panama Canal Zone before it was returned to Panama, are U. S. citizens at birth (unless born to foreign diplomatic staff), regardless of the citizenship or nationality of the parents.

2. Nationals from American Samoa or Swain's Island are citizens for Medicaid purposes.

Source: 42 CFR § 435.406(a) (Rev. 2007).

Rule 2.2: Child Citizenship Act of 2000.

A. The Child Citizenship Act of 2000, enacted February 21, 2001, amended the Immigration and Naturalization Act to provide automatic acquisition of U. S. citizenship by operation of law to certain foreign born children, including orphans with a full and final adoption by U. S. citizens, either abroad or in the U. S., and the biological or legitimated children of U. S. citizens. Prior to the implementation of this act, these children had to go through the naturalization process to become citizens.

Source: 42 CFR § 435.407(a) (Rev. 2007).

Rule 2.3: Establishing Citizenship and Identity.

A. The citizenship and identity of applicants and recipients declaring to be U. S. citizens will be established in accordance with provisions of the Deficit Reduction Act (DRA) of 2005, which was effective with applications and reviews on and after July 1, 2006. Documentary verification of citizenship is required.

B. The evidences of citizenship are divided into a hierarchy of primary, secondary, third level and fourth level documents. Primary evidence has the highest reliability and conclusively establishes both a person's citizenship and identity. When the individual has secondary, third or fourth level documentation of citizenship, additional verification must be provided to establish identity. The evidences of identity are not prioritized.

C. The highest level of verification must be used if it is available. "Available" means the document exists and can be obtained within the time period allowed for providing information, i.e., thirty (30), forty-five (45) and ninety (90) days based on application type. Therefore, when a higher level document is not available, it is permissible to use a lower level document.

D. Applicants must be provided a reasonable opportunity to provide verification of citizenship and identity. An application cannot be approved if required citizenship and identity verification has not been provided.

E. It is generally the individual's responsibility to provide required documents and pay associated fees to obtain them. However, when individuals are economically disadvantaged and unable to pay fees associated with obtaining necessary documents, lower level evidences of citizenship and identity will be accepted.

F. Assistance must be provided when an applicant or beneficiary, who is homeless, an amnesia victim, mentally impaired or physically incapacitated and lacks someone to act for them, does not have the required verifications. Contact must be attempted and assistance provided to any applicant or recipient who is known to be deaf, hard of hearing, blind, mentally or visually impaired, physically incapacitated or otherwise disabled, illiterate, limited English proficient, homeless and/or requires communication assistance with reading agency notices and other written correspondence prior to denying or terminating their case.

    1. Eligibility will not be denied or terminated until all avenues of verification have been exhausted. However, when the individual has been given a reasonable opportunity to provide the information and all avenues of assistance have been exhausted and documented, eligibility must be denied or terminated if needed information is not provided.

G. Aliens applying for Emergency Medicaid services only are not required to provide information about citizenship, immigration status or Social Security Number and should not be asked to do so.

Source: 42 CFR § 435.407 (Rev. 2007).

Rule 2.4: Exemptions from Citzenship/Identity Requirements.

A. Individuals declaring to be U. S. citizens are exempt from citizenship and identity documentation requirements if they are in one of the following categories:

1. Medicare recipients entitled to, or enrolled in, Medicare Part A or B under any claim number are exempt from the verification requirements.

2. Individuals receiving Social Security benefits under "A" claim number based on their own disability are exempt from the verification requirements. The individual must be a current recipient of Social Security Disability. Prior receipt of disability does not qualify an individual for this exemption. In addition, this exemption does not apply to individuals receiving early retirement or to dependants drawing off the disabled individual's record.

3. Individuals receiving SSI benefits are exempt. The individual must be a current SSI recipient. Prior receipt if SSI does not qualify a person for this exemption. Former SSI recipients applying for Medicaid must provide evidence of citizenship and identity. However, current SSI recipients applying only for retroactive coverage are exempt.

4. Children in receipt of Title IV-B services or Title IV-E Adoption Assistance or foster care payments are exempt.

5. Deemed eligible children are exempt from citizenship and identity verification requirements until the end of the deemed year. All eligibility factors, including documentation of citizenship and identity, must be met for eligibility to continue beyond the first year.

Source: 42 CFR § 435.406(v) (Rev. 2007).

Rule 2.5: Evidences of U.S. Citizenship.

A. Primary Evidence has the highest reliability. If provided, no further verification is needed. If any other level of evidence is used to verify U. S. citizenship, a second document verifying identity must be obtained.

   1. The following documents may be accepted as primary proof of an individual's citizenship and identity.

      a) U.S. Passport. A U.S. Passport does not have to be currently valid to be accepted as evidence of U.S. citizenship as long as it was originally issued without limitation. On an emergency basis, the passport office will issue a U.S. passport without proof of citizenship. In this instance, the passport is issued with the limitation that is valid for one (1) year rather than the usual five (5) or ten (10) years. When the holder of a passport with limitation returns to the country, he has to provide proof of citizenship to have the passport reissued without limitation. To determine if a passport was issued with limitation, compare the issuance date, with the expiration date. If the expiration date is less than five (5) years from the issuance date, the passport was issued with limitation and cannot be used as proof of citizenship. Each passport must be examined closely to determine whether or not the passport was issued with limitation. Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship

when it was issued with a limitation. However, such a passport may be used as proof of identity. NOTE: Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.

b) Certificate of Naturalization (N-550 or N-570). Issued by Department of Homeland Security (DHS) for Naturalization.

c) Certificate of Citizenship (N-560 or N-561). Issued by DHS to individuals who derive citizenship through a parent.

B. Secondary Evidence of citizenship is a documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available within the reasonable opportunity period. In addition, a second document establishing identity must be presented.

1. The following documents are secondary evidence of citizenship:

a) A U.S. public birth record. A birth certificate may be issued by the State Commonwealth, territory, or local jurisdiction. The birth record must have been recorded before the person was five (5) years of age. A delayed birth record document recorded after five (5) years of age is considered fourth level evidence of citizenship.

1) The U.S. birth record should show one of the following:

(a) One of the fifty (50) U.S. States;

(b) District of Columbia;

(c) American Samoa;

(d) Swain's Island;

(e) Puerto Rico (if born on or after January 13, 1941);

(f) Virgin Islands of the U.S. (on or after January 17, 1917);

(g) Northern Mariana Islands (after November 4, 1986, NMI local time);
Guam (on or after April 10, 1899).

b) Verification through the Department of Homeland Security's Systematic Alien verification for Entitlements (SAVE) database to verify U.S. citizenship for a naturalized citizen when original naturalization papers are not available.

c) When a child derives U.S. citizenship from a parent and meets the requirements of the Child Citizenship Act of 2000, establish the parent's U.S. citizenship and the child's

legal immigration status, if applicable, through SAVE to verify the child's citizenship. Primary verification through a Certificate of Citizenship should be available if child was issued a Visa rather than a permanent resident alien card upon entry into the country.

d) Certification of Report of Birth Abroad (FS-1350). The Department of State issues a DS-1350 to U.S. citizens who were born outside the U.S. and acquired citizenship at birth, as verified by the information recorded on the FS-240,Consular Report of Birth Abroad. When the birth was recorded on the FS-240, certified copies of the Certification of Report of Birth Abroad can be obtained from the Department of State. The DS-1350 contains the same information as recorded on the current version of the Consular Report of Birth FS-240. The DS-1350 is not issued overseas and can be obtained from the Department of State in Washington D.C.

e) Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240). The Department of State consular office prepares and issues this document. A Consular Report of Birth can only be prepared at an American consular office overseas, while he child is under eighteen (18). While original FS-240's are not issued within the U.S., lost or mutilated documents can be replaced through the Department of State in Washington D.C. Children born to military personal are usually issued as FS-240.

f) Certification of Birth Abroad (FS-545). Before November 1, 1990, the Department of State consulates also issued Form FS-545 along with the prior version of FS-240. In 1990, U.S. consulates ceased to issue Form-545. Treat a FS-545 the same as a DS-1350.

g) U.S. Citizen ID Card (I-197) or prior version I-179. The former Immigration and Naturalization Service (INS) issued the I-179 from 1960 until 1973. It revised the form and renumbered it as form I-197. INS issued the I-197 from 1973 to April 7, 1983. INS issued the form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican Border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.

h) American Indian Card (I-872) and Documents Issued by a Federally-Recognized Indian Tribe. DHS issues an American Indian Card to identify a member of the Texas Band of Kickapoos. A classification code "KIC" and a statement on the back denote U.S. citizenship. In addition, tribal enrollment or certificate of degree Indian Blood documents meet the citizenship requirement.

i) Northern Mariana Card. Ins issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.

j) Final adoption decree. The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the

child was born will not release a birth certificate prior to final adoption, a statement from a State-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

k) Evidence of civil service employment by the U.S. government. The document must show employment by the U.S. government before June 1, 1976.

l) Official military record of service. The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth.

C. Third Level Evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary or secondary evidence of citizenship is not available. Third level evidence may only be used when primary and secondary evidence does not exist or cannot be obtained and the applicant/beneficiary alleges being born in the U.S. In addition, a second document establishing identity must be obtained.

1. The following are third-level evidences of citizenship:

a) An extract i.e. part(s) of one or more documents from medical records of hospital, on hospital letterhead established at the time of the person's birth and was created five (5) years before the initial application date and shows a U.S. place of birth. Do not accept a souvenir "birth certificate" issued by the hospital. NOTE: For children under sixteen (16), the document must have been created near the time of birth or five (5) years before the application date.

b) Life or health or other insurance record which shows a U.S. place of birth and was created at least five (5) years before the initial application. Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. NOTE: For children under sixteen (16), the document must have been created near the time of birth or five (5) years before the application date.

c) Religious record recorded in the U.S. within three (3) months of birth showing birth occurred in the U.S. and showing the individual's birth date or age at the time the record was recorded. The record must be an official record with a religious organization. In questionable cases, i.e. religious document recorded near an international border, the religious record must be verified and/or verify that the mother was in the U.S. at the time of birth. NOTE: Entries in a family Bible are not considered religious records.

d) Early school record showing a U.S. place of birth. The record must show the name of the child, the date of admission to the school, the date of birth (or age at the time record was created), a U.S. place of birth and the name(s) and place(s) of birth of the child's parents.

D. Fourth Level Evidence of citizenship is of lowest reliability. It should only be used in the rarest of circumstances. It is used when primary evidence is not available and both secondary and third level evidence do not exist or cannot be obtained within the reasonable opportunity period and the applicant alleges a U.S. place of birth. In addition, a second document establishing identity must be obtained. Accept any of the following documents as fourth level evidence of U.S. citizenship if the document meets the listed criteria, the applicant/beneficiary alleges U.S. citizenship and there is nothing indicating the person is not a U.S. citizen or lost U.S. citizenship. Fourth level evidence consists of documents established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The U.S. place of birth on the document and documented place of birth on the application must agree. The written affidavit may be used only when the specialist is unable to secure evidence of citizenship in any other chart.

1. The following are fourth level verifications:

a) Federal or State census record showing U.S. citizenship or a place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's age. NOTE: Census records from 1900 to 1950 contain certain citizenship information. To secure this information for the applicant, beneficiary, or State complete Form BC-600, Application for Census records for Proof of Age. ADD in the remarks portion "U.S. citizenship data requested." Also, add that the purpose is for Medicaid eligibility. This form requires a fee.

b) Other Documents. To be valid, the documents in this section must have been created at least five (5) years before the application for Medicaid (or for children under sixteen (16), the document must have been created near the time of birth or five (5) years before the application date. This document must show a place of birth:

1) Senecca Indian tribal census record;

2) Bureau of Indian affairs tribal census records of the Navaho Indians;

3) U.S. State Vital Statistics official notification of birth registration;

4) A delayed U.S. public birth record that is recorded more than five (5) years after the person's birth;

5) Statement signed by the physician or midwife who was in attendance at the time of birth.

c) Medical (clinic, doctor or hospital) record and was created at least five (5) years before the initial application date (for children under sixteen (16), record was created near time of birth or five (5) years before application date) and indicates a U.S. place of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

1) Immunization records maintained by the family or school are not considered a medical record for purposes of establishing U.S. citizenship. However, such records maintained by a clinic, doctor or hospitals are considered medical records. Institutional admission papers from a nursing home, skilled nursing facility or other institution that were created at least five (5) years before the initial application date and indicate a U.S. place of birth.

d) Written Affidavit. Written affidavits may be used as fourth level evidence only in rare circumstances when no other acceptable evidence of citizenship is available.

1) The affidavits may be used for U.S. citizens, including naturalized citizens.

2) Affidavits must be supplied by the applicant/recipient and at least two (2) additional individuals, one of whom is not related to the applicant or recipient.

3) Each of the two (2) additional individuals must attest to having personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship.

4) The individuals providing supporting affidavits must be able to prove their own U.S. citizenship and identity for the affidavit to be accepted.

5) The applicant/recipient (or guardian or representative for a child) also submits a separate affidavit explaining why other documentary evidence is not available.

6) Affidavits are signed under penalty of perjury, but do not have to be notarized.

7) For a child, an affidavit cannot be used to verify both identity and citizenship.

E. If the document used to verify U.S. citizenship indicates the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Marinara Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories.

1. Puerto Rico. Evidence of birth in Puerto Rico on or after April 11,1899, and the applicant/beneficiary's statement that he or she was residing in the U.S. possession of Puerto Rico on January 13, 1941 or evidence that the applicant/beneficiary was a Puerto Rican citizen and the applicant/beneficiary's statement that he or she did not take an oath of allegiance to Spain.

2. U.S. Virgin Islands. Evidence of birth in the U.S. Virgin Islands and the applicant/beneficiary's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927. The applicant/beneficiary's statement indicating resident in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a possession or the U.S. Virgin Islands on February 25, 1927 and that he or

she did not make a declaration to maintain Danish citizenship; or evidence of birth in the U.S. Virgin Islands and the applicant/beneficiary's statement indicating residence in the U.S., a U.S. possession or territory or the Canal Zone on June 28, 1932.

3. Northern Mariana Islands (NMI), formerly part of the trust territory of the Pacific Islands (TTPI. Evidence of birth in the NMI, the U.S., or a U.S. territory or possession on November 3, 1986 (NMI local time) and the applicant/beneficiary's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant/beneficiary's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI l local time); or evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant/beneficiary's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time). NOTE: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

Source: 42 CFR § 435.407 (Rev. 2007).

Rule 2.6: Evidences of Identity.

A. Proof of identity is required when primary evidence of citizenship cannot be obtained and a secondary, third or fourth level evidence is used.

1. The identity of all applicants and recipients must be verified.

2. When a child younger than age sixteen (16) or a disabled individual living in a residential care facility does not have one of the following documents available to verify identity, an alternate document indicated below may be used.

3. Documents may be recently expired provided there is no reason to believe the document does not match the individual.

4. The following are evidences of identity:

   a) A current state driver's license bearing either the individual's picture or containing other identifying information such as name, age, sex race, height, weight or eye color. School identification card with a photograph of the individual.

   b) U.S. military card or draft record.

   c) Identification card issued by the Federal, State, or local government containing the same information included on driver's licenses.

   d) Military dependent's identification card.

e) Certificate of Indian blood or other U. S. American/Alaska Native tribal document if the document carries a photograph of the individual, or has other personal identifying information relating to the individual such as age, weight, height, race, sex, eye color.

f) U.S. Coast Guard Merchant Mariner card.

g) Three or more corroborating documents such as marriage licenses, divorce decrees, high school diplomas (including general education or equivalency diplomas), employer ID cards, property deeds/titles or other similar types of documents issued by local or state governmental entities when no other higher-level evidence is available to verify identity. All documents must be originals or certified copies. They must include at a minimum, the individual's name plus any additional information to establish identity. Use only when second or third level, but not fourth level, evidence of citizenship was obtained.

h) Do not accept a Voter Registration Card or Canadian Driver's License as identity verification.

B. When another document is not available to verify the identity of a child under the age of sixteen (16), alternate verification may be used.

1. School record including report card, daycare or nursery school record. If a school record is used, it must be verified with the issuing school.

2. Clinic, doctor, or hospital record, showing a date of birth. This includes an immunization record maintained by the medical provider if it shows a date of birth.

3. If none of the above documents are available, an affidavit signed under penalty of perjury by a parent, guardian or caretaker relative attesting to the child's identity and stating the child's date and place of birth may be obtained.

a) The Statement of Child's Identity should be used as an application attachment for this purpose. It is not necessary to have this form notarized. The form is completed one time to verify a child's identity. A new form is required only if new children are added to the case.

1) The Statement of Child's Identity cannot be used if an affidavit for citizenship was provided. For a child, an affidavit cannot be used for both citizenship and identity.

C. Disabled individual in residential care facility.

1. When another document is not available to verify the identity of a disabled individual living in a residential care facility, an affidavit may be used.

2. Disabled individuals in residential care facilities may have identity attested to by the facility director or administrator when the individual has no other acceptable document available. The affidavit is signed under penalty of perjury, but need not be notarized.

    a) All other means of verifying identity must be pursued prior to use of an affidavit.

D. Citizenship and/or identity do not have to be verified if the applicant is not otherwise eligible.

Source: 42 CFR § 435.407 (Rev. 2007).

Rule 2.7: Establishing a Non-Applicant's Identity.

A. The identity of the responsible person who is a non-applicant filing an application for others must be verified.

    1. The responsible person is defined as a non-applicant parent, relative, non-relative or an authorized representative filing the application on behalf of others.

    2. Non-applicants must not be asked to provide any document that discloses their own citizenship, immigration status or Social Security Number (SSN); however, such documents may be provided voluntarily.

    3. A good cause determination for non-applicants can be made to waive or reduce the requirement if it is determined the non-applicant head of household or authorized representative cannot meet the identity verification requirement.

    4. To establish identity, applicants must provide original documents or copies certified by the issuing agency. Other copies, including faxed or notarized copies of documents, are unacceptable. Like the documents used to verify citizenship, copies of the original identity documents must be certified by the supervisor or Medicaid Specialist who viewed them and retained as a permanent part of the case record for review and audit purposes.

Source: 42 CFR § 435.407(e) (Rev. 2007). Miss. Code Ann. 43-13-121.1 (Rev. 2005).

Part 102 Chapter 3: Aliens

Rule 3.1: General Information.

A. In general, eligibility and level of coverage is based on the alien's date of entry into the U. S., the date qualified alien status was obtained and/or the alien's immigration status.

Source: 42 CFR § 435.406(a)(2) (Rev. 2007).

Rule 3.2: Qualified Aliens.

A. Individuals living in the United States, who are not citizens, by birth or acquisition, and are

not U. S. Nationals, are aliens.

B. For Medicaid purposes, certain aliens are referred to as “qualified”, meaning they are potentially eligible for full Medicaid services just like U. S. citizens.

C. Each applicant declaring to be a qualified alien is responsible to provide, or cooperate in obtaining, documentation of alien status.

Source: 42 CFR § 435.406(a)(2) (Rev. 2007).

Rule 3.3: Non-Qualified Aliens.

A. "Non-qualified aliens" are non-citizens are potentially eligible only for Emergency Medicaid services; however, there may be exceptions.

B. Non-citizens applying for Emergency Medicaid services are not required to disclose information regarding citizenship, alien status or enumeration and should not be requested to do so.

C. All applicable program requirements must be met before an alien is eligible for either full Medicaid or Emergency Medicaid services.

Source: 42 CFR § 435.406(b) (Rev. 2007).

Rule 3.4: Grandfathered Aliens.

A. Effective 8/22/96, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) limited alien eligibility for Medicaid and other federal programs. However, Mississippi elected to “grandfather in” aliens who were receiving and eligible for Medicaid on that date. This means the grandfathered alien, who is lawfully residing in the U. S., has the right to have his eligibility continue under the alien rule in effect prior to 8/22/96. He also retains grandfathered rights if benefits are terminated and eligibility is later reestablished. If the alien was receiving Medicaid on 8/22/1996, but was subsequently determined to be ineligible, his status as a qualified alien must be determined for full Medicaid coverage. If he is not a qualified alien, he may be eligible for Emergency Medicaid services.

Source: 8 USC § 1612.

Rule 3.5: Classifications of Qualified Aliens.

A. There are nine (9) classifications of qualified aliens. Seven (7) are based on INS alien status, one (1) is based on battery or extreme cruelty and INS alien status, and one (1) is based on severe forms of trafficking and certification by U. S. Health and Human Services.

B. The nine (9) classifications of qualified aliens are:

1. An Alien Lawfully Admitted for Permanent Residence (LPR). Under the Immigration and Nationally act (INA);

2. A refugee. Admitted under Section 207 of the INA;

3. An Alien granted Asylum.Under Section 208 of the INA;

4. A Cuban and Haitian Entrant. As defined in section 501(e) of the Refugee Education Assistance Act of 1980;

5. An Alien Granted Parole For At Least One (1) Year. Under Section 212(d)(5) of the INA;

6. An Alien Whose Deportation Is Being Withheld. Under (1) Section 243(h) of the INA as in effect prior to April 1, 1997; or (2) Section 241(b)(3) of the INA, as amended;

7. An Alien Granted Conditional Entry. Under Section 203(a)(7) of the INA in effect before April 1, 1980;

8. A Battered Alien. Meeting the conditions set forth in Section 431(c) of PRWORA, as added by Section 501 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 PL 104-208(IIRIRA), and amended Section 5571 Balanced Budget Act of 1997, PL105-33(BBA) and Section 1508 of the Violence Against Women Act of 2000, PRWORA as amended, is codified at 8 USC 1641(e);

9. A Victim of a Severe Form of Trafficking. In accordance with Section 107(b)(1) of the trafficking Victims Protection Act of 2000, PL 106-86.

Source: 8 USC § 1641; Victims Protection Act of 2000, PL 106-86, §107(b)(1).

Rule 3.6: Verification/Documentation Of Qualified Alien Status.

A. The Systematic Alien Verification for Entitlements (SAVE) process is used to verify:

   1. The authenticity of the alien's USCIS documents,

   2. The date of the alien's admission to the U.S. and

   3. The current immigration status of the alien.

Source: 42 CFR § 435.406 (Rev. 2007); Social Security Act §1137(d).

Rule 3.7: Aliens Not Subject to SAVE Verification.

A. Victims of a severe form of trafficking and aliens applying for Emergency Medicaid services only are not subject to the SAVE verification process.

Source: 42 CFR § 435.406 (Rev. 2007).

Rule 3.8: 5-Year Disqualification Period.

A. Unless an exemption is met, qualified aliens admitted to the U. S. on or after August 22, 1996, are disqualified from receiving public benefits for:

   1. The first five (5) years from the date they entered the country or

   2. The first five (5) years from the day they obtained qualified alien status, whichever is later.

B. During this five (5) year ban or disqualification period, these aliens are eligible only for emergency services if they meet all other eligibility requirements.

Source: 42 CFR § 435.406(2) (Rev. 2007); 8 USC § 1613.

Rule 3.9: Requirement for 40 Qualifying Quarters.

A. At the end of the five (5) year disqualification period, an alien classified as lawfully admitted for permanent residence (LPR) is potentially eligible for full Medicaid benefits only if he has forty (40) qualifying quarters (QQs) of earnings covered by Social Security or can be credited with forty (40) QQs which satisfy the requirement.

B. If forty (40) QQs cannot be credited, the LPR remains potentially eligible for Emergency Medicaid only. Aliens who are subject to the mandatory five (5) year disqualification period are not eligible for full Medicaid for the first five (5) years, even if they can be credited with forty (40) qualifying quarters prior to or during the five (5) year disqualification period.

C. The disqualification period must be imposed before an assessment of eligibility based on the forty (40) quarter requirement.

D. Aliens classified as granted parole for at least one year, battered aliens and aliens granted conditional entry are not required to have forty (40) QQ.

Source: 1902(a)(46)(B); 8 USC § 1611, 1612,1613, and 1641; 1903(v)(2),(3) and (4); 42 CFR §§ 435.4, 435.406, 435.956; SPA 2013-0023.

History: Revised to correspond with SPA 2013-0023 (eff. 01/01/2014), eff. 09/01/2014.

Rule 3.10: 40 Qualifying Quarters of Earnings.

A. A qualifying quarter means a quarter of coverage as defined under Title II of the Social Security Act, which is worked by the alien, and/or:

   1. All the qualifying quarters worked by the spouse of the alien during their marriage, provided the alien remains married to the spouse or the marriage ended by death and not

divorce, and

2. All of the qualifying quarters worked by a parent of an alien while the alien was under age eighteen (18). The alien does not have to be under eighteen (18) at the time of the application.

Source: 8 USC § 1645.

Rule 3.11: Combining Quarters.

A. Subject to the limitations above, the alien's own QQs can possibly be combined with those of his parent(s) and/or spouse to attain the required forty (40) quarters.

Source: 8 USC § 1645.

Rule 3.12: Receipt of Means-Tested Benefits.

A. After December 31, 1996, any quarter in which any of these individuals, i.e., the alien, his parent(s) and/or spouse, received Federal means-tested benefits, such as TANF, SSI and Medicaid, cannot be credited to meet the forty (40) quarter requirement.

Source: 8 USC § 1645.

Rule 3.13: Classifications Subject to 5-Year Ban.

A. Non-exempt aliens in the following classifications, admitted to the U. S. on or after 8/22/96, are subject to the five (5) year disqualification.

   1. Lawful Permanent Resident Aliens;

   2. Aliens Granted Parole for at Least One Year; and

   3. Battered Aliens.

   4. Aliens granted conditional entry under Section 203(a)(7) in effect before April 1, 1980, are not exempt from the five (5) year disqualification per se; however, as a practical matter the disqualification will never apply since by definition, they entered the United States and obtain qualified alien status prior to 8/22/96.

B. During the disqualification period these aliens are potentially eligible only for Emergency Medicaid services.

Source: 8 USC § 1613.

Rule 3.14: Classifications Exempt from 5-Year Ban.

A. The following alien classifications are exempt from the five (5) year ban:

1. Refugees,

2. Asylees,

3. Amerasian immigrants,

4. Cuban/Haitian entrants,

5. Aliens who have been granted withholding of deportation,

6. Victims of trafficking, and

7. Qualified aliens who are honorably discharged veterans, or

8. Active duty military and certain of their family members.

Source: 8 USC § 1613.

Rule 3.15: Seven-Year Eligibility Limit.

A. Some aliens in the above classifications have a seven (7) year time limit imposed on eligibility.

B. When the seven (7) year period ends, eligibility terminates the following month unless the alien's status has changed or he meets an exemption.

Source: 8 USC § 1612.

Rule 3.16: Status Adjustments to LPR.

A. When the time-limited alien's status adjusts to LPR during the seven (7) year period, the alien can continue to be eligible for the remainder of his seven (7) year period.

B. However, to continue to be eligible beyond the seven (7) year period, the alien must be credited with forty (40) QQs or meet an exemption. If that is not the case, his eligibility ends the first month after the seven (7) year period ends.

Source: 8 USC § 1612.

Rule 3.17: Alien Classifications Subject to Seven Year Limit on Eligibility.

A. These qualified aliens are subject to the seven (7) year eligibility limit:

1. Refugees. Qualify until seven (7) years after date of entry into the U. S.;

2. Asylees.- Qualify until seven (7) years after the grant of asylum;

3. Cuban and Haitian entrants. Qualify until seven (7) years after grant of that status;

4. Aliens whose deportation is being withheld. Qualify for the first seven (7) years after grant of deportation withholding;

5. Aliens admitted to the country as Amerasian immigrants. Qualify for seven (7) years from entry into the U.S.;

6. Victims of trafficking and their derivative beneficiaries. Qualify during the first 7 years after obtaining the status.

Source: 8 USC § 1612.

Rule 3.18: Qualified Aliens Not Subject to Eligibility Restrictions.

A. The following groups of qualified aliens are exempt from both the five (5) year disqualification and the seven (7) year eligibility time limit and if otherwise eligible, qualify for full Medicaid:

   1. Non-citizen members of a Federally-recognized Indian tribe, as defined in 25 U.S.C 450(b)(e); and American Indians born in Canada to whom Section 289 of the INA applies;

   2. Any qualified alien who is also

      a) An honorably discharged veteran or

      b) On active duty in the U. S. military or

      c) The spouse (including a surviving spouse who has not remarried) or

      d) An unmarried dependent child of an honorably discharged veteran or individual on active duty in the military;

   3. Grandfathered aliens, i.e., those eligible for and receiving Medicaid on 8/22/96;

   4. Aliens who entered the U. S. and obtained qualified status prior to 8/22/96;

   5. Aliens who entered the U. S. prior to 8/22/96, but obtained qualified status on or after that date, and remained "continuously present" in the U.S. from their last entry date into the country prior to 8/22/96 until becoming a qualified alien. Refer below for the definition of "continuously present".

B. Aliens filing an application for Emergency Medicaid services only are not subject to either the five (5) year disqualification or seven (7) year time limit.

Source: 8 USC § 1612.

Rule 3.19: Requirement for Continuous Presence in the U.S.

A. As previously indicated, a qualified alien who entered the U. S. prior to 8/22/96 and obtained qualified status on or after that date, must have remained "continuously present" in the U. S. from their last entry date into the country prior to 8/22/96 until becoming a qualified alien. "Continously Present" in the U. S. is defined as

   1. The alien had no single absence from the U.S. of more than thiry (30) days and

   2. The alien had no total of aggregate absences of more than ninety (90) days.

B. The qualified alien who meets the above definition is deemed to have entered the U. S. prior to 8/22/96 and if otherwise eligible, qualifies for full Medicaid.

Source: Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Act of 1996; 62 Federal Register 61344 and 61415 (November 17, 1997).

Rule 3.20: Aliens Not Continuously Present.

A. Aliens who were not "continuously present" are considered to have entered the U. S. on or after 8/22/96 and unless an exemption is met, are subject to the five (5) year disqualification period from the date qualified status was obtained and the forty (40) QQ requirement.

Source: Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Act of 1996; 62 Federal Register 61344 and 61415 (November 17, 1997).

Rule 3.21: Victims of Severe Forms of Trafficking.

A. Trafficking victims are not included in the statutory definition of qualified alien. Under Section 107(b) (1) (A) of the Trafficking Victims Protection Act, however, they are eligible for means-tested benefits to the same extent as refugees, i.e., victims of trafficking and their derivative beneficiaries qualify for Medicaid during the first seven (7) years after obtaining this qualified status.

Source: 22 USC § 7105(b).

Rule 3.22: Certification by Office of Refugee Resettlement.

A. The qualified status of a trafficking victim is not based on immigration status. The Office of Refugee Resettlement (ORR) issues a certification letter for an adult who has been subjected to a severe form of trafficking and meets statutory certification requirements. The ORR also issues a similar eligibility letter for children. Other agencies may issue letters or documents

to victims of severe forms of trafficking; however, the ORR letter is the acceptable verification. Victims of trafficking are not required to provide immigration documents. SAVE verification is not required.

Source: 22USC § 7105(b).

Rule 3.23: Battered Aliens.

A. Battered aliens were not initially included in PRWORA's definition of qualified aliens. In passing Section 501 IIRIRA, Congress added a new Section 4319(c), which provides that the term "qualified alien" shall include such immigrants.

1. The alien must be either the person battered, the parent of a child who is battered or a child whose parent has been battered.

2. The battered alien must not be residing in the same household with the person responsible for battery or extreme cruelty. If the battered alien resumes living with the one who is responsible for the battery or extreme cruelty, the battered alien's eligibility will end the month after the month of reconciliation.

3. The alien must be the beneficiary of a petition for immediate relative status; classification to immigrant status based on relationship to a lawful permanent resident alien; or suspension of deportation and adjustment to lawful permanent resident status.

4. The alien must also be able to show a substantial connection between the battery or extreme cruelty and the alien's need for Medicaid.

B. This may include such reasons as Medicaid is needed to obtain medical attention or mental health counseling caused by abuse, to replace medical coverage and/or health services lost when the individual separated from the abuser, to enable the individual to become self-sufficient following separation from the abuser or to provide medical care during a pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the individual.

Source: 8 USC § 1641.

Rule 3.24: Veteran or Active Duty Military.

A. To be eligible as a veteran, the qualified alien must have been honorably discharged, not based on alienage, and must have fulfilled minimum active duty service requirements. A qualified alien who is an active duty member of the Armed Forces, but not on active duty for training purposes only, can also be eligible. A qualified alien who is the spouse of a veteran or active duty service member may be eligible. The veteran's exemption also includes the unmarried surviving spouse of a veteran or active duty military person. To qualify as a surviviving spouse, at least one of the following conditions must be met:

1. The spouse must have been married to the veteran for at least one (1) year; or

2. The spouse must have had a child with the veteran, or

3. The veteran's death must have been due to an injury or illness incurred during military service and the marriage must have been in existence sometime within fifteen (15) years after the period of service in which the injury or disease was incurred or aggravated.

Source: 8 USC § 1612.

Rule 3.25: Loss of Exemption.

A. Surviving spouses who remarry lose the benefit of this exemption the month after the month of the remarriage. Spouses whose marriage ended in divorce lose the benefit of this exemption the month after the month of divorce.

Source: 8 USC § 1612.

Rule 3.26: Qualifying Children.

A. To qualify as a child of a veteran or active duty service person, the biological, adopted or stepchild must be:

1. Unmarried and claimable as a dependent on the military person's tax return; and

2. Under eighteen (18) years of age or under twenty-two (22) and a student regularly attending school; or

3. A child with disabilities who is over eighteen (18), if the child had a disability and was dependent on the veteran or active duty service member before the child's eighteenth (18th) birthday; or

4. A surviving unmarried minor child of a veterans or person killed in active duty and dependent on the veteran at the time of the veteran's death.

Source: 8 USC § 1612.

Rule 3.27: Non-Qualified Aliens.

A. An alien who does not meet the specific requirements of a qualified alien is a non-qualified alien for Medicaid purposes. A non-qualified alien who meets MS residency requirements and other applicable eligibility factors can receive Medicaid Emergency Services only. An applicant for Emergency Medicaid services is not required to provide information regarding citizenship, immigration or enumeration and should not be requested to do so. The SAVE process is not used for a non-qualified alien.

Source: 42 CFR § 440.255(c) (Rev. 1991).

Rule 3.28: Illegal Aliens.

A. Illegal aliens are non-qualified aliens. This group of individuals includes:

1. Undocumented aliens who entered illegally without knowledge of USCIS; or

2. Aliens who were admitted for a limited period of time and did not leave the U.S. when the period of time expired.

B. These individuals, if they meet all eligibility criteria except citizenship/alien status, are enntitled to Medicaid only for treatment of an emergency medical condition. The specialist must accept the applicant's statement if they say they have no documentation and assess the alien for emergency services only. Undocumented and illegal aliens do not have to provide a Social Security Number or provide information regarding citizenship or immigration status. The alien status of an illegal alien is not verified through the SAVE process.

Source: 42 CFR § 440.255(c) (Rev. 1991).

Rule 3.29: Ineligible Aliens.

A. Ineligible aliens may be lawfully admitted to the U. S., but only for a temporary or specified period of time. These aliens are never qualified aliens, because of the temporary nature of their admission status, most ineligible aliens are not entitled to any Medicaid benefits, including emergency services.

B. However, in some instances, an alien in a currently valid non-immigration status may meet state residency requirements, such as intent to reside in MS for purpose of employment. If state residency requirements are met, the alien is potentially eligible for Emergency Medicaid services only.

C. Examples of ineligible aliens who are lawfully admitted:

1. Foreign Students;

2. Visitors;

3. Tourists;

4. Foreign government representatives and their families and servants;

5. Crewmen on shore leave;

6. International organization representatives and their families and servants;

7. Temporary workers (individuals allowed entry temporarily for employment purposes;

8. Members of the foreign press, radio, film, etc., and their families; and

9. Short term parolees.

B. Ineligible aliens who are admitted lawfully must possess one of the following:

1. Visa, Passport, or Form I-766; or

2. Form I-94, Arrival/Departure Record annotated with A-M; or

3. Form I-688 Temporary resident Card annotated with Section 210 or 245 A.

Source: 42 CFR § 440.255(c) (Rev. 1991).

Rule 3.30: Other Aliens.

A. Aliens who are admitted legally to the U. S., but do not fall into one of the specific categories of qualified aliens are non-qualified aliens. These individuals may include Legal Temporary Residents (LTR's), as well as individuals who are given temporary administrative statuses, i.e., a stay of deportation or voluntary departure until they can formalize permanent status or individuals who are paroled for less than one year or aliens under deportation procedures.

Source: 42 CFR § 440.255(c) (Rev. 1991).

Rule 3.31: Immigration Reporting.

A. Applicants who are found to be in the U. S. illegally through the application process are not subject to immigration reporting requirements. Persons who apply for benefits on behalf of others, i.e., a mother applying for her children, are not subject to immigration reporting requirements.

B. Declining to provide documentation of immigration status is not a valid reason to report an alien to immigration. The alien applicant who declines to present documentation of qualified alien status or a Social Security Number will only be able to receive Emergency Medicaid if otherwise eligible. In this instance, there is no reason to seek further verification of alien status beyond interviewing the applicant.

C. All rules of confidentiality must be applied in regard to an individual's alien status.

Source: 42 CFR § 440.255(c) (Rev. 1991)).

Rule 3.32: Criteria for Approval of Emergency Services.

A. Aliens who are not entitled to full Medicaid benefits may be eligible for emergency services only, if the following conditions exist:

1. All other eligibility requirements are met except satisfactory immigration status;

2. Care and services needed are not related to an organ transplant procedure or routine prenatal or postpartum care;

3. The alien has, after sudden onset, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such as the absence of immediate medical attention could reasonably be expected to result in:

4. Placing the patient's health in serious jeopardy,

5. Serious impairment to bodily functions,

6. Serious dysfunction of any bodily organ or part, or

7. Is for labor and delivery.

B. The services provided in this situation must relate to the injury, illness, or delivery causing the emergency. Services that are not directly related to the injury, illness, or delivery are not compensated by Medicaid. Once the medical condition is stabilized, even if it remains serious or results in death, it is no longer an emergency.

Source: 42 CFR § 440.255(c) (Rev. 1991).

Rule 3.33: Processing Eligibility for Emergency Medicaid Services.

A. At the point of application, the applicant, who is a non-qualified alien or a qualified alien subject to five (5) year disqualification, must be informed that if all applicable program eligibility requirements are met, Medicaid may reimburse for emergency services only (including labor and delivery) after the services have been received.

Source: 42 CFR § 440.255(c) (Rev. 1991).

Rule 3.34: Determining Eligibility for Emergency Medicaid Services.

A. When determining eligibility for Medicaid coverage for treatment of an emergency medical condition only, information obtained must:

1. Establish eligibility based on emergency services criteria, such as copy of the hospital bill or other documentation from the hospital including treatment or services received, dates of service and the diagnosis for the individual's condition; and

2. Establish eligibility on technical factors, except citizenship, alien status and enumeration,

and financial factors.

Source: 42 CFR § 440.255(c) (Rev. 1991).

Rule 3.35: Financial Eligibility.

A. The alien must be financially eligible. If not, the application will be denied.

Source: 42 CFR § 435.406(b) (Rev. 2007).

Rule 3.36: Budgeting for Citizen Children of Non-Qualified Alien(s).

A. Children born in the United States to parent(s), who is a non-qualified alien as discussed in may be eligible for full Medicaid. The parent(s) and any sibling(s) who are non-qualified aliens cannnot be eligible for full Medicaid benefits; however, they may be assessed for Emergency Medicaid Services. A child born to a mother eligible for emergency services for labor and delivery is deemed eligible for Medicaid through the month of the child's first birthday, provided the child remains a member of the mother's household and a resident of the state. When the child reaches the age of one, a review is required. Verifications postponed during the deemed eligible child's first year must be provided.

Source: 42 CFR § 435.117(b) (Rev. 2007).

Rule 3.37: Public Charge.

A. Aliens who seek admission to the U.S. must establish that they will not become 'public charges.'

B. A "public charge" is an alien who has become (for deportation purposes), or who is likely become (for admission/adjustment purposes), solely dependent on government assistance as demonstrated by either

   1. Receipt of public cash assistance for income maintenance (including Work First or SSI); or

      a) "Income Maintenance" does not include one-time cash payments for emergency assistance or Benefit Diversion. The receipt of public cash assistance for income maintenance for a child does not create a public charge problem for the parent unless that cash assistance is the only source of income for the family.

   2. Institutionalization for long-term care at government expense.

      a) Institutionalization for short periods of rehabilitation does not constitute primary dependence. Many aliens establish that they will not become public charges by having 'sponsors' who pledge to support them.

b) Aliens may ask staff about the consequences of becoming a public charge by applying for assistance. This is of concern to aliens who want to become Legal Permanent Residents and obtain a Green Card.

c) Long term institutionalized care under Medicaid may result in a public charge determination; however, this does not include short-term rehabilitation stays in long-term care facilities.

d) However, being institutionalized for long-term care does not automatically make an individual inadmissible to the U.S., ineligible for legal permanent resident status, or deportable on public charge grounds. The law requires that USCIS officials consider several additional issues. Each determination is made on a case-by-case basis and the regional office is not involved in this determination.

3. It should be noted that refugees and persons granted asylum may receive any benefit, including Work First, without affecting their chances of becoming a Legal Permanent Resident (LPR) or a U.S. citizen.

Source: INA § 212(a)(4).

Part 102 Chapter 4: Enumeration

Rule 4.1: Social Security Number (SSN).

A. Enumeration is the process of assigning Social Security Numbers. In general, applicants for Medicaid must be enumerated as a condition of eligibility by either;

1. Furnishing the Social Security Number.

a) The applicant can verbally provide the SSN when they do not have a card or other document with the number on it; or

2. Providing verification of an application for a Social Security Number when a number has not already been assigned.

Source: 42 CFR § 435.910 (Rev. 2001).

Rule 4.2: Exceptions to the Enumeration for Applicants.

A. There are four (4) exceptions to the enumeration requirement for Medicaid applicants:

1. Non-qualified aliens applying for Emergency Medicaid services only do not have to provide a Social Security Number or provide proof of an application for a number as a condition of eligibility for emergency benefits.

2. The requirement is postponed for deemed eligible children until the first redetermination.

3. The Social Security Administration (SSA) does not issue SSN's to deceased individuals. The enumeration requirement is applicable if the SSN was issued prior to death.

4. The enumeration requirement may be waived for an applicant who, because of well-established religious objections, refuses to obtain a Social Security Number. The specialist will obtain the applicant's written statement which includes his religious affiliation and reasons for objecting to the requirement. The statement will be forwarded to the state office for final determination.

Source: 42 CFR § 435.910 (Rev. 2001).

Rule 4.3: Non-Applicants and Enumeration.

A. Non-applicants cannot be required to disclose their own SSN as a condition of eligibility.

B. For example, a mother who is applying for Medicaid only for her children cannot be required to provide her SSN even though she has financial responsibility for the children.

C. Voluntary disclosure of the SSN will enable the agency to make a more accurate eligibility determination and ensure correct benefits.

D. The application must not be denied solely because a non-applicant's SSN is not disclosed.

E. If the non-applicant's income is countable in the budget and is from a source usually verified using the SSN, alternate verification will have to be provided.

Source: 42 CFR § 435.910 (Rev. 2001).

Rule 4.4: Use of SSNs.

A. SSNs will be matched with the following agencies:

1. Employment Security to obtain data regarding wages and unemployment compensation;

2. Social Security to obtain net earnings from self-employment, wage and retirement information; and

3. Title XVI benefit information; and Internal Revenue Service (IRS) to obtain unearned income information such as interest, dividends, etc.

Source: 42 CFR § 435.910 (Rev. 2001).

Rule 4.5: Verification of the SSN.

A. When the applicant provides a document with the SSN or provides the number verbally, the number must be validated through SVES.

   1. If the number originally submitted to SVES is not verified, the correct information must be obtained and re-submitted for the SVES inquiry.

   2. If discrepancies exist, such as an applicant/beneficiary has more than one SSN or has the same SSN as another individual, the client must be referred to the SSA office for resolution.

Source: 42 CFR § 435.910 (Rev. 2001).

Part 102 Chapter 5: Categorical Eligibility

Rule 5.1: Categorical Eligibility.

A. Eligibility for the Medicaid program is limited to certain groups of individuals authorized by Congress.

B. When authorizing a group, Congress also establishes specific requirements which must be met to qualify as a member of that group.

   1. Each designated group is assigned a category of assistance.

   2. The requirements which must be met to fit into a group or category are known as categorical requirements.

   3. The Division of Medicaid is responsible for the following categories of assistance: aged, blind, disabled, children under age nineteen (19), pregnant women and families with dependent children.

Source: Miss. Code Ann. § 43-13-121 (Rev. 2005).

Rule 5.2: Aged.

A. An individual categorically eligible as aged must be sixty (65) years of age or older.

B. According to the SSI program, a given age is attained on the first moment of the day preceding the anniversary of the individual's birth.

   1. Example**:** A person born on January 1, 1943, is considered to be age sixty (65) as of December 31, 2007, and meets the definition of an aged individual in the month of December 2007. A person born January 2, 1942, meets the definition of an aged individual in January 2008.

Source: 42 CFR § 435.522 (Rev. 1993).

Rule 5.3: Blindness and Disability.

A. To be categorically eligible for Medicaid as blind or disabled, the individual must, at a minimum, meet the Supplemental Security Income (SSI) definition of blindness or disability.

   1. The Disability Determination Service (DDS) makes all decisions relating to disability and blindness for the Division of Medicaid and the Social Security Administration (SSA).

Source: 42 CFR § 435.540 (Rev. 1989).

Rule 5.4: Children Under Age 19.

A. The Families. Children and CHIP (FCC) programs serve children in specific age groups.

B. Children have continuous eligibility for a twelve (12) month certification period unless an "early-out" termination reason is met.

Source: 42 CFR § 435.116 (Rev. 1993).

Rule 5.5: Pregnant Women.

A. A pregnant woman of any age is categorically eligible.

B. A pregnant woman's eligibility includes a two (2) month post partum period following the month of delivery, miscarriage or other termination of pregnancy.

Source: 42 CFR § 435.116 (Rev. 2012).

History: Deleted Miss. Admin. Code Part 102, Rule 5.5.C.

Rule 5.6: Parents and Caretaker Relatives of Dependent Children

A. Low-income parent(s) or caretaker relatives with children under age eighteen (18) are categorically eligible for Medicaid.

B. This group includes intact two (2) parent families and families in which the children are deprived of one or both parents.

C. A caretaker relative is related by blood, adoption or marriage with whom the dependent child is living, who assumes primary responsibility for the child's care, as may be indicated by claiming the child as a tax dependent for federal income tax purposes and meets a specified degree of relationship.

D. A dependent child is under the age of eighteen (18) and is deprived of parental support by reason of the death, absence from the home, physical or mental incapacity, or unemployment (or underemployment) of at least one parent.

Source: 42 CFR § 435.110 (Rev. 2012).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Part 102 Chapter 6: General Eligibility Requirements

Rule 6.1: Basic Eligibility Requirements.

A. An eligible individual must:

1. Be in one of the categories of assistance;

2. Be a citizen of the United States or a qualified alien;

3. Be a resident of Mississippi; and in addition,

4. Have income and resources, when applicable, within specified program limits; and

5. File an application.

B. Notwithstanding the above, an individual is not eligible in any program if the person:

1. Fails to apply for any and all other benefits for which he may be eligible;

2. Fails to assign rights to any third party medical support or cooperate with Medicaid in obtaining third party payments;

3. Is a resident of a public institution;

4. Refuses to accept vocational rehabilitation services (ABD Programs); or.

5. Is a resident of a long term care facility (FCC programs).

Source: 42 CFR § 435 et. seq. (Rev. 1986).

Rule 6.2: Eligible Individuals - ABD Programs.

A. The eligible ABD adult or child is one who meets all basic program requirements.

B. An eligible spouse is a person who:

1. Meets all of the basic program requirements,

2. Is the husband or wife of an eligible individual; and

3. Lives with the eligible individual.

4. This includes a man and woman who hold themselves out as husband and wife.

5. The individual and spouse must each apply and meet all of the basic program requirements to establish eligibility as a couple.

Source: 42 CFR § 435 et. seq. (Rev. 1986).

Rule 6.3: Eligible Individuals - FCC Programs.

A. Children under age nineteen (19), pregnant women of any age and parents or needy caretakers, within the specified degree of relationship, are eligible individuals for the FCC programs if they apply and meet program requirements.

B. For family coverage, parents must live together, have a biological, adopted or step child, apply and meet all of the basic program requirements.

Source: 42 CFR §. 435.110 (Rev. 2012).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Rule 6.4: Verification of Age.

A. The age of an individual must be verified in the following situations:

1. The applicant is an adult or child applying for benefits which are based on age;

2. There are ineligible children in an ABD deeming household;

3. A disabled or blind applicant under age twenty-one (21) applies for ABD and any of the following conditions exist:

   a) Deeming;

   b) Student earned income exclusion; or

   c) Support from absent parent exclusion.

4. Age will be verified by matching with electronic data sources, as required by the ACA. If age cannot be verified by available data sources, the applicant will be required to provide acceptable verification of age.

Source: 42 CFR § 435. 522 (Rev. 1993).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Rule 6.5: Marital Relationships - ABD Programs.

A. A marital relationship is one in which members of the opposite sex are:

1. Married under State law;

2. Married under common law provided the couple began holding out prior to April 1, 1956;

3. Married for Title II purposes, meaning one member of the couple is entitled to spouse's benfits on the record of the other;

4. Living in the same household in a 'holding out" relationship as man and wife.

   a) A man and woman who live in the same household are married for SSI/Medicaid purposes if they hold themselves out to the community in which they live as husband and wife.

   b) It is possible for a couple to live together and not be "holding out" as man and wife, depending on the economic and social circumstances. The only way to make a determination of marital status is examine how the couple holds themselves out to the community. If the couple is determined to be living separately and apart, each is treated as an individual. However, when evidence does not support that a couple is living separately and apart, couple rules and deeming applies.

   c) When a couple lives together, but denies "holding out", as many items of evidence as possible are needed to make a determination as to the couple's relationship and living arrangement. Such evidence may include mortgages, leases rent receipts, property deeds, bank accounts, tax returns, credit cards, information from other government programs, (SSA, public housing, food stamps, etc), and statements from friends, relatives and neighbors.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 6.6: Termination of a Marital Relationship - ABD Programs.

A. For ABD programs, the marital relationship no longer exists as of the date that:

1. Either individual dies;

2. A final decree of divorce or annulment is issued for the marriage; (If a divorced couple resumes living together, the specialist must develop whether they have a holding-out relationship.)

3. Either individual begins living with another person as their spouse;

4. The couple is determined not to be married for Title II purposes if that was the basis for considering the couple married;

5. The couple begins living in separate households;

   a) When a married couple claims to be living apart, As many items of evidence as possible must be obtained to make a determination as to the couple's relationship and living arrangement. Such evidence may include mortgages, leases rent receipts, property deeds, bank accounts, tax returns, credit cards, information from government programs (SSA, public housing, food stamps, etc), and statements from friends, relatives and neighbors.

   b) If the couple is living apart, each person is treated as an individual.

6. A man and woman who are still legally married and resume living together after having lived part is a married couple, regardless of the reason for having resumed living together.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 6.7: Verification of a Marital Relationship - ABD Programs.

A. A marital relationship is presumed for an ABD couple unless the client states otherwise and provides the types of evidence listed above which indicate the relationship does not exist or has terminated.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 6.8: Changes in Marital Status - ABD Programs.

A. A man and woman are married for a month if they meet any of the criteria for a marital relationship within the month.

B. When a change occurs and an individual marries, resumes living with a spouse, enters a "holding out" relationship, etc., use couple budgeting beginning the month of the marriage.

   1. An increase in benefits can be effective immediately if policy otherwise allows it.

   2. Adverse action rules apply when ineligibility or a decrease in benefits results for a recipient. Termination of marriage is effective the month after the month of a death, divorce, annulment or separation.

C. For the spousal impoverishment allocation, the couple must be legally married under state law or in a common-law marriage which began prior to April 1, 1956.

1. The spousal impoverishment allocation is not applicable to couples in "holding-out" situations which began on or after April 1, 1956.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 6.9: Marital Relationships - FCC Programs.

A. A marital relationship is one in which members of the opposite sex are:

1. Married under State law;

2. Married under common law prior to April 1, 1956 as recognized by MS.

3. Couples in "holding out" situations are unrelated individuals for FCC purposes.

Source: 42 CFR § 435. 603 (Rev. 2012).

History: Deleted Miss. Admin. Code Part 102, Rule 6.9 A(4).

Rule 6.10: Termination of a Martial Relationship - FCC Programs.

A. The marital relationship no longer exists for FCC purposes as of the date that:

1. Either individual dies;

2. A final decree of divorce or annulment is issued for the marriage;

a) If a divorced couple resumes living together, the adults are unrelated.

3. The married couple begins living in separate households.

a) A legally married man and woman who resume living together after having lived apart are treated as a married couple, regardless of the reason for having resumed living together.

Source: 42 CFR § 435. 603 (Rev. 2012).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Rule 6.11: Changes in Marital Relationship – Applications, FCC Programs.

A. Marriage or termination of marriage, including separation, is effective the month the event occurs.

B. In application situations, individuals must be in the home at least one day of the month to be included in that month.

Source: 42 CFR § 435. 603 (Rev. 2012).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Rule 6.12: Changes in Marital Relationship – Active Cases, FCC Programs.

A. A change in marital staus must reported by adult recipients eligible in the Medical Assistance Program.

B. When an adult becomes ineligible due to a change in maritable staus, eligibility is terminated after allowing ten (10) day (plus two (2) days mailing time) notice of the adverse action.

C. Any changes resulting for the children will be handled at review.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 6.13: Definition of a Child - ABD Programs.

A. In the ABD programs, a child is defined as someone who is:

1. Neither married nor head of a household; and

2. Either under age eighteen (18); or

3. Under age twenty-two (22) and a student regularly attending school or college or training that is designed to prepare him for a paying job.

Source: 42 CFR § 435.201 (a) (4) (Rev. 1993).

Rule 6.14: Termination of Child Status - ABD Programs.

A. Status as a child ends:

1. Effective with the month the child becomes age eighteen (18) or age twenty-two (22), if a student, or

2. The month he last meets the definition of a child.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993)

Rule 6.15: Student Status as an Eligibility Requirement - ABD Programs.

A. A child under age eighteen (18) who does not expect to earn over $65 in any month meets the definition of a child without regard to student status.

B. Student status must be explored whenever an applicant or recipient between the ages of eighteen (18) and twenty-two (22) alleges being a student.

1. An individual meets the definition of a child for purposes of allocation and budgeting if he is :

a) Under age twenty-two (22); and

b) Regularly attending school, college or training designed to prepare him for a paying job.

1) Regular attendance means the individual takes one or more courses of study and attends classes:

(a) In a college or university for at least eight (8) hours a week under a semester or quarter system;

(b) In grades seven to twelve (7–12) for at least twelve (12) hours a week; or

(c) In a course of training to prepare him for a paying job for at least fifteen (15) hours a week if the course involves shop practice or twelve (12) hours a week if it does not involve shop practice.

(d) This kind of training includes antipoverty programs, such as Job Corps and government-supported courses in self-improvement.

2) Attendance may be less than the time indicated above for reasons beyond the student's control, such as illness, if the circumstances justify the reduced credit load or attendance.

(a) Example of school attendance less than required hours: A paraplegic is forced to limit vocational school attendance to one (1) day a week due to the unavailability of transportation. Although the student is enrolled for attendance of less than twelve (12) hours a week, he qualifies as regularly attending school because lack of transportation is a circumstance beyond his control.

3) Student status is also granted to homebound students who have to stay home due to a disability.

4) Student status is granted if the child studies courses given by a school (grades seven to twelve (7–12), college, university or government agency and a home visitor or tutor directs the study or training.

5) A child remains a student when classes end if he attends classes regularly prior to school vacation and intends to return when school reopens.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 6.16: Definition of a Child - FCC Programs.

A. To be categorically eligible as a child in the FCC programs, the individual must be under the age of nineteen (19).

B. Age is verified, primarily through electronic sources.

C. An individual's status as a child ends effective the month after he turns age nineteen (19).

Source: 42 CFR § 435.603 (Rev. 2012).

Rule 6.17: Emancipated Children - FCC Programs.

A. Most children are dependents of their parents or have another adult caretaker. However, some children may be emancipated. An emancipated minor is authorized to act on his own behalf. Though not a dependent child, the emancipated minor under age nineteen (19) is a categorically eligible child for FCC programs.

B. Emancipation may occur by court-ordered emancipation, marriage or living independently; however, how an emancipated child under age 19 is treated for Medicaid or CHIP purposes depends on the living arrangement of the child, the child's tax dependent or tax filer status and/or whether the child must be treated as an exception to tax filer rules or under non-filer rules, as described in budgeting rules.

Source: 42 CFR § 435. 603 (Rev. 2012).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Rule 6.18: Minor Parents - FCC Programs.

A. An unmarried parent under age nineteen (19) who resides in the home with his children and his parents (the children's grandparents) has his own eligibility determined using tax filer or exception rules applies; however, the minor's children are included in the household composition with the minor parent as children cannot be separated from their parent(s) if living together.

B. The minor's children are dependent children of the minor parent for determining their eligibility.

Source: 42 CFR § 435. 603 (Rev. 2012).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Rule 6.19: Minor Heads of Household - FCC Programs.

A. There are instances in which it is permissible for a child to be the head of household.

1. Children living independently, including those in group homes, orphanages and other situations in which parents have relinquished or abandoned custody, often have individuals filing on their behalf, such as a social worker, administrator or foster parent.

2. However, it is also permissible for the child to file the application when he is capable of doing so.

B. In addition, a child living with parents can be the head of household, i.e., the person filing the application, under certain circumstances:

1. A married minor living with a spouse can file an application as head of household, independent of parents.

2. A pregnant pre-teen or teen can file an application as a pregnant woman, independent of parents.

3. A minor parent can file an application for his/her children as head of household. However, a minor parent must have his own eligibility determined with his parents.

Source: Miss. Code Ann. § 43-13-121 (Rev. 2005)

Rule 6.20: Utilization of Other Benefits – General.

A. As a condition of eligibility, an ABD or FCC applicant or recipient must take all necessary steps to obtain all benefits to which they are entitled when the benefit(s) is one of the following types:

1. Medicare;

2. Unemployment Benefits;

3. Worker's Compensation Benefit;

4. Social Security Retirement, Survivors and Disability Insurance Benefits, Including Early Retirement at Age Sixty-Two (62);

5. Retirement or Disability Benefits Including Veterans' Pensions And Compensation except VA Aid and Attendance is not a required benefit under this provision.

6. Annuity Or Pension Such As Private Employer Pensions, Civil Service Pensions, Union Pensions, Railroad Retirement Annuities and Pensions, Municipal, County, or State Retirement Benefits.

   a) Explore entitlement for private sector benefits if the client or former/deceased spouse worked for a private sector employer with a pension plan and if not already receiving or has not received a pension based on that employment.

   a) Explore entitlement for benefits if the client or former/deceased spouse (or deceased parent if the client is a child) is not already receiving or has not received a pension based on such employment and was employed by the one of the following:

      1) Federal Civilian Employment for a minimum of five (5) years;

      2) Federal Uniformed Service (Military) for a minimum of twenty (20) years; or

      3) State or Local Government employment.

Source: 42 CFR § 435.608 (Rev. 1993).

Rule 6.21: Benefits Exempt from Utilization Provision.

A. The client is not required to apply for the following types of benefits:

1. Temporary Assistance for Needy Families (TANF)

2. General Public Assistance, including SSI

3. Bureau of Indian Affairs General Assistance

4. Victim's Compensation payments

5. Other Federal, state, local or private programs with payments based on need

6. Earned Income Tax Credits

Source: 42 CFR § 435.608 (Rev. 1993).

Rule 6.22: Individuals Exempt from Utlization Provision.

A. This provision applies only to eligible individuals (applicants or recipients).

B. It does not apply to non-applicants or ineligibles.

1. This includes the ineligible spouse or community spouse in ABD and non-applicant or ineligible parents or caretaker relatives of children.

2. However, the responsible adult is required to file on behalf of children potentially eligible for other benefits as a condition of the child's eligibility.

Source: 42 CFR § 435.608 (Rev. 1993).

Rule 6.23: Exception to the Utilization Provision.

A. An individual is not required to accept another benefit if the resulting payment would be a reduction in current benefits payable to the individual.

B. This does not include a reduction in Medicaid benefits.

Source: 42 CFR § 435.608 (Rev. 1993).

Rule 6.24: Good Cause for Not Complying with Utilization Provision.

A. The agency must require clients to take all steps necessary to apply for other benefits to which they are entitled, unless good cause can be shown for not doing so.

B. A denial or dismissal of a claim for other benefits due to failure to submit required verification does not satisfy this requirement.

C. Good cause for not applying for other benefits may be found to exist if the individual does not apply due to:

1. Illness and there is no authorized representative to apply on the client's behalf; or

2. The individual previously applied and was denied and the reason for thedenial has not changed; or

3. The individual was unaware of the availability of a benefit and the agency did not advise him of its availability.

D. If good cause does not exist for failure to comply with this requirement, eligibility will be denied or terminated as discussed later in this section.

Source: 42 CFR § 435.608 (Rev. 1993).

Rule 6.25: Applying the Utilization Provision.

A. The utilization of other benefits provision is applicable at the time of application and for the duration of eligibility.

B. The individual potentially eligible for the types of benefits listed above or the responsible person, if the client is a child, must take steps to apply for the benefits.

C. If eligible, the individual must accept the payment regardless of the impact the additional income will have on Medicaid eligibility.

Source: 42 CFR § 435.608 (Rev. 1993).

Rule 6.26: Notification Requirements for Utilization Provision.

A. The client must be furnished with written request notice explaining the responsibility to apply for the potential benefit within thirty (30) days of the notice for ABD and within fifteen (15) days of the notice for FCC.

B. A Request for Information will be used to inform the individual of the following:

1. The type of benefit the client appears to be eligible for;

2. The agency or organization where an application should be filed;

3. That the client has thirty (30) days (or fifteen (15) for FCC) from the date of the notice in which to file an application for the potential benefit; and

4. Proof that that application has been filed must be provided to the Regional Office within the thirty (30) day (or fifteen (15) day) timeframe.

Source: 42 CFR § 435.608 (Rev. 1993).

Rule 6.27: Agreement to Comply with Utilization Provision.

A. An agreement to comply does not negate any prior action to deny or terminate benefits.

B. The effective month of eligibility is the month in which the individual takes the steps necessary to obtain benefits from the other agency.

Source: 42 CFR § 435.608 (Rev. 1993).

Rule 6.28: Other Issues Related to Utilization Provision.

A. A client may be eligible for more than one type of benefit. All potential sources of benefits must be identified.

B. The election of a lower benefit when the individual has an option between a high and low benefit will result in denial or loss of eligibility.

C. When a client has a choice regarding payment as a lump sum or an annuity, the annuity must be selected.

1. A one (1) time total withdrawal of pension plan funds in this situation does not comply with the statutory requirements that mandate application for the annuity or pension, i.e., money payment at some regular interval.

2. Recommend conversion of lump-sum applications in appropriate situations to focus on maximizing the use of the other benefits to provide ongoing support.

Source: 42 CFR § 435.608 (Rev. 1993).

Rule 6.29: Failure to Comply without Good Cause - ABD Programs.

A. If the ABD individual has failed without good cause to take all steps to obtain the other benefits, action to deny or terminate benefits until the requirement is fulfilled must be taken.

B. An agreement to comply does not negate any prior action to deny or terminate benefits.

C. The effective month of eligibility is the month in which the individual takes the steps necessary to obtain benefits from the other agency or provides proof of ineligibility for the benefit.

Source: 42 CFR § 435.608 (Rev. 1993).

Rule 6.30: Failure to Comply Without Good Cause - FCC Programs.

A. When the application for other benefits has not been filed and good cause does not exist, the FCC adult or child who was potentially eligible for the other benefits cannot be approved for Medicaid.

B. However, any other eligible children included in the application can be placed in an appropriate program.

Source: 42 CFR § 435.608 (Rev. 1993).

Rule 6.31: Assignment of Third Party Rights – FCC Programs.

A. Federal law requires that all Medicaid applicants and recipients must, as a condition of eligibility, cooperate with the Medicaid Agency in identifying, to the extent they are able, potentially liable insurers and other third parties who may be liable to pay for care and services covered by Medicaid.

B. Cooperation includes repaying any monies to the Medicaid Agency received from a third party source to the extent that Medicaid has paid for the covered service.

C. By accepting Medicaid each applicant/recipient is deemed to have made an assignment to the Medicaid Program of his rights to medical support or any third party benefits, including hospitalization, accident, medical or health benefits owed to the individual, as well as rights

to such benefits owed by any third party to the children or any other person for whom the applicant/recipient has legal authority to execute such an assignment.

1. The individual's signature on the application form at initial application and each redetermination of eligibility acknowledges the automatic assignment of all third party rights.

Source: 42 CFR. § 435.610 (Rev. 1993).

Rule 6.32: Failure to Cooperate With Third Party Assignment - FCC Programs.

A. The Third Party Liability (TPL) Unit has the responsibility for determining if an individual has failed, without good cause, to cooperate with assignment of third party rights.

B. If the TPL Unit determines there was good cause for failure to cooperate, the individual will be exempted from the cooperation requirement.

C. A determination of failure to assign rights or lack of cooperation in obtaining third party payments, without good cause, will result in denial or termination of Medicaid benefits after affording the right to appeal.

D. If the TPL Unit determines an individual has failed, without good cause, to cooperate with third party assignment, action may be taken to deny or terminate eligibility with advance notice and state appeal rights.

Source: Miss. Code Ann. 43-13-121 (Rev. 2005)

Rule 6.33: CHIP and Other Insurance Coverage - FCC Programs.

A. There is no requirement for assignment of third party rights in the Children's Health Insurance Program because the program is for uninsured children only.

B. Children who are covered by creditable third party insurance at application are not eligible for CHIP. This is true regardless of who pay the health insurance premiums.

C. Creditable insurance coverage is full health insurance. Children covered only by the following types of insurance may qualify for CHIP: accident insurance, disability income insurance, liability insurance, supplemental policies for liability insurance, worker's compensation, automobile medical payment insurance, credit-only insurance, coverage for onsite medical clinics or limited-scope dental or vision or long term care insurance.

D. Termination of creditable coverage must be verified when the application indicates insurance coverage will terminate within the thirty (30) day application processing period or terminated within the six months prior to the application.

E. As indicated above, a child covered by insurance at the time of application is not eligible; however, when insurance coverage will terminate within the thirty (30) day application processing period, an otherwise CHIP-eligible child is not denied.

F. If all other factors of eligibility will be met, the the application will be held and action taken to approve the child after the insurance coverage has ended.

Source: 45 CFR. § 457.310(a) (Rev. 2006). Miss. Code Ann. § 43-13-121 (rev. 2005).

Rule 6.34: Child Support Requirements in General.

A. State child support (IV-D) agencies are required to provide all appropriate child support services available under IV-D of the Social Security Act to families with an absent parent who receive Medicaid benefits and who have assigned rights for medical support to the State.

B. State IV-D agencies are required to petition for medical support when health insurance is available to the absent parent at a reasonable cost. In order for the IV-D agency to provide the services required by law, the Division of Medicaid must refer the following children to the Mississippi Department of Human Services (MDHS), Child Support Enforcement Office:

   1. Disabled children in an ABD program with an absent parent; and

   2. Children in the Medical Assistance Program (85) with an absent parent.

C. IV-D Cooperation is not required for the FPL programs; however, the client can volunteer for the child support services for children in FPL Medicaid programs.

Source: 45 CFR. § 233.90 (Rev. 1994).

Rule 6.35: Child Support Requirements for Parents and Caretaker Relatives

A. Referral to and cooperation with child support is required as a condition of the adult's eligibility if the deprivation reason for at least one child is continued absence.

B. The parent or caretaker relative must cooperate with child support requirements and assist the state by cooperating with enforcement of existing court orders or in obtaining at least medical support from the absent parent.

C. A referral to the IV-D agency is made whether or not there is an existing court order and regardless of whether child support is being paid by the absent parent.

Source: 45 CFR. § 233.90 (Rev. 1994). Miss. Code Ann. § 43-13-121 (Rev. 2005).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Rule 6.36: Non-Cooperation and Good Cause Determinations - FCC Programs.

A. At time of application, if the 85 parent or caretaker relative refuses to cooperate with child support, the adult's Medicaid eligibility will be denied.

B. After a referral to the IV-D agency, satisfactory cooperation, good cause for failure to cooperate and satisfactory cooperation after a period of non-compliance are determined by the IV-D agency.

   1. If a non-compliance decision is received from the IV-D agency, the 85 adult's eligibility will be terminated allowing adverse action notice.

   2. The sanction can only be removed when the adult has complied fully with child support requirements as required by the IV-D agency.

   3. The requirement to cooperate as a condition of eligibility impacts the eligibility of an adult only. The eligibility of a child is not impacted.

Source: 45 CFR. § 233.90 (Rev. 1994). Miss. Code Ann. § 43-13-121 (Rev. 2005).

Part 102 Chapter 7: Non-Financial Requirements - ABD Programs

Rule 7.1: Definition of Adult Disability.

A. The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

   1. This means the adult is unable to do his previous work or any other substantial gainful activity which exists in the national economy.

   2. The adult's residual functional capacity, age, education and work experience are considered in the disability determination process.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 7.2: Definition of Childhood Disability.

A. An individual under the age of eighteen (18) is considered disabled under the SSI program if that child has a medically determinable physical or mental disability, which results in marked and severe functional limitation, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least twelve (12) months.

   1. No individual under the age of eighteen (18) who engages in substantial gainful activity may be considered disabled.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 7.3: Definition of Blindness.

A. Statutory blindness is central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which has a limitation in the field of vision so that the widest diameter of the visual field subtends an angle no greater than 20 degrees is considered to have a central visual acuity of 20/200 or less.

   1. An individual's ability to work will not affect eligibility based on blindness.

   2. Throughout the remainder of this section, the term "disability" also refers to blindness.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 7.4: Disability Determination Process.

A. In Mississippi, an application for SSI is also an application for Medicaid.

   1. This does not mean a separate Medicaid application cannot be filed by an SSI applicant; however, the Medicaid agency is not required to obtain a separate Medicaid disability determination for any months of potential SSI eligibility, starting on the effective filing date of the SSI application.

      a) The applicant is required to wait until SSA makes the SSI eligibility determination.

Source: Miss. Code Ann. § 43-13-115(2) (Rev. 2003).

Rule 7.5: Independent Disability Determinations.

A. An independent disability determination when a separate Medicaid application has been filed under one of the following circumstances**:**

   1. The individual has not applied for SSI or has applied and been denied for a reason other than disability;

   2. An individual applies separately for both SSI and Medicaid and SSI fails to make a decision within ninety (90) days.

      a) In this instance, DDS must provide Medicaid with a decision prior to the SSI decision.

   3. An individual applies for Medicaid and alleges a disabling condition that is different from, or in addition to, that considered by SSA.

   4. An individual meets all three (3) of the criteria below:

a) Applies for Medicaid more than twelve (12) months after SSA last made a final determination that the individual was not disabled; and

b) The individual alleges his condition has deteriorated since that final decision; and

c) The individual has not reapplied for SSI.

B. If the above conditions do not exist and the individual is potentially eligible for SSI, he must file or re-file for SSI benefits. This does not mean a separate Medicaid application cannot be filed; however, Medicaid eligibility decision will be tied to the SSI decision.

1. Example: An individual applied for SSI and was denied due to disability in June 2008. In October 2008, the individual files for Medicaid only, but alleges no change in his physical condition since his SSI application was denied. In this case, the SSI disability denial controls the Medicaid decision. The individual must be denied Medicaid eligibility based on the previous SSI denial and referred to SSA to reapply for SSI.

Source: Miss. Code Ann. § 43-13-121.1 (Rev. 2005).

Rule 7.6: Exceptions to Obtaining Disability Approvals.

A. There may be instances when DDS has already determined disability using SSI criteria for the same period of time to be covered by a Medicaid application. If so, a separate Medicaid determination is not needed.

B. However, if the disability onset date, as established by SSA, does not include all months of requested Medicaid eligibility, a separate DDS decision is required.

Source: Miss. Code Ann. § 43-13-121.1 (Rev. 2005).

Rule 7.7: Situations Not Requiring a Separate DDS Decision.

A. In the following situations a separate blindness/disability determination for Medicaid is not needed. The applicant/beneficiary is considered to be blind/disabled:

1. Applicant Receives Title II Disability;

a) The Medicaid applicant receives Title II disability benefits on an ongoing basis based on his own disability and the disability onset date is verified to include all months to be covered by the Medicaid application, i.e. the month of application and any retroactive months. Receipt of Title II disability must be re-verified at each redetermination.

2. Disability Decision Overturned by Administrative Law Judge (ALJ) Order;

a) An Administrative Law Judge (ALJ) reverse a disability denial and establishes disability with a disability onset date which covers all months of the Medicaid application. If the Medicaid applicant is otherwise eligible, eligibility can be established as of the date of the onset of disability as established by the ALJ order, but no earlier than:

1) The Medicaid application date; or

2) Three months before the Medicaid application date if retroactive benefits are an issue.

(a) Example: An ALJ order reversed a disability decision and established disability effective February 2008. The application for Medicaid is filed on July If the Medicaid applicant met all other requirements retroactive benefits, eligibility could be established effective April 1, 2008.

3. Deceased Applicants;

a) A verified death date establishes disability if a disability, due to any illness or accident which resulted in death, existed in all months for which Medicaid eligibility was requested.

1) Example: A traumatic onset of disability occurred on September 14, 2008, due to an accident. On October 12, 2008, individual dies as a result of injuries sustained in the accident. The application for Medicaid is filed on November 3, 2008. Under this exception, Medicaid eligibility can only be established starting September, the month of the accident, forward.

4. Disabled Adult Children.

a) Disability has been established by SSA for an applicant who is over 18, entitled to Medicare and receiving Title II benefits as a child (C1-C9 beneficiary). The disability onset date must be determined.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 7.8: Separate Disability Decisions.

A. If there is no indication that any of the above exceptions apply, a separate disability decision must be obtained from Disability Determination Services when an applicant applies for Medicaid on the basis of disability or blindness.

Source: Miss. Code Ann. § 43-13-121.1 (Rev. 2005).

Rule 7.9: Temporary SSI Closures..

A. Some cases that are SSI-eligible terminate once per quarter and are reinstated by SSI after one or two (2) months of ineligibility.

B. The usual cause of the temporary SSI closure is earned income in a five (5) week month.

C. The individual whose SSI is temporarily terminated can apply for Medicaid coverage during the missing SSI months by filing an application with the regional office.

Source: Miss. Code Ann. § 43-13-121.1 (Rev. 2005).

Rule 7.10: Estate Recovery Requirements.

A. The Division of Medicaid is required to seek recovery of payments for nursing facility services and Home and Community-Based Services (HCBS) as well as related hospital and prescription drug services from the estates of deceased Medicaid recipients who were fifty-five (55) or older when Medicaid benefits were received.

B. The estate recovery provision applies to all Medicaid recipients in a nursing facility as of July 1, 1994, and all Medicaid recipients who entered the Home and Community-Based Waiver (HCBS) Program on or after July 1, 2001, who:

   1. Are age fifty-five (55) or older at time of death;

   2. Own real or personal property at time of death that can be considered an estate.

C. Individuals who entered the HCBS Waiver Program prior to July 1, 2001, are "grandfathered in" and will not have their case referred to estate recovery unless the individual is discharged from the program and readmitted after July 1, 2001. In which case, "grandfathered" status is lost and the individual will be referred to estate recovery as a new HCBS client subject to the provision**.**

Source: MS Code Ann. § 43-13-317.1 (Rev. 2005).

Rule 7.11: Estate Property.

A. Estate property includes any real or personal property owned by the recipient in its entirety or by shared ownership.

   1. Ownership of life estate interests or ownership of property that has been transferred into a trust is not subject to estate recovery.

B. Real property includes the home and any other real property, including ownership of mineral rights and/or timber rights.

C. Personal property includes ownership of any cash reserves, stocks, bonds, automobiles, RVs, mobile homes or any other type of property with value known to be owned by the recipient in full or in part.

Source: MS Code Ann. § 43-13-317.1 (Rev. 2005).

Rule 7.12: Exceptions to the Estate Recovery Provision.

A. Estate recovery rules to not apply to a deceased recipient if at the time of death the recipient has:

1. A legal surviving spouse, or

2. A surviving dependent child under the age of twenty-one (21); or

3. A dependent blind or disabled child of any age.

   a) The blind or disabled individual must be dependent on the Medicaid recipient for home or income, such as a disabled child drawing benefits from the parent's record.

Source: MS Code Ann. § 43-13-317.1 (Rev. 2005).

Rule 7.13: Assets and Resources Exempt from Estate Recovery

A. The following assets and resources of American Indians and Alaska natives are exempt from estate recovery:

1. Interest in and income derived from Tribal land and other resources currently held in trust Status and Judgment funds from the Indian Claims commission and the U. S. claims court;

2. Ownership interest in trust or non-trust property, including real property and I improvements located on a reservation.

3. Reservation payments to special populations.

Source: P.L. 111-5 American Recovery and Reinvestment Act of 2009 § 5006.

Part 102 Chapter 8: Non-Financial Requirements - FCC Programs

Rule 8.1: Deprivation.

A. Deprivation is an eligibility factor for dependent children under age eighteen (18). Deprivation must exist within the household in order for the parent(s) or caretaker relative to obtain eligibility. The child's eligibility is not tied to deprivation but there must be a dependent child under the age of eighteen (18) in the home in order for the adult to qualify for coverage.

B. A condition of deprivation is not applicable in any other Medicaid programs or CHIP.

C. The deprivation factor means a dependent child is deprived of the support of one or both of their parents for one of the following reasons:

1. Death;

2. Continued absence from the home;

3. Physical or mental incapacity (two (2) parent families only); and

4. Unemployment or Underemployment (two (2) parent families only).

D. Deprivation is established for the dependent child in relation to the child's legal and/or natural parents.

1. The biological parent of a child who has been legally adopted is no longer a legally responsible parent. Deprivation is determined only in regard to the adoptive parents.

2. Deprivation due to continued absence is always met in a single parent adoption.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Rule 8.2: Legally Responsible Parents.

A. The following are legally responsible parents:

1. The child's biological, adoptive or step mother;

2. The child's biological, adoptive or step father;

3. The adoptive parent who has been legally granted a final decree of adoption.

Source: 42 CFR § 435.603 (Rev. 2012).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Rule 8.3: Legal Father.

A. For the deprivation determination, a child's legal father is one of the following:

1. A man whose name appears on the child's birth certificate unless a court has determined otherwise;

2. A man who has been declared to be the child's father by a court order;

3. A man who has acknowledged paternity of the child in an Admission of Paternity if there is no legal father either on the birth certificate or in a court order;

4. A man who married the child's mother subsequent to the birth and publicly acknowledges that he is the father of the child when there is no legal father listed on the child's birth certificate and a paternity order has not been issued establishing a different person as the father.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993). Miss. Code Ann. 43-13-121.1
(Rev. 2005).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Rule 8.4: Continued Absence.

A. Continued absence exists when a parent does not live in the home with the child as the result of divorce, legal separation, desertion, incarceration, long term hospitalization, institutional care, court-ordered removal of the child from the home or because paternity has not been established.

B. Deprivation is also established if the parent is convicted of an offense and sentenced to perform unpaid public work or community service during working hours and is allowed by the court to live at home.

C. However, deprivation does not exist when a parent lives at an address separate and apart from the child, and:

   1. The parent is out of the home solely to seek or accept employment or

   2. The parent is out of the home solely due to active duty in the uniformed service of the United States.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 8.5: Incapacity.

A. A child who lives with biological, legal or adoptive parents is deprived of parental support or care if one (1) or both parents receive Social Security Disability or SSI.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 8.6: Under/Unemployment.

A. A child who lives with both of his parents is deprived of parental support or care if the combined family income is equal to or below the program gross and net income limits for the appropriate family size.

Source: 42 CFR §§ 435.601 (a) and (b) (Rev. 1993).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Rule 8.7: Temporary Absence from the Home..

A. The temporary absence of the parent, other adult caretaker or the child from the home does not affect the eligibility determination, provided the absent member does not establish a home elsewhere and the reasons for the absence is temporary.

B. In addition, the adult must retain legal responsibility for the child during the absence. The case must be documented with the reason for separation, the approximate duration and plan for the child or adult to return to the home.

C. The following situations are considered temporary absences:

1. Either the adult or child is temporarily out of the home receiving care or treatment in a medical facility, such as a hospital, a maternity home or drug treatment facility;.

2. Either the adult or child is out of the home for a visit;

    a) Example: A child spending a summer vacation with his non-custodial parent, who lives in MS or out-of-state;

3. Either the adult or child is out of the home to attend school or training;

    a) Example: The child is in Job Corps or the parent is attending college;

4. The adult works away from home and retains responsibility for the child, even though day-to-day care is delegated to someone else;

5. The child is in a juvenile facility that is not a state institution and the qualified relative retains legal responsibility for the child even though the facility has physical custody;

6. The child is in a Psychiatric Residential Treatment Facility (PRTF);

7. Absence of parent(s) due to fulfilling a military obligation;

    a) A legal parent who is away from home on military duty is considered part of the budget group unless there is abandonment of the family. Benefits will not be authorized for the person away on military duty.

D. Any family member who is residing elsewhere permanently cannot be considered temporarily absent.

Source: 42 CFR § 435.601 (a); 42 CFR § 435.601 (b) (Rev. 1993).

Rule 8.8: Relationship.

A. The responsible adult may be a relative or a non-relative for children eligible under a federal poverty level and CHIP.

B. To meet the requirement of relationship as a parent or caretaker relative, a child must live in the home with a biological, adopted or step parent or one of the following relatives within the specified degree of relationship:

1. Grandfather or grandmother (extends to great, great-great and great-great- great);

   a) A grandparent-in-law is within the required degree;

   b) The relationship of grandparent-in-law occurs when one of the child's grandparents remarries;

   c) For instance, if the child's paternal grandmother dies and his paternal grandfather marries again, this second wife of the child's grandfather becomes the child's grandmother-in-law;

   d) A step-grandparent is not within the degree of relationship;

      (1) A step-grandparent is the parent of a child's stepmother or stepfather;

2. Brother or sister (including half-brother and half-sister);

3. Uncle or aunt (extends to great and great-great);

4. First cousin, including first cousin once removed (child of a first cousin);

5. Nephew or niece (extends to great and great-great);

6. Stepfather or stepmother; or

7. Stepbrother or stepsister.

C. Relationship extends to the legal spouse of the above listed relatives even after the marriage is terminated by death or divorce.

D. The relationship requirement is met when the child lives with any of the above named relatives.

E. Legal custody is not a factor in determining relationship.

F. Legal adoption terminates all prior relationships except that the biological parent remains a qualified relative to the child for eligibility.

   1. A natural or biological parent whose child has returned to the parent's home after being legally adopted by another individual is within the degree of relationship.

   2. In such instances the natural parent is not legally responsible for the child and the adoptive parents must be reported as absent parents to the Division of Child Support.

   3. Example: The maternal grandmother adopts her grandchild. The biological mother returns to live in the home. The biological mother is not within the degree of relationship because the legal mother (the grandmother) is living in the home.

   4. Example: The maternal grandmother adopts her grandchild and the child later returns to live with the biological mother. In this case, the biological mother is within the degree of relationship because the legal mother is not living in the home. The adoptive mother (grandmother) is the absent legal parent for child support purposes.

G. Relationship as a caretaker relative must be verified.

   1. While parents may provide the child's birth certificate or other legal documents to prove relationship, another relative will need to provide additional documents to show the relationship to the child's parent and to the child.

Source: 42 CFR §§ 435.601 (a) and (b) (Rev. 1993).

History: Revised to correspond with the ACA (eff. 01/01/2014) eff. 04/01/2014.

Part 102 Chapter 9: Residents of an Institution

Rule 9.1: Residents of an Institution.

A. Residence in an institution can affect an applicant's or recipient's eligibility for any Medicaid program and for CHIP.

B. An individual is not eligible when:

   1. The individual is an inmate; and

   2. The facility in which the individual is residing is a public institution.

Source: 42 CFR § 435.1010 (Rev. 2006).

Rule 9.2: Age and Institutionalization.

A. Individuals under age twenty-two (22) may receive Medicaid while in an institution for mental diseases if they are receiving psychiatric services.

B. Individual between the ages of twenty-two (22) and sixty-five (65) are not eligible to receive any Medicaid benefits while residing in an institution for mental diseases.

C. Individuals age sixty-five (65) or older may not receive Medicaid benefits while in an institution unless they reside in a long term care facility.

Source: 42 CFR § 435.1010 (Rev. 2006).

Rule 9.3: Inmate Eligibility.

A. Inmate status is interrupted when an individual is admitted as an inpatient to a medical institution.

B. An inmate may be eligible for Medicaid only while an inpatient in a medical facility (hospital, nursing facility, juvenile psychiatric facility or intermediate care facility).

C. When determining inmate eligibility, all groups of Medicaid coverage are considered, including children, pregnant women and aged, blind or disabled.

D. Inmates must meet all non-financial and financial eligibility factors of the program for which they are being considered.

E. If an inmate does not meet citizenship requirements, but qualifies for Emergency Service, the inmate is eligible for emergency inpatient services only.

Source: 42 CFR § 435.1009 (Rev. 2006).

Rule 9.4: Institutions.

A. An institution is an establishment that provides food, shelter and some treatment or services to four or more person unrelated to the proprietor.

Source: 42 CFR § 435.1010 (Rev. 2006).

Rule 9.5: Public Institutions.

A. A public institution is an institution which is the responsibility of a government unit or over which a governmental unit exercises administrative control including:

1. A penal institution or correctional facility is a facility under the control and jurisdiction of the governmental agency in charge of the penal system or a facility in which convicted criminals can be incarcerated, such as a hospital for the criminally insane. This includes

state prisons which operate their own hospitals; state mental hospitals and privately-owned prisons under contract to a correctional facility.

2. An institution for mental diseases (IMD) is a hospital, nursing facility or other institution of more than sixteen (16) beds which is primarily engaged for providing diagnosis and treatment or care, including medical attention, nursing and convalescent care and related services, to persons with mental diseases.

3. Intermediate Care Facility for the Mentally Retarded provides active treatment for individuals with mental retardation.

4. A VA nursing facility falls under the definition of a public institution.

Source: 42 CFR § 435.1010 (Rev. 2006).

Rule 9.6: Medical Institutions.

A. A medical institution is not considered a public institution. Residents may receive Medicaid benefits if otherwise eligible.

B. A medical institution is one that:

1. Is organized to provide medical care, including nursing and convalescence care;

2. Has the necessary professional personnel, equipment and facilities to manage the medical, nursing and other health needs of patients on a continuing basis in accordance with accepted standards;

3. Is authorized under state law to provide medical care; and

4. Is staffed by professional personnel who provide professional medical and nursing services.

Source: 42 CFR § 435.1010 (Rev. 2006).

Rule 9.7: Inmate Status.

A. An individual is an inmate if serving time for a criminal offense or is confined involuntarily in a state or federal prison, jail, detention facility or other penal facility.

B. An individual who voluntarily resides in a public institution is not considered an inmate.

C. Likewise, an individual who voluntarily resides in a public education or vocational training institution for purposes of securing education or vocational training or is voluntarily residing in a public institution for a temporary period while other living arrangements appropriate to meet his needs are being made is not considered an inmate.

D. There is no difference between juveniles and adults when applying this rule.

Source: 42 CFR § 435.1010 (Rev. 2006).

Rule 9.8: Individuals Ineligible for Medicaid Due to Inmate Status.

A. There are a variety of alternatives to traditional incarceration. An individual is considered an inmate of a penal institution as long a penal authorities remain responsible for providing (or arranging for provision of) food and shelter to the individual.

B. An individual is considered an inmate regardless of use of an alternative method of incarceration.

C. In addition, inmate status continues during period of authorized or unauthorized absence from the penal facility.

D. Inmate status is not terminated until the individual is paroled or otherwise unconditionally and permanently released.

E. Situations in which Medicaid is not available due inmate status:

1. Inmates who are sent to work on farms on a seasonal basis;

2. Inmates involuntarily residing at a wilderness or boot camp under governmental control; (If such a facility is privately owned and/or operated, residents may receive Medicaid, if they are otherwise eligible, based on home living arrangements.)

3. Individuals who are on home or work release for a temporary period of time or who have to report to the facility for incarceration at night or on weekends;

4. Individuals in correctional or holding facilities, who have been arrested or detained involuntarily and are awaiting trial and disposition of charges, or who are held under court order as material witnesses or juveniles;

5. Inmates involuntarily residing in half-way houses under governmental control;

6. Inmates receiving care on the premises of a prison, jail, detention center or other penal setting;

7. Inmates receiving outpatient care;

8. Escaped prisoners.

Source: 42 CFR 435.1009 (Rev. 2006).

Rule 9.9: Non-Inmate Status - Potentially Eligible for Medicaid.

A. Admittance as an inpatient in a hospital, nursing facility, juvenile psychiatric facility or intermediate care facility interrupts inmate status.

B. If otherwise eligible, the individual can be approved for Medicaid. This does not include medical facilities on the grounds of or under the control of a penal facility.

C. Situations in which Medicaid is potentially available if all factors of eligibility are otherwise met:

1. Infants living with the inmate in the public institution;

2. Paroled individuals; Individuals in violation of the terms of their parole remain potentially eligible for Medicaid even though SSI or Social Security Disability benefits have been terminated due to fugitive status.

   a) These individuals can qualify or continue to qualify for Medicaid unless or until they are under the direct control of the penal system, at which time, they fall under the "inmate" rule discussed previously.

3. Individuals on probation;

   a) Individuals in violation of the terms of their probation remain potentially eligible for Medicaid even though SSI Social Security Disability benefits have been terminated due to fugitive status. These individuals can qualify or continue to qualify for Medicaid unless or until they are under the direct control of the penal system, at which time, they fall under the "inmate" rule discussed previously.

4. Individuals on house arrest or home release when not required to report to the public institution for an overnight stay;

5. Individuals voluntarily living in a detention center, jail or penal facility after their case has been adjudicated and other living arrangements have been made;

6. Inmates who become inpatients at a medical facility, i.e., acute care hospital, nursing facility, juvenile psychiatric facility or intermediate care facility. The individuals may be approved for the period of their inpatient care, if otherwise eligible.

Source: 42 CFR 435.1009 (Rev. 2006).

Rule 9.10: Public Educational or Vocational Training Institutions.

A. Children attending these facilities to obtain an education or vocational training may receive Medicaid if they are eligible in their home living arrangement.

   1. Schools for the deaf or blind are examples of such facilities.

Source: 42 CFR 435.1009 (Rev. 2006).

Rule 9.11: Special Considerations.

A. The inmate cannot be considered a sole applicant until they have been separated from other household members for thirty (30) days. When determined Medicaid-eligible as a member of the community, the inmate is eligible for full Medicaid services.

B. The inmate can be considered as the sole member of the budget group for the month in which the thirty-first (31st) day falls. When determined eligible as an inmate and as the sole member of the budget group, the inmate is eligible only for inpatient services.

C. If the inmate is receiving Social Security Retirement, Disability or Survivors benefits, and convicted of a crime and confined to the correctional institution for more than thirty (30) continuous days, Social Security will suspend benefits. Similarly, Social Security must suspend benefits to individuals receiving Supplemental Security Income (SSI) payments when the person is incarcerated for at least one full calendar month.

1. These suspended payments are disregarded as income.

Source: Miss. Code Ann. § 43.13.121.1 (Rev. 2005).

Rule 9.12: End of Inmate Status.

A. Inmate status is not terminated until the individual is paroled, otherwise unconditionally and permanently released. Inmate status ends when the individual is no longer residing in a penal institution and is released from the penal system due to:

1. End of sentence;

2. Pardon;

3. Probation or parole;

   a) Parole is the conditional release of an offender from prison before he or she has served the full sentence of the court; thereby, allowing the offender to serve a portion of the sentence in the community under supervision.

   b) Parole differs from probation in that most probationers have never been in prison for a felony conviction. The sentencing judge in such cases orders probation instead of a prison term.

   c) Parole is distinguishable from the pardon process in that any convicted felon, including those that are not eligible for parole, may apply for pardon, restoration of citizenship rights or commutation (reduction) of sentence.

4. Unconditional release.

Source: 42 CFR 435.1009 (Rev. 2006).

Rule 9.13: Verification of Inmate Status.

A. Verification sources for inmate status may include:

1. State Department of Corrections
2. Local prison/mental health authorities;
3. Court documents;
4. Court clerk for court which sentenced the individual;
5. A representative of the prosecutor's or State's Attorney's office;
6. Discharge arrangements and agreements between the individual and the penal/judicial authority.

Source: Miss. Code Ann. § 43.13.121.1 (Rev. 2005).

Rule 9.14: Inmate Application Process.

A. The Mississippi Department of Corrections forwards the applications of inmates who have had inpatient treatment in a medical facility to the Division of Medicaid. Inmate applications are processed by state office staff.

Source: Miss. Code Ann. § 43.13.121.1 (Rev. 2005)

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 103
Resources

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Title 23: Division of Medicaid

Part 103: Resources

Part 103 Chapter 1: Introduction to Resources

Rule 1.1 Families, Children and CHIP Programs.

A. The Medicare Catastrophic Coverage Act of 1988, (P.L.100-360), added provision 1902(r)(2) to the Medicaid statute which allows the state to apply income and resource rules to certain Medicaid coverage groups that are more liberal than the most closely related cash assistance group.

B. For the FCC programs, the most closely related cash assistance group is the former Aid to Families with Dependent Children (AFDC) program. For the ABD programs, the most closely associated cash assistance group is the Supplemental Security Income (SSI) program.

C. Under 1902(r)(2) and other authorization, the FCC programs operate under liberalized resource policy and have no resource test for eligibility in any coverage group.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.2 Aged, Blind and Disabled Programs.

A. Medicaid uses the value of a person's resources as a factor in determining eligibility. It is generally expected that individuals or couples whose resources exceed the limit will use the excess to meet their needs before becoming eligible for Medicaid.

B. As a 1634 state, Mississippi is required to use SSI resource rules for ABD eligibility determinations. However, as indicated previously, the state is allowed to apply income and resource rules to certain ABD coverage groups that are more liberal than the SSI program. The Division of Medicaid requested and received approval to liberalize resource policies for some ABD coverage groups.

C. Some coverage groups are exempt from liberalization under 1902(r)(2) because they are considered "deemed" cash assistance groups. These coverage groups continue to follow SSI resource rules. The remainder of this section describes the treatment of resources in determining eligibility in the Aged, Blind and Disabled programs and discusses the use of strict SSI rules or liberalized resource policy, as applicable.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.3 General Resource Principles.

A. The following general principles about resources should be noted:

1. Not everything a person owns is a resource.

2. Not all resources count against the limit.

3. The Social Security Act and other Federal laws require certain types and amounts of resources to be excluded.

   a) If a resource is not specifically excluded, it is countable.

4. In certain situations, federal law requires other people to share financial responsibility for an individual or couple.

   a) In those situations, Medicaid considers the resources of the person(s) along with those actually belonging to the individual couple. If countable resources exceed the limit, an individual or couple is not eligible.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.4 Resource Limits.

A. Federal law establishes a limit on the value of resources an individual or couple may own and still be eligible for Medicaid.

B. Countable resources must not exceed the limit in effect for the applicable time period.

C. Beginning 07-01-2000 ongoing:

   1. The indivdual limit is $4,000; and

   2. The couple limit is $6,000.

      a) The increased limits above are applicable to most coverage groups subject to liberalized resource policies.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b).

Rule 1.5 SSI Resource Limits.

A. The individual/couple limits for groups subject to SSI resource limits remain $2,000/$3,000.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.6 Coverage Groups Subject to SSI Resource Limits.

A. SSI resource limits apply to the following coverage groups:

1. SSI Retro Determinations,
   a) Unless the client must be placed in a liberalized coverage group for the retroactive period.

2. Former SSI Recipient Coverage Groups, which include:

   a) Disabled Adult Child (DAC),

   b) Cost of Living (COL) and

   c) OBRA widows/widowers.

3. Disabled Child Living at Home (DCLH), and

4. Qualified Working Disabled Individuals (QWDI),

   a) QWDI is a reduced coverage group which has resource limits that are twice SSI limits.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.7 Coverage Groups Subject to Liberalized Resource Limits.

A. Liberalized resource limits apply to the following coverage groups:

1. Long Term Care coverage groups (LTC);

2. Home and Community Based Waiver groups (HCBS);

3. Poverty Level Aged and Disabled (PLAD);

   a) Program ended December 31, 2005.

4. Healthier Mississippi Waiver (HM);

5. Working Disabled (WD) and

6. Medicare Savings Programs (MSP)

   a) See discussion on these reduced coverage groups below.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.8 Reduced Coverage Groups.

A. The reduced coverage groups for non-institutional individuals have or had a resource limit that is twice the SSI-related resource limit.

1. Under liberalized policy, the Medicare Savings Programs (QMB, SLMB, and QI) have no assets test.

2. The individual/couple limit for QWDI remains twice the SSI-related resource limit or $4,000/$6,000.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.9 Resource Limits Applicable to Institutional Groups.

A. For Medicaid coverage groups considered to be "institutional" coverage groups, the following set of resource limits apply:

1. Effective 10-01-1989, Spousal Impoverishment resource rules apply to married couples whereby one spouse is in a medical facility while the other spouse remains at home.

2. The Community Spouse is allowed a higher resource limit set by federal law and subject to increase each year.

3. Effective 04-01-1993 until the coverage group ended 04-30-2005, Spousal Impoverish rules applied to Hospice Coverage group.

4. Effective 01-01-1994, Spousal Impoverishment resource rules began to be applied to the HCBS Waiver programs.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.10 Liberalized Resource Policy Overview.

A. The following briefly describes the liberalized resource policies currently in effect. The liberalizations are described in greater detail in the discussion of each resource type:

1. Spend down of resources within a month to become eligible in that month, i.e., eligibility may be established effective the first day of the month if countable resources fall below the applicable limit within the month.

2. Excess resources earmarked for payment of private pay in a nursing facility in month(s) prior to Medicaid eligibility are not considered countable resources.

3. Income that accumulates pending Medicaid approval that results in excess resources can be excluded if this income is obligated for Medicaid income purposes.

4. Certain property and types of ownership are totally excluded, regardless of value:

a) Home property located in Mississippi, life estate and remainder interests in any property, 16th Section land leaseholds, mineral rights or timber rights that are not under production and housing on government-owned land are excluded under liberalized policy,

b) Income producing property is excluded if it produces at least six percent (6%) of the equity value of the property,

c) Promissory notes, loans and property agreements are excluded if the note produces a net annual return of six percent (6%) of the principal balance,

d) Up to two (2) automobiles may be excluded,

e) Household goods are totally excluded and personal property up to five thousand dollars ($5,000.00) in equity value is excluded,

f) The cash value of whole life insurance is excluded if the combined face value of all life insurance policies on any one individual is ten thousand dollars ($10,000.00) or less,

g) Burial spaces for family members are excluded as resources, and

h) Burial funds set aside in a revocable arrangement are subject to a six thousand dollar ($6,000.00) limit effective April 1, 2001.

5. The current market value of real property is established using the county tax assessed true value as shown or calculated using the appropriate county property tax assessment notice.

Source: 42 U.S.C. § 1396a; 42 C.F.R. § 435.601.

History: Revised to correspond to SPA 16-0009 (eff. 01/01/2016) eff. 01/01/2017.

Rule 1.11 SSI Resource Policy Overview.

A. SSI policy specifies different exclusion limits or different ways to determine countable resources. If the resource policy has not been liberalized, SSI policy is applicable unless a subsequently issued federal statue or Medicaid regulation supersedes SSI policy.

B. SSI policies include:

1. Eligibility is based on the individual's countable resources as of the first moment of the first day of the month and is applicable to the entire month.

a) If resources exceed the limit as of the first moment of the first day of the month, the individual or couple is not eligible for that month.

b) It is not possible to "spenddown" resources within a month to establish eligibility for that month under SSI resource policy.

2. One automobile is automatically excluded regardless of value.

3. The value of life estates and remainder interest in real property is a countable resource.

4. The cash value of whole life insurance is excluded, if the combined face value of all policies on any individual is $1,500 or less.

   a) The combined face value of these excluded policies is used as an offset in determining burial fund exclusion.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.12 First of the Month Rule for Making Resource Determinations.

A. In the programs using SSI policy, resource determinations are made as of the first moment of a calendar month.

B. Any increase or decrease in the value of resources during a month is considered as of the first moment of the month following the month the change occurred.

   1. Example; Tom Lee applies for assistance on March 30th. His only resource is 20 shares of XYZ stock that are worth $800.00 on the date he applied. On April 30th, the value increased to $1,000.00. His countable resource amount for April is $800.00. The countable value for May is $1,000.00.

   2. Example; Rhonda Mooney applies for assistance on April 5th. On April 1st, her resources were $500 in checking and $700 in savings. On April 5th, her son gave her money and she purchases a CD worth $1,800. Her savings balance increased to $750 on April 30th, but her checking balance dropped to $350. For April, countable resources are $1,200 ($500 + $700). For May, they are $2,900 ($1,800 + $750 + $350). The CD is not considered until May since it was acquired in the middle of the month.

C. Do not consider as a resource any advance dated checks or advance posted direct deposit checks received prior to the month of normal receipt. If retained, funds from such checks will be considered a resource as of the first moment of the first day of the month following the month in which the check is normally paid.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.13 Resource Definitions.

A. Resources (General Definition): All assets, including real and personal property which an individual or couple:

   1. Owns;

2. Can apply toward basic needs of food, clothing and shelter, either directly or by conversion to cash, (if not already cash); and

3. Are not legally restricted from use for support or maintenance.

    a) Examples of resources include, but are not limited to:

        1) Home,

        2) Land,

        3) Bank Accounts,

        4) Burial Assets,

        5) Life Insurance,

        6) Automobiles, and

        7) Investments.

B. Liquid Resources:

1. Cash or items that are readily converted to cash (within 20 workdays).

2. Liquidity or nonliquidity of a resource has no effect on a resource's countability.

3. Absent evidence to the contrary, assume the following types of resources to be liquid:

    a) Stocks, bonds and mutual fund shares;

    b) Checking and savings accounts, time deposits, CDs;

    c) US Savings Bonds, treasury bills;

    d) Mortgages and promissory notes;

    e) This is not an all-inclusive list of liquid resources.

C. Non-liquid Resources:

1. Are not cash and are not readily convertible to cash;

2. Liquidity or non-liquidity of a resource has no effect on a resource's countability; and

3. Absent evidence to the contrary, assume the following resources to be non-liquid:

    a) Buildings, land and other real property rights,

    b) Vehicles,

    c) Farm machinery and livestock,

    d) Household goods and personal effects, and

    e) Non-cash business property.

    f) This is not an all-inclusive list of non-liquid resources.

D. Real Property:

1. Land, including buildings or immovable object attached permanently to the land.

E. Personal Property:

1. Any property that is not real property.

2. Personal property includes such items as:

    a) Cash,

    b) Jewelry,

    c) Household goods,

    d) Tools,

    e) Life insurance policies, and

    f) Automobiles

F. Exclusion:

1. A resource, or part of a resource's value, that is not considered in the eligibility determination.

G. Countable Resources:

1. Resources remaining after all exclusions are applied.

2. The value of a resource is the amount of an individual's or couple's equity in it. The current market value and debt on a resource must be verified to determine the equity value.

H. Current Market Value (CMV):

1. The amount a resource can reasonably be expected to sell for on the open market in the particular geographical area involved or the sale price, if sold for a higher amount.

I. Equity Value:

1. The current market value (CMV) minus any encumbrance (payoff amount), i.e., a piece of property has a CMV of $35,000. The mortgage payoff is $20,000. The equity value is $15,000.

J. Encumbrance:

1. An encumbrance is a legally binding debt against a specific property.

2. The debt reduces the value of the encumbered property, but does not prevent the owner from transferring ownership (selling) to a third party.

   a) However, if the owner does sell it, the creditor will nearly always require payment from the proceeds of a sale.

K. Conserved Funds:

1. Funds or property being held for an individual by another person, such as a daughter has $30,000 in a bank in her name but it is verified to be her parent's money and is used for their needs.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.14 Income vs Resources.

A. It is important to distinguish between resources and income to know which counting rules to use for any given month. The same item is not evaluated under two sets of counting rules for the same month; that is, one item cannot be counted as both income and a resource in the same month:

B. Income Counting Rules. Items received in cash or in-kind during a month are evaluated under the income rules.

C. Resource Counting Rules. Items retained for use in the month following the month of receipt are subject to evaluation under resource rules, as are all other items not defined as income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.15 Distinguishing Resources from Income.

A. If an individual sells, exchanges, or replaces a resource, what he receives in return is not income; rather, it is a different form of resource.

B. In order to distinguish resources from income, a determination must be on what has occurred and the monetary gain.

C. The monetary gain would be considered a resource when it:

   1. Was an increase in value of an existing resource;

   2. Was for the receipt or replacement of a resource;

   3. Was from the conversion or sale of a resource; or

   4. Was a cash or in-kind item for the replacement or repair of an excluded resource which is lost, damaged or stolen. (This is discussed further later in this chapter.)

D. Dividends and interest are defined as returns on investments, stocks, bonds, and savings accounts, etc. Refer to the income section for handling.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.16 Converted Resources.

A. If an individual sells, exchanges or replaces a resource, what he receives in return is a resource that has been converted from one type of resource to another.

B. Examples of converted resources are:

   1. A lot with equity value of $5,000.00 is sold and the money is deposited into a money market account.

   2. A life insurance policy is cashed in and the proceeds are used to purchase a pre-need burial contract.

C. Handling Changes in a Converted Resource. When a resource changes form, it may also change:

   1. From an excluded resource to a countable one,

   2. From a countable resource to an excluded one or

3. To something that is not considered a resource for Medicaid purposes.

    a) Example: An excluded vehicle is sold and proceeds are deposited into a checking account. The money received is a countable resource, rather than income.

    b) Example: A life insurance policy with a face value of $15,000.00 and a countable cash surrender value of $1,000.00 is cashed in and the proceeds are used to purchase a cemetery plot which is excluded in the resource determination.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.17 Evaluation of Receipt of Property as Income.

A. When an individual first receives property (as a gift or inheritance, for instance, and not as a purchase or trade of one resource for another), the new property is subject to evaluation under the income rules for the month of receipt and under resource rules thereafter.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.18 Factors That Make Property a Resource.

A. Property of any kind, including cash, is a resource only if it meets all three criteria listed below by resource criteria and description:

    1. Ownership Interest.

        a) An individual must have some form of ownership in property in order for the property to be considered a resource. The fact that an individual has access to property, or has a legal right to use it, does not make it a resource if there is no ownership interest.

    2. Legal Right to Access (spend or convert) Property.

        a) An individual must have a legal right to access property. Even with ownership interest, property cannot be a resource if the owner lacks the legal ability to access funds to spend or convert non-cash property into cash. The fact that an owner does not have physical possession of property does not mean it is not his resource. It is a resource if the owner still has the legal ability to spend it or convert it into cash. An individual has free access to, and unrestricted use of, property even when he can take actions only through an agent (such as a representative payee or conservator).

    3. Legal Ability to Use for Personal Support and Maintenance.

        a) Even with ownership interest and legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not a resource.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.19 Access to Resources.

A. Unless an individual has been declared legally incompetent, he is assumed capable of managing his own affairs and his resources are considered. Competency does not affect consideration of resources.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.20 Individuals Declared Legally Incompetent.

A. The following is applicable to individuals who have been declared legally incompetent:

    1. Court Appointed Guardian or Conservator or Conservator. If the court has appointed a guardian or conservator, resources owned by the individual are considered available.

        a) Seeking court approval is not a legal restriction to the sale or disposal of the property and does not change the property's status as a countable resource to the individual.

B. No Court Appointed Guardian. If the court has not yet appointed a guardian or conservator, resources owned by the individual are not considered available.

    1. The individual does not have access to the resource until a guardian or conservator has been appointed.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.21 Types of Access.

A. Resources are accessible through an agent, litigation or a petition-conservatorship account under SSI and liberalized resource policy:

    1. Access Via an Agent. An individual is considered to have free access to, and unrestricted use of, property even when he can take those actions only through an agent, such as a representative payee or guardian.

        a) Example: Joan Shoto receives Social Security. Her mother, Laura Shoto, is her representative payee and has Power of Attorney. The bank account is a countable resource to Joan because she has unlimited access through her mother.

    2. Access Only Via Litigation. If there is a legal restriction, or a bar, to the sale or use of property, uch as a co-owner legally blocks the sale of jointly-owned property, an individual is not equired to undertake litigation to accomplish the sale or access. The

property is not a resource under such circumstances in a month if a legal bar exists any time in the month.

a) Example: Shelley Lumpkin and her sister, Susan Smith, co-own a piece of property they inherited from their parents. Last year Susan took legal action to prevent Shelley from selling. Shelley is not required to enter into litigation to gain the ability to sell, so the property is not a resource to her.

3. Access Via Petition. Petitioning a court is different from undertaking litigation, and:

a) Seeking court approval is not a legal restriction against use.

b) Although the individual does not have access to the asset, the conservator does. Therefore, it is available for the individual's support and maintenance and is, therefore, that individual's resource. This is true despite the fact that the individual or his agent is required to petition the court to withdraw funds for the individual's support and maintenance.

c) The conservator will be allowed a period of time to petition the court. Once the conservator has verified a petition has been filed with the court, the regional office will follow-up to determine the outcome.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.22 Assets vs Resources.

A. Not everything a person owns (assets) are resources for Medicaid purposes. As previously indicated, a resource is cash or other real or personal property that an individual (or spouse, if any):

1. Owns,

2. Has the right, authority or power to convert to cash, (if not already cash),

3. Is not legally restricted from using for his support or maintenance.

B. In certain situations, an asset that is not a resource may become one at a later date or vice versa. The distinction is important since:

1. An asset that is not a resource does not count against the resource limit (while a resource may count); and

2. Proceeds from the sale or trade of a resource, i.e., the amount representing conversion of principal from one form to another, are also resources; however,

3. What a person receives from a non-resource is subject to evaluation as income at the time of receipt. For example, an individual is the beneficiary of a trust which is not his resource; therefore, when the trust pays him his monthly allowance, he receives income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.23 Resources With Zero Value.

A. Property does not cease to be a resource simply because it has no current market value. Even though there is no value to count, the property remains a resource for as long as it meets the definition of a resource. If the property develops market value at a later time, this will be an increase in the value of a resource rather than receipt of income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.24 Property That Is Not a Resource.

A. Any property (asset) that does not meet the above definition of a resource is not a resource, e.g., an individual who has an ownership interest in property, but is not legally able to transfer that interest to anyone else does not have a resource.

B. Example: An individual owns a block of stock with his brother. Although the form of ownership is one which would permit either to sell the property without the other's consent, the brothers have a legally binding agreement that one will not sell without consent of the other. The individual's brother refuses his consent, making the stock a non-resource for the individual. If the brother subsequently agrees to sell, the stock would be evaluated under resource-counting rules beginning with the month following the month of consent. The value of the stock would not be counted as income to the individual in the month consent is given.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.25 Unknown Assets.

A. An individual may be unaware of his ownership of an asset. If this is the case, the asset is not a resource for the period during which the individual is unaware of his ownership.

B. Once the asset is discovered by the individual, the value, including any monies accumulated on it through the month of discovery, must be treated as follows:

1. Month of discovery. The value of the unknown asset, including any monies (such as interest) that have accumulated on it through the month of discovery, is evaluated under regular income-counting rules.

2. Months after month of discovery. For months after the month of discovery, the previously unknown asset is a resource and subject to usual resource counting rules.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.26 Valuation of Resources.

A. The value of a resource is the amount of an individual's or couple's equity in it. As indicated in the definitions section, the equity value (EV) of a resource is its current market value (CMV) less any encumbrance(s). The pay-off amount for each encumbrance on the property is used in the calculation of its equity value.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 1.27 Whose Resources to Count.

A. When eligibility is determined or re-determined, the resources of the following must be considered**:**

    1. Applicant/recipient; and

    2. Spouse of the applicant/recipient;

        a) If the spouse is included in the household;

        b) Even if the spouse is not applying or is ineligible;

        c) An exception exists for institutionalized individuals.

    3. Parent(s) of an applicant/recipient who is a child under age 18 living in the same household.

        a) There is no deeming of parental resources to the eligible child in the Disabled Child Living at Home group or in any institutional group for the month of entry.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Part 103 Chapter 2: Ownership Interest

Rule 2.1 Significance of Ownership.

A. Since the type and form of ownership may affect the value of real or personal property and even its status as a resource, ownership interests are significant in determining resource eligibility.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.2 Sole Ownership.

A. Only one person owns the property (real or personal) and may sell, transfer or dispose of the property. However, sole ownership may be subject to conditions imposed by others, such as sole ownership of a remainder interest in property.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.3 Shared Ownership.

A. Two or more people own the property (real or personal) together. The different types of shared ownership are discussed below.

1. Tenancy in Common.

   a) Two or more people have an undivided fractional interest in the whole property for the duration of the tenancy. These interests are not necessarily equal, i.e., two joint tenants do not necessarily each owns half of the property.

   b) One owner may dispose of his share without permission of the other owner(s), but cannot take these actions with respect to the entire property.

   c) When one owner dies, his interest passes to his heirs or estate.

   d) There is no automatic right to survivorship for the surviving tenants-in-common.

   e) Example, Don, Charles and Fred Evans own property as tenants-in-common. Charles and Fred each own an undivided ¼ interest while Don owns the remaining ½ interest. If Don Evans were to sell his ½ interest to Stan Long, Mr. Long would be a tenant-in-common with Charles and Fred. If Mr. Long were then were then to die so that property passed to his 4 children, each of them would own 1/8 interest as tenants-in–common with Charles and Fred, who would each continue to own ¼ interest.

2. Joint Tenancy

   a) Each person has an undivided ownership interest and possession of the whole property for the duration of the tenancy. In effect, each owns all of the property.

   b) Right to survivorship applies to the other owner(s).Upon the death of one of only two joint tenants, the survivor becomes the sole owner. On the death of one of three or more joint tenants, the survivors become joint tenants of the entire interest.

3. Tenancy by the Entirety.

   a) Exists only with married couples.
   b) While married, the wife and husband own the property as a unit and the property can only be disposed of if both give consent;

c) If divorced, the former spouses become tenants-in-common and each can sell his/her share without the other's consent.

d) Right to survivorship applies upon the death of one tenant by the entirety, the survivor takes the whole.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.4 Fee Simple Ownership.

A. Relates only to real property;

B. Means absolute and unqualified legal title to real property;

C. Fee simple ownership is completely free of conditions imposed by others.

D. The owner has the unconditional power of disposition during his lifetime.

E. Upon the owner's death, property held in fee simple can always pass to the owner's heirs.

F. May exist with respect to property owned jointly or solely.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.5 Less Than Fee Simple Ownership.

A. Equitable Ownership.

1. Exists without legal title to property;

2. Legal title may belong to another or to no one;

3. Examples of equitable ownership include ownership in unprobated estates or trust property.

a) Unprobated Estate. An individual may have an equitable ownership in an unprobated estate if he is an heir or relative of the deceased, receives income from the property or acquires rights through intestacy laws. Under liberalized policy, estates in process of probation are excluded. Under SSI resource policy an unprobated estate becomes a resource the month following the month it meets the definition of income.

b) Trust Property. A trust is a right of property, established by a trustor or grantor. A Trustee holds legal title and manages the property for the benefit of a beneficiary. The beneficiary does not have legal title, but does have an equitable ownership interest. Clearance procedures must be followed in determining how the trust affects eligibility

B. Life Estate Interest.

1. Individual has certain property rights during his life or someone else's life.

2. May be conditional See instructions below for handling a conditional life estate.

3. Legal document is required (such as will or deed).

4. Unless the legal document restricts rights, the life estate owner has the right to possess, use, and obtain profits from the property (such as rents).

5. Life estate interest can be sold.

6. Life estates do not descend to heirs.

7. Example: Mr. Heath, now deceased, willed his daughter a life estate in property which he owned fee simple. The will also designated Mr. Heath's two sons as remaindermen. The daughter has the right to live on the property until her death at which time, under the terms of her father's will, the property will pass to her brothers as joint tenants.

8. If there are joint owners of a life estate, the CMV is divided by the number of owners to determine an individual's share.

9. When one joint owner of the life estate dies, the surviving owner(s) increases their interest. If a couple has a life estate and one spouse dies, the remaining spouse is the sole owner of the life estate. When the remaining spouse dies, the person holding the remainder interest then has the right to possess and use the property.

10. It is possible to have a life estate interest in a structure (house) and not surrounding land. The CMV of the structure or whatever the tenant has the right to use as established by the deed or a will would be determined.

11. Under liberalized policy, a life estate is an excluded resource. The exclusion is not limited to property located in Mississippi. In addition, if the individual has a life estate interest in more than one piece of property, all are excluded**.** However, there are some exceptions to excluding a life estate:

    a) If a life estate is transferred or sold, eligibility for vendor payment or HCBS waiver services may be affected. A transfer of a life estate is sanctionable.

        1) When the value of a life estate interest needs to be determined for a potential transfer, follow the procedures below, using the age of the individual as of their last birthday at the time of the transfer. Verify the Current Market Value (CMV) of the property. Use the Unisex Life Estate and Remainder Interest Table for the following steps:

(a) Find the age of life estate owner as of their last birthday at the time of the transfer.

(b) Locate the factor in the Life Estate column that corresponds to the age.

(c) Multiply the CMV of the property by the life estate factor to obtain the value of the life estate. (CMV of the property X Life Estate Factor = CMV of the life estate).

(i) Example: Jane Ayers took a life estate in her home in 1988. Now at age 97, she is applying for nursing home care. It is discovered she transferred her life estate interest to her son two years ago. Her age as of her last birthday at the time of the transfer was 95 and at that time the property had a CMV of $250,000. The uncompensated value is determined as follows:

$250,000 (CMV) x .22887 (Life Estate Factor for Age 95) = $52,217.50 (Uncompensated Value).

12. Conditional Life Estate.

a) A conditional clause establishes limitations on the life estate. For example, the grantor may reserve a life estate for as long as the grantor lives and maintains a home on the property.

b) For deeds dated on or after February 8, 2006, consider the entire property transferred if the deed contains a conditional life estate clause. The transfer date will be the date of the deed.

c) The life estate can be corrected if a revised deed is prepared removing the conditional clause with the grantor reserving a life estate without limitations. However, the transfer of the remainder interest, if it occurred within the 5-year look back period, must be considered if the grantor enters long term care. Therefore, removing the conditional life estate clause may only shorten the transfer period.

13. Under the DRA the purchase of a life estate in another individual's home on or after February 8, 2006, is a transfer of assets unless the purchaser resides in the home for at least 12 consecutive months after the date of purchase.

a) Do not deduct vacations, overnight visits, and hospital stays from the one-year period as long as the home continued to be the individual's legal residence. Count the entire purchase price as an uncompensated transfer if the purchaser resides in the home for any period less than one year.

b) Also the DRA provides that even if the life estate purchaser lives in the home for 12 consecutive months, the purchaser must not pay more than CMV for the life estate.

Any amount paid above CMV is considered a transfer and should be penalized according to the transfer policy. Verify the purchase price and calculate the CMV of the life estate. Any amount paid over the CMV of the life estate is considered a transfer

14. Under strict SSI policy, the value of a life estate is a countable resource unless an exclusion exists.

    a) Verify the Current Market Value (CMV) of the property.

    b) Use the Unisex Life Estate and Remainder Interest Table for the following steps:

        1) Find the age of life estate owner as of their last birthday.

        2) Locate the factor in the Life Estate column that corresponds to the age.

        3) Multiply the CMV of the property by the life estate factor to obtain the value of the life estate. (CMV of the property X Life Estate Factor = CMV of the life estate)

    c) If there is joint ownership of a life estate, first determine the CMV of the entire property. Divide the CMV by the sharer of joint owners to determine the individual's share and then calculate the individual's life estate value as described above.

        1) Example. 75 year-old Harry Thomas has a life estate in non-homestead property with a current market value of $80,000. An exclusion for the property cannot be developed. Using the table, his life estate interest is valued as follows:
        $80,000 (CMV) x .52149 (factor for age 75) = $41,719.20 (value of the life estate)

        2) Example. 75 year-old Max Berry is living with his daughter due to illness, but states he intends to return home when health permits. Ten years ago, he transferred his home to his children retaining a life estate interest. An exclusion can be developed for the home property since his desire is to be able to return home.

C. Ownership by Will or Descent.

1. An individual may have ownership interest in an unprobated estate acquired through a will or through the death of a relative who died intestate (without a will). The heir(s) may be the sole owner or joint or common owners, etc.

2. Heirs by Will.

    a) Have ownership or control of the property or their joint or common share.

b) If the will has not been filed with the proper court and has not been probated, there is question of whether the will is legally binding. Legally, wills are supposed to be filed for probate; however, there is no time limit.

c) Absent evidence to the contrary, assume the client owns the property in proportion, whereby he has the right to the will's directives.

3. Heirs by Descent.

a) Acquire ownership interest to property by virtue of the heir's relationship to the deceased. Intestate property of a deceased person with a spouse and children is shared equally by the surviving spouse and children. Grandchildren become involved in ownership interest only when their parent, who was a child of the original owner, is deceased. The grandchildren's interest is only in the share that their deceased parent held in interest.

b) Intestate property of an individual with no spouse or children at the time of death descends equally to his parents and brothers and sisters. If the deceased's parents are also deceased, the property descends to his brothers and sisters. Nieces and nephews become involved only if their parent who was a brother or sister to the deceased is also deceased. Their ownership interest is only in the share that their deceased parent held an interest in.

c) Absent evidence to the contrary assume an heir inherited property based on their laws of descent where the property is located.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.6 Property Rights With No Ownership.

A. Leasehold.

1. Does not designate rights of ownership, but conveys an individual control of the property so that he has use and possession for a specific period of time and usually for a specified rent, such as 16th section land leases.

a) 16th Section Land. 16th section land or land acquired in lieu of 16th section land is land controlled by the State Board of Education under the general supervision of the State Land Commissioner. Generally each county Board of Supervisors has the authority to approve or renew leases on the land. An individual who leases such land does not own the property and has limited rights. The value of the lease decreases as the expiration date nears. Lease rights to 16th section or lieu lands are negotiable. These rights may be sold to another person provided the governing authority which approves such leases is agreeable to such a sale.

B. Incorporeal Interests.

1. No ownership of the physical property;

2. The owner has certain rights to use the property without the right to dispose of property;

3. Applies to mineral rights, timber rights and easements, which may be sold by the owner.

   a) Mineral Rights. Ownership in natural resources, usually obtained from the ground, such as coal, oil, sulphur, sand or natural gas, etc., coming from the property.

   b) Timber Rights. These rights permit one party to cut and remove trees from property owned by another, as designated by a contract with the owner of the land on which the timber stands.

   c) Easements. Property right whereby one has the right to use the land of another person for a special purpose.

C. Valuation of leaseholds and incorporeal interests.

1. They may be countable resources under both SSI and liberalized resource policy if they have a cash value available to the individual upon disposition.

2. However, in some cases these property rights are not saleable and would not be a countable resource:

   a) An individual may own an easement to pass through another person's property to get to his own property. There would be little or no market for the sale of this property right.

   b) Timber rights to land which has been stripped of its trees or mineral rights to land with no viable natural resources would have little or no market value.

3. To verify the value of property ownerships such as mineral rights or timber rights, determine the CMV from a knowledgeable source. If the property right is under production, it is necessary to obtain a copy of the land lease to determine if the lease is transferrable in order to determine if the property right is a countable resource.

4. Under liberalized policy, 16th Section land leases and mineral rights, timber rights and leaseholds that are not under production are excluded in the resource determination regardless of value. If one of these types of ownership is income-producing, net annual return is tested against the 6% income-producing rule when applicable.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.7 Other Rights to Use of Real Property.

A. Homestead Rights

1. Under state law a surviving spouse (widow or widower) is entitled to the homestead on the real property used as the home at the time of the death of the spouse and to receive income from it for his lifetime. This is not a life estate interest in the property, but is quite similar.This situation occurs when spouses jointly or commonly own property without the right of survivorship clause in the property.The surviving spouse has homestead rights to the portion of the property that belonged to the deceased spouse. The surviving spouse would also own his/her own interest in the property. A homestead right does not have value and cannot be sold.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.8 Evidence of Real Property Ownership.

A. Property ownership must be verified. Obtain a copy of the official document used to verify ownership and file it in the case record. The following official records may be used to establish real property ownership:

1. Current Deed. If the client does not have a copy of the current deed, a copy may be obtained from records in the Chancery Clerk's office in the county where the property is located. Any discrepancies which exist between a deed and a tax receipt must be resolved in order to determine the true ownership situation. A deed must be recorded in the appropriate county office to be considered a true deed documenting ownership.

2. Tax Assessment Notice or Most Recent Tax Receipt. Tax records and receipts describe the property. Phrases such as "Et al" and "Et ux" beside the name on a tax receipt indicate joint or common ownership in some form. Current Mortgage Statement. Mortgages are recorded in the Chancery Clerk's office; however, the name of the mortgage holder must be known. Report of Title Search Wills, Court Records or Relationship Document.- Which show rights of an heir to the property after death of the former owner.

Source: Miss. Code Ann. 43-13-121.1 (Rev. 2005).

Rule 2.9 Verifying Current Market Value (CMV).

A. Once ownership or ownership interest in property has been verified, the current market value (CMV) of the client's ownership interest is determined based on the coverage group of the applicant or beneficiary and whether Supplemental Security Income (SSI) or liberalized resource policy is applicable.

B. Under liberalized resource policy, the CMV is established using the most recent county property tax assessment notice unless a tax assessment for a prior time period is needed, such as to establish CMV when a transfer of assets occurred.

1. The true value of the property as shown on the county property tax assessment notice is

used to establish CMV. If the true value is not shown, the property tax assessed true value is calculated as follows:

a) A tax assessed value divided by the county tax assessment ratio is the CMV based on the assessment. Class 1 property is home property and Class 2 property is non-home property. Class 2 property may adjoin home property and therefore be included in the definition of home property.

b) Property in Mississippi is assessed at ten percent (10%) for Class 1 (home) property and fifteen percent (15%) for Class 2 (non-home) property.

c) The assessed value divided by the applicable assessment ratio is used to arrive at the true value of property. For example, Class 1 (home) property has an assessed value of five thousand dollars ($5,000.00). Divide five thousand dollars ($5,000.00) by ten percent (10%). The true value is fifty thousand dollars ($50,000.00) based on the county tax assessment.

2. If the individual disagrees with the true value as shown on the appropriate county property tax assessment notice or calculated using the county property tax assessed value, the individual must obtain a knowledgeable source estimate to establish CMV as required under SSI policy.

C. SSI Policy requires obtaining a knowledgeable source estimate to establish the CMV of real property. Knowledgeable sources include, but are not limited to:

1. Real estate brokers,

2. Local office of the Farmer's Home Administration (for rural land),

3. Local office of the Agricultural Stabilization and Conservation Service (for rural land),

4. Banks, savings and loan associations, mortgage companies and similar lending institutions, and

5. An official of the local property tax jurisdiction (must obtain an estimate rather than the office's assessment).

6. Licensed Mississippi real estate appraisers.

D. When CMV has an impact on eligibility and applicants or beneficiaries disagree with the CMV evidence submitted or obtained by the Medicaid specialist, a rebuttal determination must be made.

1. The rebuttal determination must take into account:

a) All the evidence previously in the file including, but not limited to, the individual's original allegation, any tax assessment notices and any estimates from knowledgeable sources,
b) Any additional evidence the individual wishes to submit including, but not limited to, evidence that the individual's ownership interest in the property is worth less than the CMV determined total value of the property divided by the number of owners, and

c) Any other facts about the property or about market conditions where it is located.

2. The rebuttal must be supported by a preponderance of the evidence which may require one (1) or more additional estimates from knowledgeable sources.

E. For both SSI and liberalized policy, the CMV less any legally binding debts against the property is the countable equity value for real property that cannot be excluded under any real property exclusion.

Source: Miss. Code Ann. § 43-13-121.

History: Revised to correspond to SPA 16-0009 (eff. 01/01/2016) eff. 01/01/2017.

Part 103 Chapter 3: Non-Countable Resources

Rule 3.1 Retirement Funds.

A. Retirement funds are annuities or work-related plans that are designed to provide income when employment ends. These funds can be held with a company or held privately at a bank or other financial institution. Listed below are some examples:

1. Pensions, disability, or retirement plans administered by an employer or union 401K;

2. Individual Retirement Account (IRA);

3. Keogh plans (plans for self-employed individuals); and

4. Some profit sharing plans

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 3.2 Treatment of Retirement Funds.

A. The terms IRA and Keogh refer only to the type of retirement account and do not identify the underlying investment vehicle for the account, which may be a bank account, Certificate of Deposit, mutual fund, etc.

1. If retirement benefits are being received out of such accounts, the principal is not considered a resource.

2. Otherwise, IRAs and Keogh accounts are developed according to the resource policy applicable to the underlying investment vehicle**.**

B. Retirement benefits are payments made at some regular interval (i.e., monthly) and result from entitlement to a retirement fund.

1. Periodic payments must be of uniform rate, principal and interest (principal must equal or exceed amount of interest) and are counted as unearned income.

C. If an individual owns a retirement fund, determine whether he is eligible for periodic payments.

1. If so, he must apply for those benefits under the utilization of other benefits provision. If he has a choice of periodic payments or a lump sum, he must take the retirement benefit payments.

D. If an individual owns a retirement fund and is not eligible for periodic payments, determine whether he can make a lump sum withdrawal.

1. If he can withdraw any of the retirement fund, the value of the fund is a resource in the month the funds become available for withdrawal.

E. The value of the retirement fund is the amount that can currently be withdrawn. If there is a penalty for early withdrawal, the fund's value is the amount available after the penalty is deducted. However, any taxes which may be due are not deductible in determining the fund's value.

F. A retirement fund is a resource when the individual has the option of withdrawing a lump sum, even if he is not eligible for periodic payments. When this is the case:

1. If the individual applies for periodic payments and is denied, the value of the fund becomes a countable resource the month after the month periodic payments are denied.

2. A delay in payment beyond the individual's control (e.g., an organization's processing time) does not mean the fund is not a resource since the individual is legally able to obtain the money.

G. A retirement fund is not a resource when a person must terminate employment to obtain payment or when a person is eligible for and receiving periodic payments.

H. Retirement funds owned by an ineligible spouse or parent are excluded from resources for deeming purposes.

I. A previously unavailable retirement fund is subject to resource rules in the month after the month the funds first become available.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 3.3 Loans, Promissory Notes & Property Agreements – General.

A. This section provides resource policies that primarily apply when the client or spouse is the creditor (lender or seller) and is, therefore, the owner of a loan agreement, promissory note or a property agreement. The principal amounts of these items are evaluated under appropriate SSI or liberalized resource policy.

B. Definitions.

1. Bona Fide Agreement. An agreement which is legally valid and made in good faith.

2. Negotiable Agreement. A type of agreement where legal title or the amount of the agreement can be transferred (sold) to another party.

   a) Generally, promissory notes, loan agreements and personal and real property agreements can be sold to a third party.

   b) An agreement may be assumed to be non-negotiable if there is a legal bar to its sale.

3. Loan. A transaction in which one party advances money to, or on behalf of another party, who promises to repay the lender in full, with or without interest.

   a) The loan agreement must be enforceable under state law and be in writing.

   b) A written loan agreement is a form of promissory note.

4. Informal Loan. With formal loans (e.g., commercial), there is rarely a question about whether the loan agreement is bona fide. An informal loan is a loan between individuals who are not in the business of lending money or providing credit. An informal loan must be written and is bona fide if:

   a) It is legally binding under state law;

   b) It was in effect at the time of the transaction (money given with no obligation to repay cannot become a loan at a later date) ;

   c) There is an acknowledgement of an obligation to repay, with or without interest, by the lender and the borrower;

   d) There is a plan or schedule for repayment and the borrower's express intent to repay by pledging real or anticipated future income; and

   e) The repayment plan is feasible.

5. Promissory Note. Written, unconditional agreement where one person promises to pay another party a specific amount at a specific time (or on demand). It can be repayment for goods, money loaned or services rendered.

6. Property Agreement. A piece of property is used to secure payment of a debt or performance of services within a specified period of time. Other names for property agreements include:

   a) Mortgages;

   b) Real estate or land contracts;

   c) Contracts for deed;

   d) Deeds of trust;

   e) Personal property agreements, e.g., pledges of crops, fixtures, inventory, etc., are known as chattel mortgages.

C. Property Agreements Prior to Settlement. A person holding a contract for sale of real estate (seller or creditor) owns two items until the settlement of the sale is completed:

   1. The real estate, which is not a resource since it cannot be sold while encumbered by the contract, and

   2. The value of the contractual agreement.

D. Determining the Value of a Contract. The status and value of a contract, i.e., loan agreement, promissory note or property agreement, must be evaluated to determine if it is a resource under appropriate SSI or liberalized resource policy.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 3.4 Treatment of Loans, Promissory Notes & Property Agreements (SSI).

A. SSI policy when the individual is the seller or creditor:

   1. Obtain a copy of the agreement and assume, absent evidence to the contrary, that the written agreement is bona fide and negotiable.

   2. A bona fide, negotiable agreement is a resource. The goods or money represented in the agreement are not a resource because they are not accessible.

   3. The debtor's payments against the principal are a conversion of a resource, not income.

   4. The interest portion received by the lender is unearned income.

5. If retained, principal and interest are counted as the lender's resource the month following the month of receipt.

    a) Example: Debtor pays $500 per month - $350 toward principal and $150 in interest. The $350 is a converted resource. The $150 is unearned income.

6. If including the original principal balance (the amount owed to the creditor when the agreement was established) causes ineligibility on resources, obtain verification of the outstanding principal balance, i.e., the balance in the month for which a determination is being made.

7. If including the outstanding principal balance causes ineligibility on resources use the outstanding principal balance in determining resources unless one of the following is submitted:

    a) Evidence of a legal bar to the sale of the agreement ; or

    b) An estimate from a knowledgeable source (in the business of making estimates, such as banks, other financial institutions, private investors, real estate brokers, etc.) showing that the CMV of the agreement is less than its outstanding principal balance.

        1) The estimate must show name, title, and address of the source.

8. For agreements determined to be Non-Bona Fide or Non-Negotiable:

    a) A non-bona fide or non-negotiable agreement is not a resource under SSI policy;

    b) The principal and interest paid to the lender are income, not a resource ; and

    c) The goods or money represented in the agreement may be a resource to the seller if the seller/creditor has access for his own use

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 3.5 Treatment of Loans, Promissory Notes and Property Agreements (Liberalized).

A. For the borrower under both SSI and liberalized resource policy, if the agreement is bona fide and negotiable:

    1. Cash paid by the lender to the borrower is not income;

    2. However, cash retained (or property received) may be a resource to the borrower the month following the month of receipt.

B. Liberalized policy when individual is the seller or creditor:

1. Obtain a copy of the agreemen and assume, absent evidence to the contrary, that the written agreement is bona fide and negotiable.

2. Determine if the bona fide, negotiable note or agreement produces at least 6% net annual return of the principal balance.

   a) Loans, promissory notes and property agreements can be excluded as a resource if the note, loan or agreement produces at least a 6% net annual return of the principal balance.

   b) The income must be received by the client/spouse and counted as income in order for the exclusion to apply.

   c) If the above criteria are not met, the note or agreement cannot be excluded as a resource.

C. Policy for institutionalized individuals in SSI or liberalized programs.

1. Even though the 6% rule is in effect and establishes a minimum acceptable payment when compared to the principal balance, the following conditions must also be met for a resource exclusion for all institutionalized individuals in either SSI or Liberalized programs:

   a) The repayment terms of the agreement must be actuarially sound;

   b) The payments must be of uniform rate, principal and interest, during the term of the agreement, with no deferred or balloon payments; and

   c) The agreement must prohibit cancellation of the debt upon the death of the lender.

   d) The institutional client or spouse must reasonably expect to receive full payoff of the note or loan during his/her lifetime. As with annuities, the average number of years of life expectancy remaining based on the Annuity Life Expectancy Charts must coincide with the payout of the promissory note or loan.

D. Agreements which do not meet requirements.

1. For non-institutional cases assessed under liberalized resource policy, a non-bona fide or non-negotiable agreement is not a resource. Principal and interest payments are income to the seller/creditor. The goods or money represented in the agreement may be a resource if the seller/creditor has access for his own use.

2. For institutional cases, funds used to purchase promissory notes, loans or mortgages that do not meet the 6% rule, are not actuarially sound or are not bona fide or negotiable will be considered a transfer of assets valued as the entire outstanding balance due as of the date of the application for long term care for contracts dated on or after February 8, 2006.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 3.6 Inheritances and Unprobated Estates.

A. Unprobated Estates.

1. Under SSI resource policy, an ownership interest in an unprobated state may be a resource if an individual:

   a) Is an heir of the deceased; or

   b) Receives income from the property; or

   c) Under state intestacy laws has acquired rights in the property due to the death of the deceased.

2. An ownership interest in an unprobated estate exists if:

   a) Documents such as a will or court records indicate an individual is an heir; or

   b) An individual has the use of, or income from, a deceased person's property; or

   c) Documents verify, or the individual alleges, a relationship to the deceased that awards him a share under the state's intestacy laws; or

   d) The inheritance, use of income and distributions are not contested.

3. Under liberalized policy, estates in the process of probation are excluded from the resource determination.

B. Inheritances.

1. An inheritance is cash, a right, or a noncash item(s), received as the result of a person's death.

2. Treatment under liberalized resource policy.

   a) An inheritance is not a resource until the month following the month it meets the definition of income i.e., it has a value and can be used, either directly or by sale or conversion to meet basic needs. Thereafter, if retained, the property is evaluated as a resource.

   b) If an applicant or recipient in a long term care program refuses or transfers an inheritance, the individual may be subject to penalty under the transfer of assets provisions.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 3.7 Real Property Exclusions.

A. Home Property Exclusion.

1. An individual's home is property he has ownership interest in and is his principal place of residence; and

2. It may include the shelter he lives in, the land on which the shelter is located, and all buildings on the land.

   a) A principal place of residence is the dwelling that an individual considers his/her principal home. It may be:

      1) Real or personal property;

      2) Fixed or mobile;

      3) Located on land or water.

   b) Example: If a person owns and resides in a houseboat on a lake, the boat may qualify as home property.

3. If a person owns land and intends to reside on it, it may be considered home property if there is no other principal place of residence. If a person owns the land, but not the shelter, the land is considered the residence.

   a) Example: A person owns the land he lives on, but lives in a mobile home owned by his parents. If a person owns the shelter, but not the land, the shelter is the residence.

   b) Example: A person owns the mobile home, but rents the lot on which it is located.

4. Applying the home exclusion.

   a) The home exclusion applies to:

      1) The shelter in which the individual lives;

      2) All buildings on the property;

      3) The land on which the shelter is located; and

      4) Any land adjoining it as long as it is not separated by land that neither the individual nor spouse has an ownership interest in.

(a) Easements and public rights of way (utility lines, roads, etc) do not separate other land from the home plot.

5. Home Out-Of-State.

a) If an applicant's home property is located out-of-state, policy governing state residency applies.

b) It is not permissible for the individual to intend to return to his principal place of residence out-of-state and at the same time intend to reside in Mississippi.

c) If the applicant intends to return home to another state, he cannot be considered a Mississippi resident for Medicaid eligibility purposes.

d) If the applicant intends to reside in Mississippi, home out-of-state cannot be excluded as his principal place of residence.

6. Treatment of Home Property Under SSI Resource Policy.

a) An individual's home, regardless of value, is an excluded resource if the individual:

1) Resides in the home; or

2) Is absent and intends to return to the home.

(a) An individual is residing with her children due to an illness, but intends to go home when health permits The intent is based on the person's desire to return home.

(b) If the individual leaves the home and does not intend to return home to it, it is no longer considered the person's principal place of residence.

(i) The home exclusion no longer applies as of the date the individual leaves with the intent not to return or the date the individual no longer intends to return.

(ii) The month after there is no intent to return, the property will be considered a countable resource unless another exclusion develops.

b) A home can be excluded without intent to return, if:

1) A spouse or dependent relative of an institutionalized individual continues to reside in the home while the individual is institutionalized;

(a) Dependency may be financial or medical;

(b) Relatives may include child, step-child, grandchild, parent, step-parent, grandparent, sibling, step-sibling, half sibling, aunt, uncle, cousin niece, nephew, in-laws;

2) Sale of the home would cause an undue hardship to a co-owner due to loss of housing.

(a) Obtain a statement from the dependent relative or the co-owner to apply either of the above exclusions.

c) Multiple Residences.

1) Only one residence can be excluded as home property.

2) If there are multiple residences, the principal place of residence must be determined, considering such points as how much time is spent at each residence; where the individual is registered to vote; and which address the individual uses for mail and tax purposes.

7. Treatment of Home Property Under Liberalized Resource Policy.

a) Home property can be excluded regardless of intent to return home or whether a dependent relative lives on the property.

b) Each client is allowed one home that can be excluded regardless of its use.

c) If more than one residence is owned, exclude the property that would be most advantageous to the client.

d) For long term care applications filed on or after January 1, 2006, there is a disqualification for individuals with equity interest in their home of greater than $500,000. This provision will not prevent an individual from using a reverse mortgage or home equity loan to reduce the total equity interest in the home.

1) This disqualification period means that the homeowner who is in long term care can qualify for all Medicaid services except vendor payment of nursing facility services as long as equity interest exceeds the $50,000. limit.

2) If Medicaid eligibility is dependent upon participation in the HCBS waiver, the individual is ineligible for full Medicaid services as long as equity in the home exceeds the limit; however, a Medicare Savings Program can be approved if criteria are met.

3) Undue hardship can be found to exist if a lien or legal impediment exists causing the individual to be unable to access the equity.

8. Reverse Mortgages.

a) A reverse mortgage is an agreement in which a lending company:

1) Makes a lump sum (subject to being counted as a resource the month following month of receipt);

2) Available line of credit (subject to being counted as a resource the month following month of receipt; or

3) Regular payments (treated as loan proceeds) to a homeowner during a specific period of time.

b) The amount of payment is determined by the amount of equity the homeowner has in the home.

c) The homeowner is allowed to remain in the home until his/her death. At that time, the home is sold and/or the lender is repaid.

d) Reverse mortgages are available to homeowners age 62 or older who own a debt-free or nearly debt-free home.

e) Funds received from a reverse mortgage in any form that are transferred, either in the month of receipt or subsequent months, are subject to a transfer penalty unless an allowable exception applies (such as spousal transfers).

B. Exclusion of Home Replacement Funds.

1. If an individual sells an excluded home, the proceeds may be an excluded resource if he:

a) Plans to buy another excluded home; and

b) Buys the home within 3 full calendar months following the month the proceeds are received.

C. Exclusion of Installment Sales Contracts.

1. If the proceeds from the sale of an excluded home are received under an installment sales contract, the contract is excluded if the individual:

a) Plans to use the entire down payment and the entire principal portion of a given installment payment to buy another excluded home; and

b) Purchases the new home within 3 full calendar months following the month the down payment or installment payment is received.

2. The proceeds of the sale include the following:

a) Lump sum. The net amount the seller receives at closing/settlement;

b) Installments. Down payment and principal portion of any installment payment.

3. Use of Proceeds. Use of the proceeds to buy another excluded home includes payment of any costs that stem from the purchase. These include, but are not limited to:

a) Down payment;

b) Closing/settlement costs;

c) Moving expenses;

d) Loan processing fees and points;

e) Necessary repairs and replacement of the new home's structures and fixtures costs, if identified and documented before the new home is occupied and stem directly from the purchase or occupancy of the new home.

1) This may include: roof, heating and cooling, plumbing, built-in appliances, etc.

f) Mortgage payments;

g) Use of proceeds to pay other costs will warrant their exclusion if such costs are identified and documented prior to occupancy and stem directly from the purchase or occupancy of the new home.

4. Proceeds Not Re-Invested in a Timely Manner.

a) If the home is not replaced within the allowable 3-month period, the unused proceeds are a countable resource retroactive to the month following the month of receipt as follows:

1) Lump sum. The exclusion of the unused funds is revoked retroactively to the date of receipt;

2) Installment contract. The exclusion of the contract itself and the unused portion of any installments received are revoked retroactively to the date the unused proceeds were received.

3) The exclusion of an installment contract, once revoked, will be reinstated if the individual intends to and does use the entire principal portion of a subsequent installment payment toward the purchase of another excluded home within 3 full calendar months of receiving such installment payment.

(a) The exclusion does not apply to that portion of the proceed of the sale of the original home that is in excess of the costs of the purchase and occupancy of the new home.

5. Exclusion of Jointly Owned Property Whose Sale Would Cause Undue Hardship.

a) The value of an individual's ownership interest in the jointly-owned property is an excluded resource for as long as the sale of the property would cause an undue hardship, due to loss of housing, to a co-owner.

b) Undue hardship would result if the co-owner:

1) Uses the property as his principal place of residence;

2) Would have to move if the property were sold;

3) Has no other readily available housing.

c) The exclusion ends when any one of the above conditions no longer exists.

1) Example: Mr. Allen and his son jointly own a piece of land. The son and his family live on the property and have no other place to live. Mr. Allen applies for Medicaid. The property is excluded because the sale would cause an undue hardship to his son. However, if the son owned another house nearby which was vacant and habitable, there would be other available housing. Under these circumstances, undue hardship would not exist and the value of Mr. Allen's interest would be countable.

E. Exclusion of Real Property Due to Reasonable Efforts to Sell.

1. Real property may be excluded from resources if the owner is making reasonable efforts to sell it and those efforts have been unsuccessful.

2. The individual must maintain their efforts to sell unless good cause, i.e., circumstances beyond the individual's control prevent his taking the required actions to accomplish reasonable efforts to sell, exists.

3. In addition, the individual must accept a reasonable offer for the property. The specific requirements listed below must be met in order for this exclusion to apply:

a) Reasonable Efforts To Sell.

1) Reasonable efforts to sell real property consist of taking all necessary steps to sell it through media serving the geographic area in which the property is located.

2) Reasonable efforts specifically mean that within 30 days of signing the Agreement to Sell Property, the owner(s) must:

(a) List the property with an agent; or

(b) Begin to advertise in at least one of the appropriate local media, place a "For Sale" signs on the property (if permitted),

(c) Begin to conduct open houses or otherwise show the property to interested parties on a continuing basis and attempt any other appropriate methods of sale; and

(d) Except for gaps of no more than 1 week, the owner must maintain efforts the type listed above; and

(e) The owner does not reject any reasonable offer to buy the property and accepts the burden of demonstrating to Medicaid's satisfaction that an offer was rejected because it was not reasonable.

b) Reasonable Offer To Buy.

1) Assume that an offer to buy the property at a particular price is reasonable if it is at least two-thirds of the estimated current market value (CMV), as evidenced by the tax receipt. If the owner disagrees with CMV as evidenced by the tax receipt, he must provide convincing evidence of a different CMV. Verification presented by the owner to support a CMV other than that evidenced by the tax receipt must be submitted to state office for review.

c) Good Cause.

1) Good cause exists when circumstances beyond an individual's control prevents the required action to accomplish reasonable efforts to sell. If good cause exists for failure to meet any of the criteria specified above, the exclusion can continue provided action is taken to resume efforts to sell.

2) Good cause includes:

(a) No offer to buy is received;

(b) A legitimate offer does not result in a sale;

(c) Escrow begins, but closing does not take place within the disposal period; and

(a) Incapacitating illness or injury, such as the individual becomes homebound or hospitalized for a prolonged period due to illness or injury and

cannot take steps necessary to sell the property or to arrange for someone to sell it on his behalf.

(b) Eample: Sandy Patterson is a Medicaid recipient whose property has been excluded due to a bona fide effort to sell. She accepted a reasonable offer for the property; however, the buyer backed out of the deal at closing. Ms. Patterson immediately started sales efforts again. Good cause exists**.**

d) Failure To Make Reasonable Efforts.

1) Unless there is good cause, failure to meet any of the criteria specified above means that:

(a) An individual is not making reasonable efforts to sell the property and is not accepting a reasonable offer to buy;

(b) The individual's countable resources include the value of the property beginning with the month following the month in which reasonable efforts to sell stop or the month following the month the owner failed to accept a reasonable offer to buy; and

(c) The individual will be charged with an improper payment, if applicable.

e) Initial Verification of Efforts To Sell.

1) The effort to sell must be documented in the case record within the 30-day time period for applying the exclusion by requiring all proof such as:

(a) Copy of the listing agreement with the real estate agent in current use;

(b) Dated advertisement(s) indicating the property is for sale;

(c) Contracts with local media to advertise the property;

(d) A photograph of the "For Sale" sign on the property, in conjunction with other efforts; or

(e) Any other relevant items.

f) Effective Date of Exclusion.

1) If the appropriate proof is submitted, the exclusion is applied back to the first of the month in which the effort to sell as initiated.

2) If a reasonable effort to sell was in existence prior to the date of application, the exclusion can be applied retroactively provided the effort is documented and DOM-320A is signed.

3) If the effort to sell is just beginning, the exclusion applies effective with the first month DOM-320A is signed (provided it is signed within 30 days). If not signed within 30 days, the exclusion applies as of the first month a reasonable effort to sell is initiated.

g) Follow-Up Contacts.

1) Contacts must be scheduled at 90-day intervals until the property is sold or the exclusion ends.

2) Follow-up contacts may be by telephone to determine efforts being made to accomplish the sale and to document whether there has been any offer to buy since the prior contact.

3) If an offer to buy has been refused, a statement must be submitted explaining the refusal.

4) The refusal of an offer to buy must be evaluated under the "Reasonable Offer to Buy" guidelines. If the refusal is unacceptable, the exclusion ends beginning with or retroactive to the month after the month of the refusal to sell**.**

5) If the reasonable efforts to sell are not continuing at each follow-up contact, determine if good cause exists. If good cause does not exist, the exclusion ends beginning with or retroactive to the month after the month the reasonable efforts stopped.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 3.8 Interests of Individual Indians in Trust or Restricted Lands.

A. Certain types of Indian-specific property are excluded from being considered as resources in determining Medicaid eligibility for an individual who is an Indian. These excluded resources include the following:

1. Property Connected to the Political Relationship between Indian Tribes and the Federal Government;

a) This exclusion includes any Indian trust or restricted land, or any other property under the supervision of the Secretary of the Interior located on a reservation, including any federally-recognized Indian Tribe's reservation, pueblo or colony, and including Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior; and

b) Individual Indian Monies (IIM) accounts, which are under the supervision of the Secretary of the Interior, and considered to be inaccessible; and

c) Property located within the most recent boundaries of a prior Federal reservation including former reservations in Oklahoma and Alaska Native regions established by the Alaska Native Claims Settlement Act;

d) Ownership interest in rents, leases, royalties or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights Monies received from the lease or sale of these natural resources remain excluded while in an IIM account.

2. Property with Unique Indian Significance, such as:

a) Ownership interest in or usage rights to items not covered under the above provisions that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or traditional lifestyle according to Tribal law or custom.

b) While the above identified assets are excluded in determining eligibility, if the assets are converted to a non-excluded asset, they become countable.

1) For instance money in an IIM account is excluded; however, once the money is removed from the IIM account it becomes a countable asset.

2) Money received by Indians from the lease or sale of natural resources, and rent or lease income, resulting from the exercise of federally-protected rights on excluded Indian property, is considered an asset conversion. Therefore, this money is not considered income, but is an excluded resource in the month the money is received (This is true even if the money is taken out of the IIM account in the same month it was deposited into the account). If some or all of the money is retained at the end of the month in which received, it is either counted or excluded based on the type of resource in which the money is retained after month of receipt.

3. Distributions of per capita judgment funds or property earnings held in trust for a Tribe by the Secretary of the Interior.

a) However, this does not include local Tribal funds that a Tribe distributes to individuals on a per capita basis, but which have not been held in trust by the Secretary of the Interior (e.g., tribally managed gaming revenues, which are countable income).

Source: P.L. 111-5 American Recovery and Reinvestment Act of 2009 § 5006.

Rule 3.9 Exclusion of Personal Property.

A. Personal property includes automobiles, life insurance, household goods and personal effects and burial funds and certain burial arrangments and items, which may be subject to a full or partial exclusion. The exclusion applicable to each is discussed under this rule.

1. Exclusion of Automobiles.

a) An automobile is any registered or unregistered vehicle used for transportation. Vehicles used for transportation can be motorized, animal drawn or even an animal. A vehicle not used for transportation is not an automobile, but may be a countable resource. A temporarily inoperable vehicle normally used for transportation meets the definition of an automobile.

b) If an exclusion cannot be developed for a vehicle the current market value must be determined. The CMV is the average price an automobile of that particular year, make and model and condition would sell for on the open market (to a private individual) in the particular geographic area involved. The most recent NADA Official Car Guide or Older Car Guide may be used to determine the average trade-in value. If there is debt on the vehicle, determine the equity value.

1) If the client states the CMV is not representative of the value of the vehicle, he must be given the opportunity to provide a value rebuttal from another knowledgeable source, such as a used car/truck dealer, automobile insurance company, classic car appraiser, etc.

c) Examples of Automobiles:

1) Car or truck;

2) Boat;

3) Motorcycle;

4) All-terrain vehicle;

5) Horse-drawn carriage;

6) Horse.

d) The following are not vehicles for purposes of this exclusion:

1) Permanently inoperable (junk) vehicle;

2) Vehicle used exclusively for recreation, such as boats, motorcycles, RVs, dirt bikes, golf carts, etc. ;

3) Leased vehicles are not considered in the resource determination, as the individual does not own the vehicle.

e) Treatment of Vehicles Under SSI Resource Policy.

1) Effective April 2005, one automobile may be excluded, regardless of value, if is used for transportation of the individual, spouse and/or a household member.

(a) Unless there is evidence to the contrary, assume the vehicle is used for transportation.

(b) If multiple vehicles are involved, apply the exclusion in a way that is most advantageous to the applicant/recipient. That is, apply the exclusion to the vehicle with the greater value.

(c) For any vehicle that cannot be excluded wholly under this provision or another provision (e.g., property essential to self-support, etc.), the equity value is countable toward the resource limit.

(d) The equity value of junk cars and vehicles used only for recreation is a resource. The personal effects exclusion does not apply to such vehicles.

f) Treatment of Vehicles Under Liberalized Resource Policy.

1) Two vehicles may be excluded, regardless of value, if used for transportation of the individual, spouse and/or a household member.

2) Unless there is evidence to the contrary, assume the vehicles are used for transportation.

3) If multiple vehicles are involved. apply the exclusions in a way that is most advantageous to the applicant or recipient. That is, apply the exclusions to the vehicles with the greater equity value.

4) For any vehicle that cannot be excluded wholly under this provision or another provision (e.g., property essential to self-support, etc.), the equity value is countable toward the resource limit.

5) Any car that is permanently inoperable (junk car) can be totally excluded as a resource.

6) Recreational vehicles are treated as personal property. The personal effects exclusion does not apply to such vehicles.

2. Exclusion of Life Insurance.

a) A life insurance policy is a contract. The purchaser (owner) pays premiums to the company (insurer). In return, the insurer agrees to pay a specified sum to a designated person(s), known as a beneficiary, upon the death of the insured individual. The owner and the insured may or may not be the same person. The policy should state the owner's name, if different from the insured.

b) Below are some common terms associated with life insurance:

1) Face Value (FV) is the amount of basic death benefit contracted for at the time the policy is purchased. The face page of the policy may show it as such or as the "amount of insurance", "the amount of this policy", "the sum insured", etc. A policy's FV does not include:

(a) The FV of any dividend addition, which is added after the policy is issued;

(b) Additional sums payable in the event of accidental death or because of other special provisions; or

(c) The amount(s) of term insurance, when a policy provides whole life coverage for one family member and term coverage for others.

2) Cash Surrender Value (CSV) is a form of equity value that it acquires over time. The owner of the policy can obtain in its CSV only by turning the policy in for cancellation before it matures or the insured dies. A loan against a policy reduces its CSV.

3) Dividends are shares of any surplus insurance company earnings, which can be applied to premiums due or paid by check or by an addition or accumulation to an existing policy.

4) Dividend Additions are the amount of insurance purchased with dividends added to the policy, increasing its death benefit and CSV. The table of CSVs that comes with a policy does not reflect the added CSV of any dividends.

5) Dividend Accumulations are dividends that the policy owner has constructively received, but left in the custody of the insurer o accumulate at interest. They are not a value of the policy; the policy owner can obtain them without affecting FV or CSV.

(a) Dividend accumulations cannot be excluded from resources under the life insurance exclusion, even if the policy that pays the accumulations is excluded from resources. Unless they can be excluded under another provision(e.g., as set aside for burial), they are countable resource.

c) Verification of Life Insurance.

1) Documentary evidence is obtained to verify the value of life insurance when the client/spouse reports ownership of whole life insurance(s) on any individual with a total FV exceeding the appropriate program exclusion limit: $1500 (SSI) or $10,000 (Liberalized).

2) The individual or authorized representative must provide a copy of all the life insurance policies and the most recent dividend statement for each one.

3) After exclusions are developed, any remaining cash value must be considered in the eligibility determination. The cash surrender value of any policy that cannot be excluded is countable toward the resource limit.

d) Types of Life Insurance.

1) Term Life Insurance is usually in effect for a specific length of time such as 20 years or length of employment. It does not accrue cash value;

2) Whole Life Insurance remains in effect unless the premiums are not paid or the policy matures; and accrues cash value;

3) Burial Insurance contracts prevent the proceeds from being used for anything other than the burial expenses of the insured.

e) Owner versus Beneficiary.

1) The owner is the one who has control of the policy. An individual may own life insurance on himself or another person. The owner may take such actions as cash in a policy, take out a loan against cash value, etc. The value of life insurance policies owne must be considered in the eligibility process.

2) The beneficiary is the individual(s) who receive the proceeds of the policy at the insured individual's death. One person may be both the owner and the beneficiary.

(a) Example: Jim Jones purchases a $10,000 life insurance policy on his mother, Jane Williams, and is the beneficiary upon her death.

f) Treatment of Life Insurance Under SSI Resource Policy.

1) Term life insurance policies do not have cash value and are excluded.

2) Burial policies are excluded.

3) For all other policies determine the total Face Value (FV) of the policies owned by the individual. Do not include the Face Value of any dividend additions in determining whether a policy is a countable or excluded resource.

4) A life insurance policy is excluded if its' Face Value and the FV of any other life insurance policies the individual owns on the same insured person total 1,500.00 or less.

5) Even if a policy is excluded, any accumulated dividends are countable toward the resource limit unless they are excluded under another provision such as set aside for burial.

6) If the policy is a countable resource, the cash surrender values (CSV), dividend additions, dividend accumulations, outstanding loan amounts reducing the (CSV) of the policies must be verified and considered in the eligibility determination.

7) The countable cash surrender values of the policies and accumulations are countable toward the resource limit unless they can be excluded as burial assets.

8) The following are examples:

(a) Lyn Reno is the owner of four life insurance policies. Two have Face Values of $500 and two have Face Values of $250. The total of all FVs is $1500 so the policies are excluded.

(b) Jerry Mann is the owner of three life insurance policies insuring his spouse. The Face Value of each one is $750. The total Face Value is $2,250. The specialist must determine the cash values of the policies and count them toward the resource limit unless a burial exclusion is developed.

(c) Roger West is the owner of two life insurance policies on his spouse. One is whole life with a Face Value of $1,200 and the other is term life with a Face Value of $10,000. The term life policy has no cash value and is excluded. The whole life policy is excluded because the Face Value is less than $1,500.

g) Treatment of Life Insurance Under Liberalized Resource Policy.

1) Term life insurance policies do not have cash value and are excluded.

2) Burial policies are excluded.

3) For all other policies determine the total Face Value (FV) of the policies owned by the individual. Do not include the Face Value of any dividend additions in determining whether a policy is a countable or excluded resource.

4) A life insurance policy is excluded if its Face Value and the FV of any other life insurance policies the individual owns on the same insured person total $10,000 or less.

5) Even if a policy is excluded, any accumulated dividends are countable toward the resource limit unless they are excluded under another provision such as set aside for burial.

6) If the policy is a countable resource, the cash surrender values (CSV, dividend additions, dividend accumulations, outstanding loan amounts reducing the CSV) of the policies must be verified and considered in the eligibility determination.

7) The countable cash surrender values of the policies and accumulations are countable toward the resource limit unless they can be excluded as a burial asset.

8) The following are examples:

(a) Lane Ryan is the owner of four life insurance policies. Two have Face Values of $1,500 and two have Face Values of $750. The total Face Value is $4,500 so the policies are excluded.

(b) Jennifer Madison is the owner of three life insurance policies on her spouse, with Face Values of $750, $2,500 and $12,000. The total Face Values are $15,250. The specialist must determine the cash surrender values of the policies and count them toward the resource limit unless a burial exclusion is developed.

(c) Roberta Warren is the owner of two life insurance policies on her spouse. One is whole life with a Face Value of $8,500 and the other is term life with a Face Value of $25,000. The term life policy has no cash surrender value and is excluded. The whole life policy is excluded because the Face Value is less than $10,000.

h) Accelerated Life Insurance Payments.

1) Proceeds paid to a policyholder before death.

2) Plans vary from company to company; however, all involve early payout of some or all of the proceeds of the policy.

3) Most of the plans fall into three basic types depending on the circumstances that cause the payments to be accelerated:

(a) Long Term Care Model. Allows payments if the policyholder requires an extended stay in a care facility or, in some instances, healthcare services at home.

(b) Dread Disease or Catastrophic Illness Model. Allows payments if the policyholder suffers from a specified covered disease or illness such as cancer or AIDS.

(c) Terminal Illness Model. Allows payments following the diagnosis of a terminal illness where death is likely to occur within a specified timeframe.

4) These payments are also called "living needs" or "accelerated death" payments.

5) Depending on the plan, the receipt of payments may reduce the FV of the policy by the amount of the payments and may reduce the CSV in a proportionate manner. In other cases, a lien may be attached to the policy in the amount of the payments that results in a proportionate reduction in the CSV.

6) If an individual has a life insurance policy that allows them to receive their death benefit while living and the individual meets the requirements set by the insurance company to receive such proceeds, they are not required to file for the proceeds.

(a) If the individual does file and receives the benefits, the payment will be considered as follows:

(i) Consider as income in the month of receipt.

(ii) Any money remaining the following month is considered a resource.

i) Life Insurance Endowment Policies.

1) A life insurance policy's primary function is to pay out upon the death of the insured.

2) A life insurance endowment policy does not do that; rather it serves as an investment medium with a maturity date or date certain payout, i.e., 5 years from purchase, at which time a benefit is paid to a designated beneficiary. The possible death of the "insured" individual before the maturity date is a secondary consideration.

3) These policies should be treated as annuities.

3. Exclusion of Household Goods and Personal Effects.

a) Household goods are personal property found in the home and used in connection with normal maintenance, use and residency of a home. They include:

1) Furniture;

2) Appliances;

3) Television sets;

4) Carpets;

5) Cooking and eating utensils;

6) Dishes.

b) Personal effects are personal property that is worn or carried by an individual or that have an intimate relation to him or her. They include:

1) Clothing;

2) Jewelry;

3) Personal care items;

4) Prosthetic devices;

5) Educational or recreational items;

(a) Books;

(b) Musical instruments.

c) Treatment under SSI Resource Policy.

1) Household goods and personal effects as defined above, are excluded in resource determinations, regardless of their dollar value.

2) Prior to April 2005, a general exclusion of up to $2,000 applies to the total equity value of household goods and personal effects, other than those excluded regardless of value: one wedding ring, one engagement ring and prosthetic devices, wheelchairs, hospital beds, dialysis machines and other items required by a person's physical condition.

3) Personal property that an individual acquires or holds because of its value or as an investment is:

(a) A countable resource; and

(b) Not considered as household goods or personal effects for purposes of exclusion.

4) When ownership of other personal property is alleged and the property is not excludable as household goods or personal effects, the Current Market Value (CMV) or Equity Value (EV), as appropriate, of the item must be verified.

5) Example: A recreational vehicle (RV) used for vacations and other recreational activities is classified as personal property. It does not meet criteria to be an automobile or meet the definition of household goods or personal effects for exclusion. If the CMV of the RV is $10,000 and the payoff is $5,000, under SSI resource policy the equity value of $5,000 is counted as a resource.

d) Treatment Under Liberalized Resource Policy.

1) Under liberalized policy, household goods and personal effects, as defined above, are excluded in resource determinations regardless of their dollar value.

2) Personal property that an individual acquires or holds because of its value or as an investment:

(a) Is a countable resource when its equity value exceeds $5,000; and

(b) Is not considered to be household goods or personal effects for purposes of exclusion.

3) When ownership of other personal property is alleged and the property is not excludable as household goods or personal effects, under liberalized resource policy, up to $5,000 in EV is excluded for other personal property.

4) The Current Market Value (CMV) or Equity Value (EV), as appropriate, must be verified.

5) Example: A recreational vehicle (RV) used for vacations and other recreational activities is classified as personal property. The RV does not meet criteria to be an automobile, nor does it meet the definition of household goods or personal effects for exclusion. If the CMV of the RV is $12,000 and the payoff is $7,500, the RV can be excluded as a resource under liberalized policy since its equity value is $5,000 or less.

3. Exclusion of Death Benefits for Last Illness and Burial Expenses.

a) Death benefits are received because of another person's death. Examples include:

1) Life insurance proceeds;

2) Social Security death benefits;

3) Burial benefits from the Railroad or Veterans Administration;

4) Inheritances;

5) Gifts from relatives, friends or the community to help with expenses.

b) Recurring survivor benefits from a pension or retirement plan or the Social Security Administration are not death benefits.

c) Last illness and burial expenses include related hospital and medical expenses; funeral, burial plot and interment expenses; and other related expenses.

d) Death benefits provided to an individual are income to the extent that the total amount exceeds the expenses of the deceased's last illness and burial expenses paid by the individual.

e) Death benefits which are not income are also not a resource for one month following the month of receipt. If retained, the second month following receipt, death benefits are resources.

f) If death benefits are not considered income, under both SSI and Liberalized Resource policy, treatment is as follows:

1) Month of receipt. Excluded.

2) Month after receipt. Excluded.

3) Second Month following receipt/ Countable resource, if retained.

4) Exception: If the death benefits are repayment for expenses already paid, they are considered resources the month after receipt, if retained.

(a) Example: When her uncle passed away, Beth Smith received 4,000 as Beneficiary of his life insurance policy. She received it in July and anticipates spending the entire amount on his last illness and burial expenses. She has already received bills totaling $900 that she paid. On August 1, she received a funeral bill for $2,900 and a few days later received a cash gift of $500 which she also intends to apply toward last illness and burial expenses. She pays the $2,900 funeral bill in August and intends to use the remainder of the life insurance to pay some hospital expenses.

(i) Treatment: Neither the $4,000 received in July nor the $500 received in August is unearned income since it is all expected to be used for burial or last illness expenses. She used $900 of the $4,000 in July. As of August 1, she had $3,100 that is not a resource for August. During August she paid the $2,900 bill and then had $200 left. However, the $500 she receives in August gives her $700 to use for hospital expenses. She must spend $200

in August for burial or last illness expenses; otherwise, the $200 will count as a resource September 1. Any portion of the $500 remaining as of October 1 will be counted as a resource.

(b) Jane Smith has total countable resources of $1,980 consisting of a $1,000 savings account and $980 in checking. Her brother died in late October. In November she receives $3,000 as beneficiary of her brother's life insurance. She has last illness and burial expenses of $2,750 to pay. There are no other bills.

(i) Treatment: Of the $3,000 Ms. Smith received, $250 is unearned income in November because the last illness and burial expenses are only $2,750. The $2,750 is not considered unearned income and will not be a resource until January 1, if she still has it at that time. Any of the $250 remaining will be a resource for December.

4. Exclusion of Burial Spaces.

a) Burial spaces are spaces or items that are used to contain the remains of a deceased person. These include:

1) Cemetery plots, crypts, mausoleums, cremation niches;

2) Caskets, urns;

3) Headstones or other grave markers;

4) Burial containers (burial vaults or grave liners);

5) Expenses related to the opening and closing of the grave sites; and

6) Perpetual care expenses

b) Treament of Burial Spaces Under SSI and Liberalized Resource Policy.

1) A burial space or an agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or a member of his or her immediate family is an excluded resource, regardless of value. The burial space exclusion is in addition to, and has no effect on, the burial funds exclusion.

2) Under SSI policy, burial spaces may be excluded if intended for use of the individual, spouse or immediate family, as defined.

3) Liberalized policy includes all of the relatives in the SSI definition and extends to family members of any degree of relationship.

4) To be “held for” the burial of an individual , the item must be paid for in full and if not paid for in full, the amount paid is considered a burial fund rather than a burial space.

5) Only one item serving the same purpose may be excluded per person. For example, exclude a casket and vault for the same person, but not a casket and an urn.

6) No limit exists on the value that may be excluded.

7) Taxes paid on burial spaces are also excluded.

8) If a burial space is being held by a funeral provider in accordance with a burial agreement, whether revocable or irrevocable, then the value of the burial space(s) is excluded under the burial space exclusion

5. Exclusion of Burial Funds.

a) Burial funds are items clearly designated for an individual’s burial. They include:

1) Revocable burial contracts;

2) Revocable burial trusts;

3) Other revocable burial arrangements (Including installment sales contracts for burial spaces);

4) Cash;

5) Financial accounts such as checking, saving or CDs;

6) Stocks or bonds; and

7) Life insurance cash value.

b) Burial funds must be clearly designated for the eligible individual’s burial, cremation or other burial-related expenses, i.e., flowers, clothing, transportation, etc.

c) Property other than that listed above will not be considered burial funds and may not be excluded under the burial funds provision. For example, a car, real property, livestock, etc., are not burial funds.

d) Burial funds may be designated by:

1) An indication on the burial funds document, such as a revocable burial contract or the title on a bank account. Whenever burial funds are already clearly set aside as burial funds, no separate signed statement or further designation is required.

2) Completion of DOM-321B, Designation of Burial Funds, provides the information required to document a burial fund, i.e., owner, value and form of funds, date set aside for burial, etc.

3) Once a fund is designated, it remains a burial fund until eligibility terminates or the individual uses the funds for another purpose, in which case a penalty may apply. See discussion of Misuse of Burial Funds later in this section.

e) The burial fund may be excluded retroactively to the date the individual originally designated the funds for burial. The individual's allegation of the date the funds were first considered set aside for burial (even prior to application) is accepted unless there is evidence the funds were used and replaced after that date.

1) Example: Mr. Hoover applies on May 1 and signs DOM-321B designating a CD for burial. He set the account up two years ago for his burial. He is seeking coverage for February, March and April. The exclusion may be given for those months.

f) Burial funds cannot be commingled with other resources which are not intended for burial. The burial fund exclusion applies only if funds set aside for burial expenses are kept separate from non-burial funds. If excluded burial funds are mixed with resources not intended for burial, the exclusion will not apply to any portion of the funds.

1) It is possible to have excluded and non-excluded funds commingled provided all funds are intended for burial. It is not permissible, however, to have burial and non-burial funds commingled.

(a) Example: Mr. Brennan has a bank account with a balance of $2,000. He plans to use $1,500 for burial and the remaining $500 for other non-burial expenses. The burial exclusion may not be applied to this bank account. Mr. Brennan may want to consider opening another account for the $500. If he does so, he must provide verification and DOM-321B must be completed to document the burial exclusion.

g) Any amount may be designated for burial; however, only the amount up to the applicable maximum exclusion may be excluded. Once the amount of the designated burial funds equals the applicable maximum, the only additions to it that can be excluded are appreciation and interest. However, until the maximum has been reached, additional amounts can be excluded if the individual designates them for burial expenses. Interest is not included in determining if the maximum has been reached.

h) SSI policy allows up to $1,500 in funds set aside for the burial of the individual and up to an additional $1,500 in funds set aside for burial of the individual's eligible or ineligible spouse.

   1) Example: Mr. Brown designates $1,500 in a bank account for burial. The entire amount may be excluded. Mr. Brown designates an account with a $2,000 balance for burial. Since $1,500 is the maximum exclusion, the remaining designated funds are not excluded and count toward the resource limit.

i) Under liberalized policy, the maximum that can be excluded for burial of the individual is $6,000. In addition, up to $6,000 is allowed for burial of the eligible or ineligible spouse.

j) The $1,500 or $6,000 maximum exclusion is reduced by:

   1) Any amount held in an irrevocable trust or burial contract or other revocable or the arrangement for the individual or spouse, if applicable, except to the extent ittresents represents excludable burial spaces.

   2) Face Value of any excluded life insurance policy on the individual or spouse, if applicable

      (a) Example (SSI): Greta Mann has a savings account designated for burial. It has a balance of $2,000. She also has an irrevocable burial contract with Hartfield Funeral Home that represents burial space items worth $2,500 and burial funds of $1,500. The burial fund portion of the burial contact totally offsets the $1,500 SSI burial exclusion: $1,500-$1,500 = 0; therefore, the entire $2,000 balance in the savings account is not excluded and counts toward the resource limit.

      (b) Example (Liberalized): Greta Mann has an excluded life insurance policy with a Face Value of $5,000. She also has a savings account with a balance of $4,000 that she designates for burial. The $6,000 burial exclusion is partially offset by the Face Value of her policy: $6,000-$5,000 = $1,000. Therefore, $1,000 of her savings may be excluded and the remaining $3,000 in non-excluded burial funds is a countable resource.

k) Irrevocable burial arrangements are not resources and are not subject to the $1,500 or $6,000 maximums; however, as indicated above, they do reduce the amount of the burial fund exclusion allowed. Burial insurance is considered an irrevocable arrangement.

l) The value of the irrevocable burial arrangements purchased by the individual must be equal to the value of the funding source used to make the purchase, e.g., cash prepayment, life insurance or annuity irrevocably assigned to the funeral home. If the

value of the burial arrangement is not equal to the value of the prepayment, a penalty may be assessed under the transfer of assets provision for institutionalized clients.

m) The maximum amount that can be excluded when a burial fund is initially designated is $1,500 under SSI resource rules or $6,000 under liberalized policy. Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements are excluded as income and resources if left to accumulate and become part of the separate burial fund.

n) Changes in the individual's circumstances may raise or lower the amount that can be excluded for burial, such as:

   1) The purchase of additional life insurance with cash surrender value may change the allowable exclusion. In addition, cashing in life insurance may raise or lower the allowable exclusion.

   2) The face amount of life insurance may change, thereby changing the allowable exclusion.

   3) An irrevocable burial contract may be purchased, thereby reducing the allowable burial exclusion.

   4) Deposits made to bank accounts designated for burial will change the allowable exclusion.

   5) If the amount designated is less than the maximum exclusion, the individual may add additional funds to the burial fund to bring up the original amount to the maximum exclusion amount.

o) The burial fund exclusion once applied must be reevaluated whenever a change bcomes becomes known that would affect the exclusion amount or at each redetermination.

p) If the fund contains both excluded and non-excluded amounts, use the formula below to determine the excludable portion:

   1) Original exclusion amount ÷ Original fund amount x Present fund amount = Excluded Portion;

   2) Example: An individual, subject to SSI rules, designated $2000 (original fund amount) as a burial fund, $1500 (original exclusion amount) was excluded and $500 is non-excluded. At the most recent review, the account had grown to $2200 (present fund amount) due to accumulated interest. The excluded amount is $1650. (1500 ÷ 2000 x 2200 = 1650)

q) If funds, including interest, that were excluded under the burial fund exclusion are used for any purpose other than burial expenses for the designated individual, a penalty for misuse is imposed only if the client would have excess resources without the burial exclusion. Upon discovery of the misuse of excluded burial funds, verification must be obtained (which may be in the form of a statement from the client or representative) that all or a portion of the funds have been used for another purpose other than burial to determine the effect the misuse will have on eligibility.

1) If the client would have excess resources without the burial fund exclusion, the amount used inappropriately is counted as income the next possible month after the month in which the misuse is discovered.

2) The misused funds will be included as income in the eligibility computation; however, misused burial funds are not counted as income in the Medicaid Income computation for the institutionalized individual unless the funds are available to the recipient.

3) If the misused funds include non-excluded burial funds, assume the funds were used in this order: non-excluded interest; non-excluded designated amount; excluded interest and excluded designated amount. The penalty only applies to excluded interest and designated amounts.

4) If ineligibility results, the case will be closed in accordance with ongoing policy, i.e., advance notice issued, etc.

5) If the misuse of burial funds does not result in excess income because the client's resources would not exceed limit even if the burial funds were not excluded or if applicable, the funds are not available to the client to include in the Medicaid Income computation, no action is required other than documenting the case record.

6) There must be a new redesignation of funds when there is a change in the amount of funds originally designated, not including accumulated interest or appreciation.

7) If eligibility is lost, the burial fund exclusion must be developed if the individual reapplies later.

(a) Example: Jennifer Shows originally designated $1,500 as a burial fund. Interest accumulated and the account grew to $1,750. In May, she withdrew $500 to repair her car. If her other resources plus the $1750 burial fund, which is now non-excluded, exceed the program resource limit, the penalty applies. In addition, she must redesignate the amount of funds for burial because the amount in the account ($1,250) is now below the original amount designated. In the alternative, she could add $250 to the account and the original designation would be accurate; however, any penalty would still apply.

6. Exclusion of Pre-Need Burial Contracts.

   a) A pre-need burial contract is an agreement between an individual and a funeral home where the buyer pays in advance for his or another person's burial arrangements.

   b) If an applicant's resources exceed the allowable limit, he is allowed to establish a pre-need contract to reduce his resources below the limit.

   c) Many pre-need contracts include both burial space and burial fund items:

      1) Expenses related to the burial space include: casket, vault, opening/closing costs at the cemetery; and

      2) Expenses related to the burial fund include: embalming, clothing, visitation room, transportation, flowers.

   d) Payment for a contract has taken place when an applicant/recipient transfers a liquid resource to the funeral provider or when specific life insurance policies have been designated on the pre-need burial contract.

   e) A liquid resource designated, but not transferred to the funeral provider as payment for a contract, is counted as an available resource.

   f) A resource cannot be designated for future payment of a pre-need contract and that resource be excluded as a resource.

   g) There are two types of pre-need burial contracts: revocable and irrevocable.

      1) Revocable contracts may be sold or the money may be refunded. They are considered resources; however, a full or partial exclusion may be developed.

         (a) Revocable Contracts That Are Paid in Full.

            (i) If the value of all the items is provided, both the burial space and the burial fund exclusion may be developed. If the value of the burial space items is not provided, only the burial fund exclusion may be developed.

         (b) Revocable Contracts That Are Not Paid In Full.

            (i) Only the burial fund exclusion may be developed unless the contract verifies the burial space items are paid for and the burial funds items are being paid on.

         (c) Under SSI and Liberalized Resource Policy, revocable pre-need burial contracts are considered a resource; however, a burial exclusion may be developed.

(d) If the revocable contract is paid in full:

(i) Any portion of the contract clearly representing burial spaces may be excluded entirely, regardless of value

(ii) Up to $1,500 (SSI) or $6,000 (Liberalized) of the remaining portion of the contract may be excluded as a burial fund

(e) If the contract is not paid in full, it should be treated as a burial fund unless it is verified that the burial spaces themselves are paid in full and considered "held for" the individual

(f) Example: Mr. Allen applies for Medicaid. He has just purchased a revocable contract at Land of Lakes Funeral Home. The contract verifies it is paid in full and includes the following:

$1,500	Casket
$1,000	Vault
$1,000	Headstone
$500	Opening/closing costs
$200	Embalming
$300	Visitation Room
$1,000	Funeral service

Because the contract is paid in full, the first four items, which are burial space items, may be excluded under the burial space exclusion. The remaining $1,500 may be excluded under the burial fund exclusion.

2) Irrevocable pre-need contracts under SSI and liberalized resource policy are not a resource since the money cannot be refunded or the contract sold without significant hardship. If the contract is irrevocable, it is not a resource retroactive to the date of purchase. The portion that represent burial funds offsets that exclusion. If the contract is not paid in full, the portion paid represents burial funds up to the maximu.

3) Life Insurance Funded Burial Contracts.

(a) A life insurance funded burial contract involves an individual purchasing a life insurance policy on his own and then assigning, revocably or irrevocably, either the proceeds or ownership of the policy to a funeral provider. The purpose of the assignment is to fund a burial contract. Life insurance funded burial contracts are not considered burial insurance.

7. Effect of the Assignment of Ownership on Burial Exclusion.

a) Revocable Assignment.

1) The burial space exclusion does not apply because the items are not paid for until the death of the individual and therefore are not being "held for" the individual. The burial fund exclusion may apply.

2) The resource value of the burial contract is equal to the Cash Surrender Value of the life insurance, subject to the maximum burial funds exclusion amount.

b) Irrevocable Assignment.

1) The burial space exclusion may apply if the values of the items are provided.

2) The life insurance policy is not a resource because the individual no longer owns it.

3) The contract is not a resource because the individual no longer owns it.

4) The value of the burial fund items offsets the value of any other burial funds items up to the allowable maximum

8. Effect of the Assignment of Proceeds on Burial Exclusion.

a) When life insurance proceeds are assigned, the burial space exclusion does not apply because the provider will not be paid until the death of the individual and spaces are not being "held for" the individual.

b) The resource value of the contract is the cash surrender value of the life insurance policy.

1) If the Face Value of all life insurance policies for the individual total $1,500/$6,000 or less, exclude the CSV under the life insurance exclusion.

2) If the FVs total more the $1,500/$6,000, verify and count the CSV toward the resource limit. The burial fund exclusion may apply.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 3.10 Exclusion of Property Essential for Self-Support.

A. The exclusion of property essential to self-support may apply to real or personal property.

1. All property must be in current use or, if not in use for reasons beyond the individual's control, there must be a reasonable expectation that the required use will resume.

2. The income generated by income-producing property is <u>not</u> excluded under this provision. Income is either earned or unearned, depending on the type of income-producing property involved.

B. Resources excluded under this provision generally fall into four categories:

1. Property Essential to Self Support;

2. Property Used to Produce Goods and Services;

3. Non-Business, Income-Producing Property; and

4. Essential Property Exclusion under Liberalized Policy.

C. For exclusion under this provision, the property must be in current use in the type of activity that qualifies it for exclusion.

1. Current use is evaluated on a monthly basis.

2. Property not in current use may be excluded only if it has been in use and

3. There is expectation that the use will resume within 12 months of last use.

a) This 12-month period can be extended for an additional 12 months if non-use is due to a disabling condition and resumption of the self-support activity can reasonably be expected to occur within that time.

1) If the individual does not intend to resume the self-support activity, the property is a countable resource for the month after the month of last use.

2) If there is a change of intent after the exclusion has been applied, the exclusion no longer applies as of the date of the change of intent. The property becomes a resource for the following month unless a different exclusion is met.

D. Exclusion Principles and Types of Property.

1. Properties essential to self-support which are excluded regardless of value or rate of return are discussed in this section.

2. The properties essential to self-support described in this section include necessary capital and operating assets of a business, e.g., real property, buildings, inventory, equipment, machinery, livestock, motor vehicles, etc.

3. The properties must be in current use or if not in current use due to circumstances beyond the individual's control, there must be a reasonable expectation that the required use will resume.

4. The following types of properties essential to self-support are excluded regardless of value or rate of return:

a) Property used in a trade or business;

b) Government permits which represent authority to engage in an income-producing activity; and

c) Personal property used by an employee in his work

5. Property essential to self-support used in a trade or business is excluded from resources, regardless of the value or rate of return. This is applicable to programs subject to both SSI and liberalized resource policy.

   a) When the individual alleges owning a trade or business property, a statement must be obtained in regard to:

      1) Description of the trade or business;

      2) Description of the assets of the trade or business;

      3) The number of years the business has been operated;

      4) Names of any co-owners; and

      5) Estimated gross and net earnings of the trade or business for the current tax year.

   b) A copy of the current year tax return (Form 1040 with schedules and attachments) must also be obtained.

      1) The tax forms are used to determine net self employment earnings and validity of the trade or business.

      2) If the current year return is not available, obtain the latest return available.

6. Government permits represent authority granted by a government agency to engage in an income-producing activity. They are excluded regardless of value or rate of return. This is applicable to programs subject to both SSI and liberalized resource policy.

   a) Examples are commercial fishing permits or tobacco crop allotments.

   b) When the individual alleges owning a government license, permit or other property which represents government authority to engage in an income producing activity, and which has value as a resource, the following information is needed:

      1) Type of license, permit or other property;

      2) Name of the issuing agency, if appropriate;

3) If license is required for engaging in this activity;

4) How the license, permit or property is being used; or

5) If not being used, why not.

c) A copy of the license, permit and/or other applicable documents is required.

7. Personal property used by an employee for work is excluded from resources. This is applicable to programs subject to both SSI and liberalized resource policy.

a) Excluded items include tools, safety equipment, uniforms, etc.

b) If the individual alleges owning items that are used in his work as an employee, obtain a statement regarding the following:

1) Name, address and telephone number of employer;

2) General description of the job duties and the items; and

3) Whether the items are currently in use

c) Absent evidence to the contrary, the individual's statement may be accepted.

8. Non-business property, real or personal property (but not cash or bank accounts), used to produce goods or services essential to daily living is excluded as follows:

a) No specified rate of return is required.

b) Property must be in use or, if not in use for reasons beyond the individual's control, there must be a reasonable expectation that the required use will return.

c) If the equity value of the property exceeds $6000, the excess is not excluded; it is countable toward the resource limit.

1) Example: If the resource is valued at $7000, then $6000 is excluded and $1000 is counted.

d) Non-Business Property, real or personal, includes:

1) Property used to grow produce or livestock raised solely for personal consumption in the individual's household;

2) Property used in activities essential to the production of food for home consumption, such as a tractor used for plowing or a boat for subsistence fishing.

(a) This does not include any vehicle that qualifies as an automobile.

e) When an individual alleges owning property that he uses to produce goods or services necessary for daily activities, the following must be obtained:

1) A description of the property;

2) How it is used; and

3) Estimate of the CMV; and

4) Any legal encumbrances.

f) The client's statement may be accepted regarding use of the property.

9. Non-business, income-producing property is excluded as follows:

a) This property is defined as property which includes land that produces rents or other land-use fees (e.g., non-liquid notes or mortgages, ownership or timber rights, mineral or oil exploration) or other non-liquid property which provides rental or other income, but is not used as part of a trade or business.

b) When an individual alleges owning non-business real property that produces income, the following must be documented:

1) The number of years he has owned the property;

2) Any co-owners of the property;

3) A description of the property;

4) The estimated CMV of the property;

5) Any encumbrances; and

c) The estimated net and gross income from the property for the current tax year. Must be obtained to establish that the property is producing income.

1) If available, a copy of the tax return for the year must be obtained.

2) When no tax returns are available, other evidence may be obtained, e.g., a person leasing land for mineral or oil exploration should have a copy of the lease agreement for the period in question.

d) The equity value of the property must be verified.

e) Under SSI policy, treat as follows:

1) This exclusion applies to non-business, income-producing property.

2) Up to $6000 of the equity value can be excluded from resources if the property produces a net annual return equal to at least 6% of the excluded equity value.

3) Any equity that exceeds $6000 counts toward the resource limit.

4) If the net annual return is less than 6%, the entire equity value is counted.

5) Example: At review, Mr. Cameron reports that he lives in an apartment and is renting out his formerly excluded home, which has an equity value of $13,000. Even if the property produces a 6% net annual return, $7000 of his equity cannot be excluded and counts as a resource under SSI policy.

6) Exceptions: If the property produces less than a 6% net annual return, the exclusion may be allowed only if the following apply; otherwise, none of the EV is excluded under this provision:

(a) Lower return that is beyond the individual's control, such as:

(i) Crop failure;

(ii) Fire;

(iii) Illness; and

(b) There is a reasonable expectation that the property will again produce a 6% Return.

7) If earnings decline for reasons beyond the client's control, up to 24 months is allowed for resumption of a 6% net annual rate of return.

(a) This 24-month period begins with the first day of the tax year following the one in which the rate dropped below 6%.

(b) The individual's progress with the business must be checked.

(c) The individual can have the additional 12 months to achieve the 6% net annual rate of return if he is actively pursuing the activity.

(d) If the individual has stopped actively pursuing the activity, the value of the property counts as a resource the month following the review.

(e) If the property is still not producing at least a 6 percent net annual return at the end of the 24-month period, the exclusion is discontinued.

(f) The value of the property counts as a resource the month following the month the 24-month period ends.

8) If an individual owns more than one piece of property, the 6% return rule applies individually to each piece.

(a) The $6000 equity value limit applies to the combined equity values of properties meeting the 6% return rule.

(b) If all the properties meet the 6% test, but total EV exceeds $6000, that portion of the total in excess of $6000 is not excluded under this provision.

(i) Example: Mr. Green has a piece of land on which he grows corn for sale at market. The equity value of the land is $7000. He nets $500 per year in sales. $500 ÷ $7000 = 7.14%; therefore, $6000 of the EV is excluded and $1000 counts as a resource. Last year his crop was struck by lightning and caught on fire. He made no money, but expects to plant and sell again next year at the regular rate. The $6000 may still be excluded because Mr. Green had no control over the fire. His 24-month period begins January 1 of the tax year following the year in which the loss occurred. A tickler is set to check on his progress in 12 months.

(ii) Example: Mr. Green owns three non-connected acres of pastureland. He rents them to different horse and cattle owners for $500 per year each. The land has equity values of $2000, $3500 and $1200 for a total of $6700. The 6% rule is met: $500 ÷ $2000 = 25% return; $500 ÷ $3500 = 14% return; $500 ÷ $1200 = 42% return. Since the 6% rule is met, $6000 is excluded and $700 is countable

10. The essential property exclusion is applied using liberalized policy as follows:

a) Property essential to self-support, defined as property used in a trade or business, government permits and personal property used by an employee for his job, is excluded regardless of value or rate of return.

b) The $6000 exclusion cap is lifted under liberalized policy; therefore, property used to produce goods or services essential to daily living is also excluded regardless of value or rate of return.

c) With the $6000 exclusion cap lifted under liberalized policy, non-business, income-producing property must produce a net annual return of 6% of the EV of each property.

d) If multiple properties are involved, each must be evaluated under the 6% rule.

e) Property that a client sells via a property settlement agreement must meet the 6% net annual return criteria and the agreement must be actuarially sound in order to avoid a possible transfer of resources penalty for the institutional client.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994)

Rule 3.11 Resources Set Aside As Part of A Plan To Achieve Self-Support (Pass).

A. The Social Security Act authorizes the exclusion of income and resources of an individual who has a disability or is blind (but not aged) when the individual needs the income and resources to fulfill a Plan to Achieve Self-Support (PASS) approved by the Social Security Administration.

B. Resources set aside as part of an approved PASS are excluded.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994)

Rule 3.12 Exclusion of Retained Cash Payments.

A. The treatment of the following types of retained cash payments is discussed below:

1. Retroactive Supplemental Security Income (SSI) and Retirement, Survivors and Disability Insurance (RSDI).

a) The unspent portion of retroactive SSI benefits and RSDI benefits is excluded from resources for nine (9) calendar months following the month in which the individual receives the benefits.

b) Retroactive SSI benefits are SSI benefits issued in any month after the calendar month for which they are paid.

1) Benefits for January that are issued in February are retroactive.

c) Retroactive RSDI benefits are those issued in any month that is at least two calendar months after the calendar month for which they are paid.

2. Disaster Assistance.

a) Disaster Assistance includes assistance received from the following sources:

1) The Disaster Relief and Emergency Act (PL 100-707);

2) Another federal statute because of a presidentially-declared major disaster;

3) A state or local government's comparable assistance; or

4) A disaster assistance organization.

b) If the disaster assistance funds are excluded from income, the unspent amount is also excluded from resources.

c) Interest earned on funds excluded in this provision is excluded from income and resources.

3. Presidentially-Declared Major Disasters.

a) Some catastrophes (such as hurricanes) cause such wide-spread destruction that the President of the United States declares them major disasters.

b) Effective 2/25/96, the exclusion period may be extended for individuals who incurred damage or loss of excluded resources under certain circumstances.

1) The 18-month period (9-month initial period plus the 9-month good cause extension) may be extended up to an additional 12 months.

2) Such an extension may be granted if the excluded resource is located within the geographical area of the disaster area (this area is defined in the presidential order); the individual intends to repair or replace the excluded resource or the individual presents evidence of good cause.

4. Netherland WUV Payments to Victims of Persecution.

a) The Netherlands Act on Benefits for Victims of Persecution 1940 – 1945, WUV (Wet Uitkering Vervlgingsslachtoffers) provides payments to individuals who were victims of persecution during World War I during German and Japanese occupation of the Netherlands and the Netherlands East Indies (now the Republic of Indonesia).

b) The unspent WUV payments made by the Dutch government are excluded from resources and the interest earned on unspent WUV payments is excluded from income.

5. German Reparation Payments.

a) German reparations payments are made to certain survivors of the Holocaust under the:

1) Federal Republic of Germany's laws for compensation of National Socialist Persecution (German Restitution Act); or

2) German Reunification Act of 1990.

b) These payments may be made periodically or in a lump sum.

c) Unspent German reparations payments are excluded from income and resources. Interest earned on unspent payments is excluded from income.

6. Austrian Social Insurance Payments.

a) The nationwide class action law suit, Bondy v. Sullivan, involved Austrian social insurance payments that were based on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act.

b) These paragraphs grant credits to individuals who suffered a loss; that is, were imprisoned, unemployed or forced to flee Austria, during the period of March 1933 to May 1945 for political, religious or ethnic reasons.

c) Unspent Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act are excluded from resources and the interest earned on unspent Austrian social insurance payments is excluded from income.

d) Austrian social insurance payments not based on wage credits granted under these paragraphs are not excluded from resources under this provision.

7. Benefits Excluded from Both Income and Resources by a Federal Statute other than Title XVI.

a) Federal statutes other than Title XVI specify many income and resources exclusions. Examples of these are discussed below:

1) Agent Orange Settlement Payments.

(a) There is no limit to the length of time unspent Agent Orange settlement funds are excluded from resources. Interest earned on conserved payments is excluded as income.

2) Victims Compensation.

(a) Some states establish funds to assist victims of crimes.

(b) Unspent payments received from such a fund are excluded for 9 months if received for expenses incurred or losses suffered because of crime, e.g., lost wages, medical expenses incurred due to injuries, etc.

(c) Interest earned on unspent victims' compensation payments is not excluded from income or resources.

3) Relocation assistance.

(a) This type of assistance is sometimes provided to persons displaced by projects which acquire real property.

(b) Relocation assistance may be provided under local, state or federal programs. Such payments may be excluded for certain lengths of time. The length of the exclusion depends on the source:

(i) State and Local Program Assistance – unspent funds are excluded from resources for 9 months;

(ii) Federal Assistance – There is no time limit on the exclusion for assistance provided under the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970

(c) Interest earned on unspent payments is not excluded from income or resources.

8. Tax Advances and Refunds related to Earned Income Tax credits (EITC) and Child Tax Credits (CTC) .

a) Unspent federal tax refunds or payments related to the Earned Income Tax Credits (EITC) or Child Tax Credits (CTC) are excluded from resources for nine (9) calendar months following the month the refund or payment is received.

b) Interest earned on any unspent tax funds related to EITC or CTC is not excluded as income or a resource.

9. Radiation Exposure Compensation Trust Fund Payments.

a) The Radiation Exposure Compensation Trust Fund (RECTF) authorized the Department of Justice to make compensation payments to individuals (or their survivors) that were found to have contracted certain diseases after exposure.

b) The payments will be made as a one-time lump sum.

c) Unspent payments are excluded from resources. Interest earned on unspent payments is excluded income.

10. Gifts of Domestic Airline Tickets.

a) The value of a ticket for domestic travel received by an individual (or spouse) is not a resource if the ticket is:

1) Received as a gift,

2) Not converted to cash, i.e., cashed in, sold, etc., and

3) Excluded from income.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 3.13 Treatment of Excluded Funds Co-Mingled with Non-Excluded Funds.

A. Otherwise excludable funds must be identifiable in order to be excluded.

B. This does not require them to be separate from other funds (such as in a separate bank account).

C. When withdrawals are made from co-mingled funds, the assumption is non-excludable funds are withdrawn first, leaving as much of the excluded funds in the account as possible.

D. If excluded funds are withdrawn, the excluded funds left in the account can only be added to by deposits of subsequent funds excluded under the same provision and excluded interest

E. Example: An individual deposits an $800 retroactive RSDI check in a checking account. The account already contains $300 in non-excluded funds.

1. Of the new $1,100 balance, $800 is an excluded retroactive RSDI payment;

2. The individual withdraws $300. The remaining $800 is still excluded;

3. The individual withdraws another $300, leaving the $500 balance excluded;

4. The individual deposits $500, creating a new $1000 balance. Only $500 of the new balance is excluded.

F. Example: An individual deposits $200 in excluded funds in a non-interest bearing checking account that already contains $300 in non-excluded funds.

1. The individual withdraws $400. The remaining $100 is excluded;

2. The individual then deposits $100 in non-excluded funds. Of the resulting $200 balance, $100 remains excluded;

3. The individual next deposits $100 in excludable funds. Of the resulting $300 balance, $200 is now excluded.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Part 103 Chapter 4: Countable Resources

Rule 4.1 Cash.

A. Cash is a countable resource.

B. Cash is defined as money on hand that is in the form of coin or currency.

1. Foreign currency or coins are cash to the extent they can be exchanged for U.S. currency.

2. Coin collections are not considered cash, even though they are a resource.

a) The value of coin collections is based on a collector's value and determined by knowledgeable source estimate.

1) Treat a coin collection as other personal property.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994)

Rule 4.2 Checking/Savings Accounts.

A. Funds maintained in checking and savings accounts are usually payable on demand.

B. When an individual has unrestricted access to an account, all of the funds in the account are considered as a resource to the owner of the account, regardless of who deposited the funds.

C. A fiduciary or trustee is authorized to act on behalf of or for the benefit of another person. A fiduciary's right to withdraw funds is the same as the account owner's right to withdraw them.

D. Bank accounts must be verified eith from the client's own records (statements, print-outs, etc.) or agency verification to establish activity on the account and account balances.

1. The person designated as the owner in the account title is assumed to own all the funds in the account.

2. Absent evidence to the contrary, the person shown as the owner in the account title is assumed to have the legal right to withdraw funds and use them for support and maintenance.

a) Example: An account is titled "In trust for John Jones and Mary Smith, subject to sole order of John Jones, balance at death of either to belong to survivor". Since John alone has unrestricted access, none of the funds in the account could be considered Mary's resources unless John is her fiduciary or his resources are deemed available to her.

b) Example**:** An account is titled" George Dahey, restricted Individual Indian Money Account". Mr. Dahy cannot withdraw funds from the account without the authorization of the Bureau of Indian Affairs. Therefore, the account is not his resource.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.3 Joint Checking/Savings Accounts.

A. Except for account ownership, all instructions in the above rule also apply to joint bank accounts. The information in this section pertains only to ownership of joint bank accounts.

B. Ownership Assumptions for Joint Accounts.

1. Ownership is assumed as follows when the individual has unrestricted access to the account as follows:

a) Ownership When Medicaid Client is Joint Owner with an Ineligible Individual(s):

1) Count the total value of the account when the Medicaid applicant/recipient holds funds jointly with an ineligible individual(s), regardless of the source of the funds.

b) Ownership When More Than One Medicaid Client is an Account Holder:

1) Count an equal share of the account if two or more Medicaid applicants/recipients are holders of the same joint account, regardless of the source of the funds.

2) If the account is also jointly-held with ineligible individuals, do not allow a share of the funds to ineligible individuals.

c) Deemors.

1) If one or more account holders is a deemor and none of the account holders is a client, all of the funds in the account are assumed belong to the deemor or in equal shares if more than one deemor.

2. Rebuttal of Joint Checking/Savings Accounts.

a) An applicant or recipient may rebut ownership of part or all of the funds in a jointly-held account and must provide verification surrounding establishment of the account and ownership and expenditure of funds to support this claim.

b) Any funds that the evidence establishes were owned by the other account holder(s), and that the client can no longer withdraw from the account, were not and are not the client's resources. Rebuttal is both retrospective and prospective.

c) The funds can be deemed to be available to the client if the account holder to whom the funds belong is a deemor.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.4 Funds Held in Another Individual's Account.

A. The value of funds deposited or held for an applicant/recipient in an account that does not have the client's name on it are countable if:

   1. The holder(s) of the account agrees that the funds on deposit, or a portion thereof, belong to the applicant/recipient, and

   2. The funds are available to the client.

B. If some or all of the funds are acknowledged as belonging to the client and are available, the account is treated as a countable resource to the extent the funds belong to the client.

C. Documentation will include written statements from the client and the holder(s) of the account.

D. Entitlement income deposited into an account which is not owned by the client does not alter the fact that the income belongs to the client and is used to determine eligibility and Medicaid Income (if applicable).

E. Funds belonging to the client (including non-entitlement income) deposited into another person's account and not accessible to the client are subject to a transfer penalty, if applicable.

   1. A transfer may exist even if the funds are not acknowledged as belonging to the client when evidence indicates the client's funds are deposited and retained in the account.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.5 Time Deposits.

A. A time deposit is a contract between an individual and a financial institution whereby the individual agrees to leave funds on deposit for a specified period of time (six months, two years, five years, etc.) and the financial institution agrees to pay interest at a specified rate for that period.

   1. Certificates of Deposit and savings certificates are common forms of time deposits.

   2. The ownership assumptions regarding ownership of bank accounts apply to time deposits.

B. Withdrawal of a time deposit before the specified period expires incurs a penalty which is usually imposed against the principal. The penalty does not prevent the time deposit from being a resource, but it does reduce its value as a resource.

1. The resource value of a time deposit at any given time is the amount the owner would receive upon withdrawing it at that time, excluding interest paid that month. Generally this is:

a) Amount originally deposited;

b) Plus accrued interest for all but the current month; and

c) Minus any penalty for early withdrawal.

C. On rare occasions, the terms of a time deposit may prohibit early withdrawal altogether. When early withdrawal is prohibited, principal and interest are treated as follows:

1. Principal.

a) If the owner of a time deposit cannot under any circumstances withdraw the principal before it matures, the principal is not a resource. It becomes a resource (not income) on the date it matures and may affect countable resources for the following month.

2. Interest.

a) If the owner has no access to the interest before the deposit matures, accrued interest is also not a resource. The interest is not counted as income in the month the deposit matures, but as a resource the month after maturity.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.6 Conservator Accounts.

A. The term "conservatorship account" refers to a financial account in which a person or institution has been appointed by a court to manage and preserve the assets of an individual which are held in the account.

B. Absent evidence to the contrary, the funds are available for the individual's support and maintenance and are countable as that person's resource.

C. The court order establishing the account verifies it.

1. The fact that an individual has to petition the court for withdrawal of funds does not mean the funds may be assumed to be unavailable.

2. The denial of a request for withdrawal of funds by the court does not necessarily mean the funds in the account are unavailable for the individual's support or maintenance.

    a) A history of the petitions for and approvals and denials of funds may reveal the court approves petitions to withdraw funds to provide maintenance and support and only denies non-essential items; or

    b) The court's denial of a request is the exception rather than the rule. In either instance, the funds are considered an available resource.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.7 Patient Accounts.

A. A nursing home patient account is a financial account set up by the nursing home for the convenience of the patient.

B. These accounts are similar to a checking and/or savings account. The facility holds funds belonging to the patient for the patient's use.

C. For Medicaid purposes, a patient account is treated in the same manner as a checking or savings account.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.8 Charitable Funds Bank Accounts.

A. The value of funds in an account set up to receive and hold charitable contributions (fundraisers) is counted if the name of the applicant/recipient is on the account and the funds are available to the applicant/recipient for support and maintenance.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.9 Contents of Safety Deposit Box.

A. Some or all of the contents of a safety deposit box may be countable as resources based on the appropriate policy applicable to the type of resource, i.e., stock certificated, coins, jewelry, life insurance policy, etc.

B. If a recipient's possessions are stored in another person's' safety deposit box, access to the contents must be deteremined. Access would be determined the owner's statement.

C. Contents are determined from statements of the applicant/recipient, spouse or authorized representative. Access tp or owner of the .

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.10 Non-Home Real Property.

A. This type of property is land and any permanent buildings/immovable objects attached to it that are not considered a principal place of residence.

B. Generally, this type of property is a countable resource; however, an exclusion may be developed if there is a bona fide effort to sell.

C. Ownership and Current Market Value must be determined.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.11 529 Plan.

A. This is a state-sponsored investment program in which parents may fund accounts to pay for a child's college education.

B. Parents are owners and the account is considered a resource.

1. Withdrawal for reasons other than to pay for qualified college education is subject to income tax and an additional 10% penalty.

2. Account statements may be used to verify ownership and value of a 529 Plan..

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.12 Stocks.

A. General.

1. Shares of stocks represent ownership in a business corporation. The term "stock" includes:

a) Preferred stock,

b) Warrants and rights; and

c) Options to purchase stock:

B. Treatment.

1. To determine value:

a) Absent evidence to the contrary, assume each owner of a stock owns an equal share of stock; and

b) Can sell the stock at will, at current value.

1) Broker fees do not reduce the value that stocks have as a resource.

2. Ownership is determined using the stock certificate or most recent account statement (including dividend account) from the brokerage firm that issued or is holding the stock.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.13 Mutual Fund Shares.

A. General.

1. A mutual fund is a company whose primary business is buying and selling securities and other investments.

2. Types of mutual funds include growth funds, income funds, balance funds, municipal bonds, money market funds, load funds, no load funds.

B. Treatment

1. Shares in a mutual fund represent ownership in the investments held by the fund and their value is a countable resource.

2. Such investments may be pooled assets (such as stocks or bonds, managed by an investment company). In this event, a mutual fund share represents ownership interest in this pool as opposed to a specific stock.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.14 US Savimgs Bonds.

A. General.

1. A US Savings Bond is an obligation of the federal government, is not transferable and can only be sold back to the federal government.

B. Treatment.

1. Ownership Determination.

a) The individual(s) in whose name the bond is registered is the owner and retains sole ownership rights during his lifetime, even if a beneficiary is also named.

2. Valuation.

a) The redemption value of US bonds must be determined through the US Treasury and counts as a resource.

1) If there are joint owners, each individual owns equal shares of the bond's redemption value.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.15 Corporate Bonds.

A. General.

1. Corporate bonds are the obligation of a private corporation. Corporations sell bonds to raise capital.

2. There are two type of corporate bonds:

a) Debenture**s** are backed by the issuer's full faith and credit; and

b) Mortgage-Backed bonds are backed by a lien on the company's assets.

3. Corporate bonds are issued in two forms:

a) Registered bonds pay interest to their registered owner; and

b) Bearer or coupon bonds pay interest to whomever holds the bond.

B. Treatment.

1. Ownership is determined by the receipt of purchase.

2. The bond value is obtained from the issuer, i.e., broker, securities dealer, etc., and is a countable resource.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.16 Municipal Bonds.

A. General.

1. Municipal bonds are to city, county and state governments what corporate bonds are to corporations.

2. Most municipal bonds are of two types:

a) General Obligation Bonds are backed by the full faith and credit of the issuing municipality and supported by the taxing power; and

b) Revenue Bonds are backed by the project being financed and the revenue or user fees it generates.

c) Other types of municipals are limited-tax bonds, anticipation notes, industrial development bonds and life-care bonds.

B. Treatment.

1. Ownership is determined by the receipt of purchase.

2. The bond value is obtained from the issuer, i.e, broker, securities dealer, etc., and is a countable resource.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.17 Government Bonds/US Securities.

A. General.

1. A government bond, distinct from a US Savings Bond, is a transferable obligation issued or backed by the federal government.

2. Examples are:

a) Treasury Bills are short-term obligations that require a minimum investment of $10,000 and can be sold before maturity.

b) Treasury Notes and Bonds are similar to T-Bills but they have longer maturities and lower minimum investment requirements. They have been registered in book form since July 1986, but were sometimes issued as bearer bonds before then.

c) TIGER (Treasury Investors Growth Receipt) and CATS (Certificate of Accrual on Treasury Securities) are government securities issued with a zero coupon concept and can be sold before maturity. y.

d) Some Federal Agencies have charters to issue securities known as Federal Agency Securities. Minimum investments range from $1,000 to $25,000. Some of these federal agencies are: the Federal Home Loan Bank Board, Federal Home Loan Mortgage Corporation (FREDDIE MAC), the Export-Import Bank and the Government National Mortgage Association (GINNIE MAE).

B. Treatment.

1. The government securities discussed above are countable resources.

2. Ownership is determined from the receipt of purchase.

3. The value is determined from the issuer and counts as a resource.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.18 Cash to Purchase Medical or Social Services.

A. General.

1. An individual cannot always disburse cash given to him/her to purchase medical or social services in the month of receipt.

2. To permit use of the funds as intended, it is reasonable to assume, for a limited time, that the individual will use them to pay for approved services and, therefore, that they are not available for support and maintenance.

B. Treatment.

1. A cash payment for medical or social services that is not income also is not a resource for the month following month of receipt.

2. Exception: Even though it is not income, cash received as repayment for bills an individual has already paid is a resource and if retained, is counted the month after receipt.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.19 Retroactive in-home Supportive Services.

A. General.

1. In limited circumstances, governmental programs will pay a spouse or parent to provide a disabled spouse or child with certain in-home supportive (attendant, homemaker) services (IHSS). IHSS payments are income when received by the ineligible spouse or parent, but are not included as income for deeming purposes. In addition, a period of time is allowed during which retroactive IHSS payments are not considered resources.

B. Treatment.

1. A payment is considered retroactive if the payment is made after the month it was due.

   a) If payment is made in the month due, but following the month services were rendered, the payment is not retroactive.

2. An IHSS retroactive payment is excluded as a resource the month of receipt and the calendar month after receipt.

3. Beginning the second calendar month after receipt, it is a resource and subject to resources deeming.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.20 Uniform Gifts to Minors Act.

A. General.

1. Most states have adopted the Uniform Gifts to Minors Act (UGMA) that permits making gifts that are tax free to minors. The UGMA is sometimes called the Uniform Transfers to Minors Act.

2. Under the UGMA legislation:

   a) An individual (donor) makes an irrevocable gift of money or other property to a minor (the donee);

   b) The gift plus any earnings it generates is under the control of a custodian until the donee reaches the age of majority established by state law;
   c) The custodian has discretion to provide to the minor or spend for the minor's support, maintenance, benefit or education as much of the assets as he/she deems equitable; and

   d) The donee automatically receives control of the assets when he/she reaches the age of majority established by state law (age 21 in Mississippi).

3. A custodian of UGMA assets cannot legally use any of the funds for his/her own personal benefit. Therefore, the assets are not the custodian's resources and additions to, or earnings on the principal are not income to the custodian who has no right to use them for his/her own support and maintenance.

4. According to Mississippi state law, gifts that are valid under the Mississippi Uniform Transfer to Minors Act must reflect that the gift is being made under this Act. This means the gift(s), e.g., annuity, CD, property, life insurance, etc., must be assigned in writing and substantially worded to show the custodian's name, minor's name and the designation that the gift is authorized under the Uniform Transfer to Minors Act (in Mississippi, MS Code Ann., Section 91-20-19).

B. Treatment.

1. Additions to principal may be income to the donor before becoming part of the UGMA principal.

a) Example: If the donor is a deemor who receives rental income and adds it to a child's UGMA funds, consider the rental income as income for deeming purposes.

2. Gifts made under the UGMA may involve a countable transfer of resources to the donor, if applicable.

3. For minor donee, consider as income:

   a) Custodian's disbursements to the minor; and

   b) Disbursements on behalf of the minor used to make certain third party vendor payments.

4. For the minor donee, the following is not income to the minor: :

   a) The UGMA property; and

   b) Any additions or earnings.

5. For the donee at age 21, the following is applicable:

   a) All UGMA property will become available to him/her; and

   b) All funds in the UGMA will count as income the month the minor reaches age 21 and is a resource thereafter.

6. The document designating a UGMA transfer and ownership assigned in writing and complying with the requirements of state law must be provided. If there is no document designating a UGMA transfer, treat as though there is no UGMA.

Source: Social Security Act §1902 (r) (2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.21: Entrance Fees to Continuing Care Retirement Communities

A. Continuing Care Retirement Communities (CCRC) or life care communities provide a range of living arrangements from independent living assistance to skilled nursing care.

   1. Some CCRC's include Medicaid certified nursing facilities while others do not participate in Medicaid.

   2. An individual or couple may be required to pay substantial entrance fees and sign detailed contracts before moving into the CCRC.

   3. The entrance fee paid to a CCRC is treated as a resource under certain circumstances for the purpose of determining Medicaid eligibility.

B. The entrance fee paid to a CCRC is a countable resource if all of the following conditions are met:

1. The entrance fee can be used to pay for care under the terms of the entrance contract if other resources of the individual become insufficient. If only a portion of the fee is refundable, this condition is met.

2. The entrance fee is refundable when the individual dies or terminates the contract and leaves the CCRC. If the individual is eligible for a refund of any remaining entrance fee, this condition is met.

3. The entrance fee does not confer an ownership interest in the CCRC.

Source: Social Security Act § 1917(g); The Deficit Reduction Act of 2005.

History: New to correspond with the Deficit Reduction Act of 2005 (eff. 07/01/2008), eff. 09/01/2014.

Rule 4.22: Disqualification for Long Term Care Assistance for Individuals with Substantial Home Equity

A. Reimbursement for nursing facility services and other long term care services must be denied for an individual who has substantial home equity. In 2009, equity interest in home property could not exceed $500,000. This amount is subject to increase based on the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000.

B. The disqualification for substantial home equity will not apply to an individual who has a spouse, child under age 21 or adult blind or disabled child residing in the individual's home.

C. The substantial home equity limitation provision can be waived in cases of undue hardship as defined in Miss. Admin. Code, Part 103, Chapter 7.

Source: Social Security Act § 1917(f); Title XVI; Deficit Reduction Act; Omnibus Budget Reconciliation Act of 1993.

History: New to correspond with SPA 2008-003 (eff. 07/01/2008), eff. 09/01/2014.

Part 103 Chapter 5: Trust Provisions

Rule 5.1: Classification of Trusts

The three classifications of trusts are as follows:

A. OBRA-93 Trusts:

1. Are trusts established on or after August 11, 1993, the date mandated by OBRA-93 Federal legislation.

2. Must meet certain criteria. If OBRA-93 criteria are not met, another trust policy applies.

3. Rules were amended by The Deficit Reduction Act of 2005 (DRA) which provides current operating procedures for trust issues.

B. Medicaid Qualifying Trusts (MQT) are trusts established on or after March 1, 1987, through August 10, 1993, that meet MQT criteria. If MQT criteria are not met, defer to Miss. Admin. Code Part 103, Rule 5.1.C.

C. Standard Trusts are trusts established prior to March 1, 1987, and/or trusts that do not meet the criteria of OBRA-93 or MQT trusts, regardless of the date established.

Source: 42 CFR § 435.601(b); Social Security Act § 1902 (r)(2); Omnibus Reconciliation Act (OBRA-93) of 1993 § 13611(Rev. 1993); Deficit Reduction Act of 2005 §6016 (Rev. 2006); Consolidated Omnibus Reconciliation Act of 1985 § 9506 (Rev. 1985).

History: Revised eff. 11/01/2014.

Rule 5.2: Clearing Trusts, Guardianships, and Conservatorships

A. Trusts, guardianships/conservatorships are often complex documents involving state law and legal principles.

B. Trust documents must be referred to the state office for clearance whenever an individual or spouse either creates a trust or is the beneficiary of one.

1. Pertinent materials needed to evaluate the terms of the trust include a copy of the trust agreement and applicable material.

2. The terms of the trust will be evaluated based on the trust provisions described in this chapter. Trusts are subject to income, resource and/or transfer of assets rules, as appropriate.

Source: Miss. Code Ann. §43-13-121.1.

History: Revised eff. 11/01/2014.

Rule 5.3: General Trust Definitions

A. Introduction.

1. The definitions in this rule apply to any/all types of trusts.

2. Each type of trust has definitions which are specific to that trust classification that are discussed under other rules.

B. Trust Definitions

1. A trust is a property interest whereby property is held by an individual (trustee) subject to a fiduciary duty to use the property for the benefit of another (the beneficiary).

2. A grantor (also called a settlor or trustor) is a person who creates a trust. An individual may be a grantor if an agent, or other individual legally empowered to act on his/her behalf (e.g., a legal guardian, person acting under a power of attorney or conservator), establishes the trust with funds or property that belong to the individual. The terms grantor, trustor, and settlor may be used interchangeably.

3. A trustee is a person or entity who holds legal title to property for the use or benefit of another. In most instances, the trustee has no legal right to revoke the trust or use the property for his/her own benefit.

4. A trust beneficiary is a person for whose benefit a trust exists. A beneficiary does not hold legal title to trust property but does have an equitable ownership interest in it.

   a) Primary Beneficiary is the first person or class of persons to receive the benefits of a trust.

   b) Secondary Beneficiary is a person or class of persons who will receive the benefits of the trust after the primary beneficiary has died.

   c) Contingent Beneficiary is a person or class of persons who will receive benefits only if a stated event occurs in the future.

5. The trust principal (corpus) is the property placed in trust by the grantor which the trustee holds, subject to the rights of the beneficiary plus any trust earnings paid into the trust and left to accumulate.

6. Trust earnings (or income) are amounts earned by trust principal. They may take such forms as interest, dividends, royalties, rents, etc. These amounts are unearned income to the person (if any) legally able to use them for personal support and maintenance.

7. A Totten trust is a tentative trust in which a grantor makes himself trustee of his own funds for the benefit of another. The trustee can revoke a Totten trust at any time. Should the trustee die without revoking the trust, ownership of the money passes to the beneficiary.

8. A grantor trust is a trust in which the grantor of the trust is also the sole beneficiary of the trust.

9. A mandatory trust is a trust which requires the trustee to pay trust earnings or principal to or for the benefit of the beneficiary at certain times. The trust may require disbursement of a specified percentage or dollar amount of the trust earnings or may obligate the trustee to spend income and principal, as necessary, to provide a specified standard of care. The trustee has no discretion as to the amount of the payment or to whom it will be distributed.

10. A discretionary trust is a trust in which the trustee has full discretion as to the time, purpose and amount of all distributions. The trustee may pay to or for the benefit of the beneficiary, all or none of the trust as he or she considers appropriate. The beneficiary has no control over the trust.

11. A testamentary trust is a trust that is an integral part of a will and takes effect upon the death of the individual making the will.

Source: 42 CFR § 435.601(b); Social Security Act § 1902 (r)(2).

History: Revised eff. 11/01/2014.

Rule 5.4: General Trust Definitions - OBRA-93 and DRA Trust Policy

A. Introduction.

1. Section 13611 of the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) amended Section 1917(d) of the Social Security Act to revise the treatment of trusts effective with trusts established after the date of enactment of OBRA-93, which was August 11, 1993. Trusts established before this date, but added to or otherwise augmented after this date, are treated under OBRA-93 Trust rules.

2. OBRA-93 Transfer of Assets policy is used in conjunction with OBRA-93 Trust policy and provisions of the Deficit Reduction Act of 2005 (DRA), which amended rules on transfer of assets for less than fair market value by broadening the spectrum of what is considered a transfer, the length of the penalty period, the look back period for transfers, the definition of assets and how penalty periods run consecutively rather than concurrently.

B. Trust Definitions (OBRA-93 and DRA).

1. For purposes of this rule, a trust is any arrangement in which a grantor transfers property to a trustee or trustees with the intention that it be held, managed, or administered by the trustee(s) for the benefit of the grantor or certain designated individuals (beneficiaries). The trust must be valid under State law and manifested by a valid trust instrument or agreement. A trustee holds a fiduciary responsibility to hold or manage the trust's corpus and income for the benefit of the beneficiaries. The term "trust" also includes any legal instrument or device that is similar to a trust. It does not cover trusts established by will. Such trusts must be dealt with using Standard Trust policy.

2. A Legal Instrument or Device Similar to Trust is any legal instrument, device, or arrangement which may not be called a trust under State law but which is similar to a trust. That is, it involves a grantor who transfers property to an individual or entity with fiduciary obligations (considered a trustee for purposes of this section). The grantor makes the transfer with the intention that it be held, managed, or administered by the individual or entity for the benefit of the grantor or others. This can include (but is not limited to) escrow accounts, investment accounts, pension funds, and other similar devices managed by an individual or entity with fiduciary obligations.

3. A trustee is any individual, individuals, or entity (such as an insurance company or bank) that manages a trust or similar device and has fiduciary responsibilities.

4. A grantor is any individual who creates a trust. For purposes of this rule, the term "grantor" includes:

   a) The individual;

   b) The individual's spouse;

   c) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; and

   d) A person, including a court or administrative body, acting at the direction or upon the request of the individual, or the individual's spouse.

5. A revocable trust is a trust which can under State law be revoked by the grantor. A trust which provides that the trust can only be modified or terminated by a court is considered to be a revocable trust, since the grantor (or his/her representative) can petition the court to terminate the trust. Also, a trust which is called irrevocable but which terminates if some action is taken by the grantor is a revocable trust for purposes of this instruction.

6. An irrevocable trust is a trust which cannot, in any way, be amended or revoked by the grantor. Being irrevocable does not make the trust unavailable as a resource for Medicaid purposes.

7. A beneficiary is any individual or individuals designated in the trust instrument as benefiting in some way from the trust, excluding the trustee or any other individual whose benefit consists only of reasonable fees or payments for managing or administering the trust. The beneficiary can be the grantor himself, another individual or individuals, or a combination of any of these parties. For purposes of this rule, the beneficiary of a trust must be the applicant or Medicaid beneficiary or another allowable person, as described in the trust and transfer of assets rules, and under specified conditions. A transfer of assets will result if the trust beneficiary named is not an allowable person and the trust is funded with assets belonging to an applicant or Medicaid beneficiary and/or spouse.

8. For purposes of this rule, a payment from a trust is any disbursal from the corpus of the trust or from income generated by the trust which benefits the party receiving it. A payment may include actual cash, as well as noncash or property disbursements, such as the right to use and occupy real property.

Source: Omnibus Reconciliation Act (OBRA-93) of 1993 § 13611 (Rev. 1993); Deficit Reduction Act of 2005 §6016 (Rev. 2006).

History: Revised eff. 11/01/2014.

Rule 5.5: Medicaid Trust Provision

The following apply to any individual who establishes a trust, and who is an applicant for or recipient of Medicaid:

A. An individual is considered to have established a trust if his or her assets (regardless of how little) were used to form part or all the corpus of the trust and if any of the parties described as a grantor established the trust, other than by will;

B. When a trust corpus includes assets of another person or persons as well as assets of the individual, the rules apply only to the portion of the trust attributable to the assets of the individual. Thus, in determining countable income and resources in the trust for eligibility and post-eligibility purposes, any amounts of income and resources will be prorated, based on the proportion of the individual's assets in the trust to those of other persons. This general rule, however, is subject to the provisions of Miss. Admin. Code Part 103, Rule 5.7.A.

C. This rule applies to trusts without regard to:

   1. The purpose for which the trust is established;

   2. Whether the trustee(s), has or exercises any discretion under the trust;

   3. Any restrictions on when or whether distributions can be made from the trust; or

   4. Any restrictions on the use of distributions from the trust.

D. Any trust which meets the basic definition of a trust can be counted in determining eligibility for Medicaid. No clause or requirement in the trust, no matter how specifically it applies to Medicaid or other Federal or State programs (i.e., an exculpatory clause), precludes a trust from being considered under these rules.

E. Exceptions to the countability of trusts as a resource do exist and are discussed in Rule 5.13.

F. Trust assets includes both resources and income the individual or individual's spouse own or that would have become the individual's or spouse's resources or income but for actions taken to direct the assets elsewhere.

G. All assets held in a trust must be verified and the value of the assets established.

Source: Omnibus Reconciliation Act of 1993 (OBRA-93) § 13611(Rev. 1993); Deficit Reduction Act of 2005 §6016 (Rev. 2006).

History: Revised eff. 11/01/2014.

Rule 5.6: Treatment of Revocable Trusts

A. The entire corpus of a revocable trust is counted as an available resource to the individual. Any income earned by the trust and paid into the trust is also an available resource.

B. Any payments from the trust made to or for the benefit of the individual are counted as income to the individual, provided the payment is counted as income under SSI cash assistance rules.

C. Any payments from the trust which are not made to or for the benefit of the individual are considered assets disposed of for less than fair market value. [Refer to Miss. Admin. Code Part 103, Chapter 7]

D. Home property placed in a revocable trust loses its excluded status if the client is in an institution.

E. Changes made to a revocable trust that restrict or limit its use for the individual or spouse may be a transfer of assets. [Refer to Miss. Admin. Code Part 103, Chapter 7]

Source: 42 CFR § 435.601(b); Social Security Act §1902 (r) (2); Omnibus Reconciliation Act (OBRA-93) of 1993 § 13611(Rev. 1993); Deficit Reduction Act of 2005 §6016 (Rev. 2006).

History: Revised eff. 11/01/2014.

Rule 5.7: Treatment of Irrevocable Trusts

A. In the case of an irrevocable trust, where there are any circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust, the following rules apply to that portion.

    1. Payments from income or from the corpus made to or for the benefit of the individual are treated as income to the individual, provided the payment is counted as income under SSI cash assistance rules.

2. Income received by the trust which could be paid to or for the benefit of the individual is treated as a resource available to the individual.

3. The portion of the corpus that could be paid to or for the benefit of the individual is treated as a resource available to the individual; and,

4. Payments from income or from the corpus that are made, but not to or for the benefit of the individual, are treated as a transfer of assets for less than fair market value. [Refer to Miss. Admin. Code Part 103, Chapter 7]

B. If no payment can be made to or for the benefit of the individual from either all of the trust or from some portion of the trust, treat the trust or the unavailable portion as a transfer of assets. The value of the trust or the value of the unavailable portion is not an available resource if it is treated as a transfer of assets. [Refer to Miss. Admin. Part 103, Chapter 7]

1. The sixty (60) month look back period for transfer of assets applies. When all or portion of the corpus or income on the corpus of a trust cannot be paid to the individual, treat all or any such portion or income as a transfer of assets under OBRA-93 transfer policy.

2. In treating these portions as a transfer of assets, the date of the transfer is considered to be either the date the trust was established or, if later, the date on which payment to the individual was foreclosed.

3. In determining for transfer of assets purposes the value of the portion of the trust which cannot be paid to the individual, do not subtract from the value of the trust any payments made, for whatever purposes, after the date the trust was established or, if later, the date payment to the individual was foreclosed. The value of the transferred amount is no less than its value on the date the trust is established or payment is foreclosed.

4. If the trustee or the grantor adds funds to that portion of the trust which cannot be paid to the individual after these dates, the addition of those funds is considered to be a new transfer of assets, effective on the date the funds are added to that portion of the trust which cannot be paid to the individual.

Source: 42 CFR § 435.601(b) (Rev 1994); Social Security Act §1902 (r) (2); Omnibus Reconciliation Act (OBRA-93) of 1993 §13611 (Rev. 1993); Deficit Reduction Act of 2005 §6016 (Rev. 2006).

History: Revised eff. 11/01/2014.

Rule 5.8: Payments Made From Revocable or Irrevocable Trusts

A. Payments are considered to be made to the individual when any amount from the trust, including an amount from the corpus or income produced by the corpus, is paid directly to the individual or to someone acting on his/her behalf, e.g., a guardian or legal representative.

B. Payments made for the benefit of the individual are payments of any sort, including an amount from the corpus or income produced by the corpus, paid to another person or entity such that the individual derives some benefit from the payment.

C. A payment to or for the benefit of the individual is counted under this provision only if such a payment is ordinarily counted as income under the SSI program.

Source: 42 CFR § 435.601(b); Social Security Act §1902 (r) (2); Omnibus Reconciliation Act (OBRA-93) of 1993 § 13611(Rev. 1993); Deficit Reduction Act of 2005 §6016 (Rev. 2006).

History: Revised eff. 11/01/2014.

Rule 5.9: Circumstances Under Which Payments Can/Cannot Be Made.

In determining whether payments can or cannot be made from a trust to or for an individual, any restrictions on payments must be taken into account, such as use restrictions, exculpatory clauses, or limits on trustee discretion that may be included in the trust.

A. Example: If an irrevocable trust provides that the trustee can disburse only $1,000 to or for the individual out of a $20,000 trust, only the $1,000 is treated as a payment that could be made. The remaining $19,000 is treated as an amount which cannot, under any circumstances, be paid to or for the benefit of the individual.

B. On the other hand, if a trust contains $50,000 that the trustee can pay to the grantor only in the event that the grantor needs, for example, a heart transplant, this full amount is considered as payment that could be made under some circumstances, even though the likelihood of payment is remote. Similarly, if a payment cannot be made until some point in the distant future, it is still payment that can be made under some circumstances.

Source: Omnibus Reconciliation Act (OBRA-93) of 1993 § 13611 (Rev. 1993); Deficit Reduction Act of 2005 §6016 (Rev. 2006).

History: Revised eff. 11/01/2014.

Rule 5.10: Placement of Excluded Assets in Trust

A. Section 1917 of the Act provides that, for trust and transfer purposes, assets include both income and resources.

B. Section 1917 of the Act further provides that income has the meaning given that term in Section 1612 of the Act and resources has the meaning given that term in Section 1613 of the Act (income and resources as defined in SSI policy).

C. Transferring an excluded asset (either income or a resource, with the exception of the home of an institutionalized individual) for less than fair market value does not result in a penalty under the transfer provisions because the excluded asset is not an asset for transfer purposes.

Similarly, placement of an excluded asset in a trust does not change the excluded nature of that asset; it remains excluded, except for the home property of an institutionalized individual.

D. Transfer of title to the home of an institutionalized individual in a revocable trust results in the home becoming a countable resource. Transfer of title to the home property of an institutionalized individual in an irrevocable trust results in the home either being treated as a countable resource or shall be considered a transfer of assets. However, if there are circumstances where payment from the irrevocable trust could be made to or for the benefit of the individual, those payments shall be treated as a countable resource for the individual. The Division will look to the terms of the trust to make this determination.

Source: Social Security Act §§ 1612, 1613 and 1917; Omnibus Reconciliation Act (OBRA-93) of 1993 § 13611(Rev. 1993); Deficit Reduction Act of 2005 §6016 (Rev. 2006).

History: Revised eff. 11/01/2014.

Rule 5.11: Undue Hardship Provision

When application of the Trust provisions would work an undue hardship, the provisions will not apply.

A. Undue hardship exists when:

1. Application of the trust provisions would deprive the individual of medical care such that his/her health or his/her life would be endangered.

2. Application of the trust provisions would deprive the individual of food, clothing shelter, or other necessities of life causing severe deprivation.

3. The applicant or spouse or representative has exhausted all legal action to have the transferred assets that caused the penalty returned.

B. Undue hardship does not exist when:

1. Application of the trust provisions merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

2. The resource was transferred to a person (spouse, child, or other person) who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless it is established that the transferred funds cannot be recovered even through exhaustive legal measures.

C. Each case situation must be reviewed individually to determine if undue hardship exists.

D. Generally, this provision is limited to financially and medically needy individuals with no possible means of accessing funds placed in a trust.

Source: Omnibus Reconciliation Act (OBRA-93) of 1993 § 13611 (Rev. 1993); Deficit Reduction Act of 2005 §6016 (Rev. 2006).

History: Revised eff. 11/01/2014.

Rule 5.12: Reviewing Trust Documents

In reviewing a trust:

A. Trust documents, including amendments and the required number of accountings must be obtained;

B. The type of trust, i.e., OBRA-93 Trust, Medicaid Qualifying Trust, or Standard Trust, ~~is~~ must be determined;

C. The trust must be determined to be revocable or irrevocable; and

D. Establish whether any income is released from the trust; and

E. The applicable policy and procedural requirements for clearing the trust and the treatment of the trust are applied.

Source: Miss. Code Ann. §43-13-121.1.

History: Revised eff. 11/01/2014.

Rule 5.13: Trust Exceptions

A. The following types of trusts are treated as exceptions to the trust provisions outlined above provided the trust is established according to criteria specific to the trust type. The trust exceptions are:

    1. Special Needs Trust;

    2. Pooled Trust; and

    3. Income Trust.

B. Funds entering and leaving these trusts are generally treated according to SSI rules or more liberal rules under Section 1902(r) (2) of the Act, as appropriate.

C. As noted under the rule for each type of trust, one common feature of all of the excepted trusts is a requirement that the trust provide that, upon the death of the individual or upon

termination of the trust for any other reason, any funds remaining in the trust go to the MS Division of Medicaid, up to the amount paid in Medicaid benefits on the individual's behalf.

Source: 42 CFR § 435.601(b); Social Security Act §1902 (r) (2); Omnibus Reconciliation Act (OBRA-93) of 1993 §13611 (Rev. 1993); Deficit Reduction Act of 2005 §6016 (Rev. 2006).

History: Revised eff. 11/01/2014.

Rule 5.14 Special Needs Trusts (SNT)

A. A Special Needs Trust (SNT) contains the assets of an individual under age sixty-five (65) who is disabled and which is established for the sole benefit of the disabled individual by a parent, grandparent, legal guardian of the individual, or a court.

B. To qualify for an exception to the rules governing trusts, the SNT must contain a provision stating that, upon the death of the individual or upon termination of the trust for any other reason, the MS Division of Medicaid receives all amounts remaining in the trust, up to an amount equal to the total amount of medical assistance paid on behalf of the individual.

C. When a SNT is established for a disabled individual under age sixty-five (65), the SNT exception for the trust continues even after the individual becomes age sixty-five (65). However, a SNT cannot be added to or otherwise augmented after the disabled individual reaches age sixty-five (65). Any such addition or augmentation after age sixty-five (65) involves assets that were not the assets of an individual under age sixty-five (65) and therefore, those assets are not subject to the SNT exception.

D. A SNT must be established for a disabled individual, as defined under the SSI Program in section 1614(a)(3). When the individual in question is receiving either Title II or SSI benefits as a disabled individual, the disability determination made for those programs is accepted. If the individual is not receiving - SSI or title II based on disability, a determination concerning the individual's disability must be made. If disability is not established using SSI criteria, the SNT exception cannot apply.

E. Establishment of a SNT as described above does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under age sixty-five (65). However, if the trust is not solely for the benefit of the disabled person or if the disabled person is over age sixty-five (65) at the time the SNT is established, transfer penalties may apply.

Source: 42 U.S.C. § 1396p(d)(4).

History: Revised eff. 11/01/2014.

Rule 5.15: Pooled Trusts

A. A pooled trust is a trust containing the assets of a disabled individual that meets the following conditions:

   1. The trust is established and managed by a non-profit entity that has been granted that status by the Internal Revenue Service (IRS);

   2. A separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds the trust pools the funds in these accounts;

   3. Accounts in the trust are established solely for the benefit of disabled individuals by the individual, by the parent, grandparent, legal guardian of the individual, or by a court; and

   4. To the extent that any amounts remaining in the beneficiary's account upon the death of the beneficiary or upon the termination of the trust for any other reason are not retained by the trust, the trust pays to the MS Division of Medicaid the amount remaining in the account up to the amount equal to the total amount of medical assistance paid on behalf of the beneficiary. To meet this requirement, the trust must include a provision specifically providing for such payment.

B. To qualify as an excepted trust, the trust account must be established for a disabled individual, as defined in Section 1614(a)(3) of the Act. When the individual in question is receiving either Title II or SSI benefits as a disabled individual, the disability determination made for those programs is accepted. If the individual is not receiving SSI or title II benefits based on disability, a determination concerning the individual's disability must be made. If disability is not established using SSI criteria, the pooled trust exception cannot apply.

Source: 42 U.S.C. §1396p(d)(4); Social Security Act §1614(a).

History: Revised eff. 11/01/2014.

Rule 5.16: SNT and Pooled Trust Guidelines and Restrictions

The MS Division of Medicaid has established guidelines and restrictions regarding payments and distributions from a SNT or pooled trust that must be followed in order for either type of trust to meet or continue to meet the conditions for exception. Medicaid eligibility of the disabled individual may be affected if these guidelines are not followed.

A. Payments for medical expenses that are not paid by Medicaid are allowed to be made from the trust. One exception is the cost differential between that of a private room and a semi-private room in an institutional setting is not an allowable expense.

B. Gifts must not be made from either type of trust,

C. Compensation must not be paid to a family member from either type of trust for services rendered as a trustee.

D. Compensation must not be paid to a family member from either type of trust for services rendered as a caretaker to the disabled beneficiary.

E. The purchase of residential real property by the trust is allowable only if the residence is specially equipped to meet the needs of the disabled beneficiary and the property serves as the disabled beneficiary's place of residence. Examples of "specially equipped" are: wider doorways to accommodate wheelchairs, ramps, handrails, etc. If the disabled beneficiary does not require a home to be specially equipped, the purchase of residential real property will not be allowed as an expense from either type of trust. The trust must be the owner of any real property purchased by the trust. Additions or improvements to an existing property will be allowed only if needed to accommodate the special needs of the disabled beneficiary.

F. The payment of advalorem taxes and/or insurance premiums on real property will be allowed only if the property has been specially equipped to meet the needs of the disabled beneficiary. Payment of utility expenses is considered as a part of maintenance and support and is not a special need; therefore, payment of utilities by either type of trust is not allowed.

G. The purchase of a vehicle by the trust is allowed only if it is specially equipped to allow the disabled beneficiary to operate the vehicle or to be transported in the vehicle; otherwise the purchase of a vehicle by either type of trust is not allowed. If the purchase of a non-specially equipped vehicle is considered a medical necessity, the MS Division of Medicaid will take into consideration an undue hardship request for the purchase of a vehicle prior to the purchase of such a vehicle. The payment for tags, insurance and repairs on a vehicle will be allowed only if the vehicle is specially equipped. Payments for gasoline and other operating expenses are not considered special needs but are considered as a part of basic maintenance and support. The trust must not be the owner of any vehicle that is purchased by funds from either type of trust.

H. Payments for vacations and other non-medical trips must not exceed $2,000 during any calendar year.

I. Payments for recreational opportunities, family visits or visits to friends must not exceed $2,000 during any calendar year.

J. Payments for non-medical expenses such as radios, televisions, audio or video equipment, computer equipment or other electronic devices and/or equipment are limited to one purchase of each type every five (5) years and the total expenditures for these types of expenses must not exceed $5,000 during any calendar year.

K. The payment of burial expenses, the purchase of pre-need burial contracts or the payment of burial insurance premiums are not considered special needs and are not to be made from either type of trust until after the MS Division of Medicaid has been reimbursed upon the termination of the trust.

L. Payments for food, clothing, rent, mortgage payments, furniture, appliances and household help are considered to be items of basic maintenance and support and not special needs. Such payments must not be made from either type of trust.

M. Distributions from either type of trust directly to the disabled beneficiary or to the beneficiary's bank account will be considered income to the disabled beneficiary in the month in which the distribution is made.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 11/01/2014.

Rule 5.17: Income Trusts

A. The purpose of an Income Trust is to allow an individual with excess income who has exhausted all available resources to become eligible for Medicaid. The trust may be used only for income belonging to the individual. No resources (assets) may be used to establish or augment the trust. Inclusion of resources voids the trust exception. It is intended to assist individuals with excess recurring monthly income who have income that exceeds the Medicaid institutional limit in effect at the time eligibility is requested but have insufficient income to pay the private cost of institutional care. Individuals with income above the private pay rate for the facility in which the individual resides will not be eligible for Medicaid under the Income Trust provision.

B. This type of trust established for the benefit of the individual is limited to institutionalized individuals, not those in an acute care hospital setting. Persons participating in the home and community-based services (HCBS) waiver may also utilize an Income Trust for eligibility purposes.

C. An Income Trust must meet all the following requirements:

1. The trust is composed only of the pension(s), Social Security, and other income due the individual from all sources, including accumulated interest in the trust. Total income does not include income that is not countable under Medicaid rules, such as payments from the Veterans' Administration for Aid and Attendance (A&A) and payments for unreimbursed medical expenses.

2. Income Trusts, once accepted by the Division of Medicaid, cannot be modified without the Division of Medicaid's approval. An Income Trust must specify that the trust will terminate at the individual's death, when Medicaid eligibility is terminated, when the trust is no longer necessary or in the event the trust is otherwise terminated. Trusts may need to be terminated prior to an individual's death due to changes in the individual's income or changes in Medicaid policy regarding how certain income must be counted or in the event the individual is discharged from the nursing facility.

3. A portion of the individual's income may be protected in the month of entry into a nursing facility. When income protection is applicable, there is no cost of care payable to the nursing facility for beneficiaries whose income is less than the institutional income limit. However, income above the amount that is one dollar ($1.00) less than the Medicaid institutional limit is payable to the Division of Medicaid for beneficiaries eligible under an Income Trust within thirty (30) days after receipt of the notice approving eligibility issued by the Division of Medicaid. The approval notice informs the Trustee of the amount payable for the month of entry.

4. For all subsequent month(s), if income of the individual is less than the individual's cost of care at the nursing facility, all income of the individual, less authorized deductions, must be paid directly to the nursing facility. In that case no funds will be retained in the trust. If the income of the individual exceeds the cost of care at the nursing facility in any month the individual is eligible under an Income Trust, the trust must retain the income in excess of the cost of care until such time that payment of the accumulated Income Trust fund is requested by the Division of Medicaid.

5. Income Trusts for HCBS Waiver enrollees require that the trust must distribute to the individual, or for his/her benefit, an amount equal to not more than one dollar ($1.00) less than the then current Medicaid income limit as approved by the Division of Medicaid. The trust should not specify the amount of the individual's income as this amount may change each year and the amount to be released from the trust will change to an amount equal to one dollar ($1.00) less than the current Medicaid income limit.

6. At the dissolution or termination of an Income Trust, the death of the individual, loss of the individual's Medicaid eligibility or in the event that the individual's income no longer exceeds the current Medicaid income limits, the trust agreement must provide that all amounts remaining in the trust up to an amount equal to the total medical assistance paid by the Division of Medicaid on behalf of the individual that has not previously been repaid will be paid to the Division of Medicaid.

7. The trust agreement must provide that at the time of each review of the individual's Medicaid eligibility (at least annually) while this trust is in existence, when notified by the Division of Medicaid, the Trustee must pay to the Division of Medicaid the amount that should be accumulated in the trust up to the amount expended by the Division of Medicaid on behalf of the individual that has not previously been repaid. Failure to make the requested payments will result in the loss of Medicaid eligibility for the individual.

8. The trust agreement must provide for an accounting of all receipts and disbursements of the trust during the prior calendar year when requested by the Division of Medicaid.

9. No fees are allowed to be paid to the Trustee for their service. In the event funds are retained in the trust, administrative fees are limited to ten dollars ($10.00) per month and are intended to cover any bank charges required to maintain the trust account.

10. Any disbursements not approved by the Division of Medicaid or provided for by the trust agreement will result in a loss of the trust exemption.

11. The trust agreement must specify an effective date. Unless the applicant is requesting retroactive eligibility of up to ninety (90) days, which will require that the applicant have the funds necessary to fund the trust for that period, the effective date will be the date of execution. If a retroactive date is being sought, the effective date will be determined through consultation with the Division of Medicaid's Regional Office. In that case the Regional Office should be consulted to determine the effective date prior to execution of the agreement.

D. An Income Trust will not be allowed on a temporary or intermittent basis except in instances when monthly excess income will be reduced at a future date. In such a case, an Income Trust will be allowed until such time as the excess monthly income no longer requires an Income Trust to allow eligibility. Income received less than monthly does not qualify as recurring excess monthly income that allows the use of an Income Trust. Income received irregularly or infrequently must be converted to monthly income before evaluating the need for an Income Trust.

E. The Division of Medicaid will provide model Income Trust agreements for individuals in need of an Income Trust. Model agreements are provided for individuals in institutional care and for individuals enrolled in an HCBS waiver that need an Income Trust in order to qualify for Medicaid based on income. The only changes to these legally binding documents that the Division of Medicaid will accept are to add language regarding a successor trustee or co-trustee. Changes must be approved by the Division of Medicaid prior to execution of the trust. In completing the Income Trust document, the individual cannot be the Trustee of the Income Trust.

F. It is possible to have an Income Trust during the time a transfer of assets penalty is in effect. Although the Division of Medicaid will not pay for an individual's room and board during a transfer penalty period, the Income Trust will allow an individual with excess income who otherwise requires an Income Trust in order to be eligible to qualify for all Medicaid covered services other than payment of room and board and will allow the penalty period to be implemented.

G. An applicant or beneficiary requiring an Income Trust who has a court appointed conservator must furnish a copy of the Chancery Court Order authorizing the conservator to establish the Income Trust. The court must be made aware of the Income Trust requirement to pay the Division of Medicaid any accumulated trust funds up to an amount expended by the Division of Medicaid under the terms of the trust.

Source: 42 U.S.C. § 1396p; Miss. Code Ann. § 43-13-121.

History: Revised to correspond to SPA 16-0009 (eff. 01/01/2016) eff. 01/01/2017; Revised eff. 11/01/2014.

Part 103 Chapter 6: Annuities

Rule 6.1: Annuities Defined for Medicaid Purposes

A. Annuities – General (Applies Regardless of Purchase Date)

1. An annuity is defined as a contract or agreement by which one receives fixed, non-variable payments on an investment for a lifetime or a specified number of years.

   a) An individual may buy an annuity by making payments over a period of time or purchase an immediate annuity by paying a lump sum to a bank or insurance company in return for regular payments of income in certain amounts.

   b) When an annuity is "annuitized," the investment is converted into periodic income payments.

   c) These payments may continue for a fixed period of time or for as long as the individual or another beneficiary lives.

2. The annuitant is the person who will receive the payments during the term of the annuity. The annuity contract should identify the purchaser (owner) and the annuitant. The owner and the annuitant may or may not be the same; however, the policy described in this chapter applies to annuities purchased with the applicant's or recipient's own funds by the applicant/recipient, spouse, guardian or legal representative and which name the applicant/recipient or spouse as the annuitant.

3. An annuity may or may not include a remainder clause under which, if the annuitant dies, the contracting entity converts whatever is remaining in the annuity into a lump sum and pays it to a designated beneficiary.

4. Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can be eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those intended to shelter assets, a determination must be made with regard to the ultimate purpose of the annuity, i.e., whether or not it is part of a bona fide retirement plan.

5. Transfer of assets policy will be considered when an applicant or recipient's own funds are used to purchase an annuity for someone other than the applicant/recipient or their spouse. Likewise, if the right to receive payment is assigned to someone other than the applicant/recipient, spouse or to a minor or disabled child of the applicant, a transfer of assets will be considered.

B. Revocable Annuities (Applies Regardless of Purchase Date)

1. An annuity that is revocable is a countable resource unless it can be excluded under another provision, such as an income-producing asset meeting the 6% of equity provision for annuities purchased prior to 02/08/2006. Some annuities which appear irrevocable may be revocable with a penalty, reducing the total value. Generally, an annuity is revocable until the time the annuity is annuitized. Verification is needed to make a determination.

2. An annuity is a countable resource if it can be sold, cashed in, surrendered or revoked. An annuity that can be revoked is valued at the amount the purchaser would receive if canceled.

3. An annuity is a countable resource if it can be assigned to a new owner or the payments transferred to someone else. If an annuity is assignable, it is valued at the amount the annuity can be sold on the secondary market.

C. Irrevocable Annuities (Applies Regardless of Purchase Date)

1. If an annuity cannot be revoked or cashed in and the annuity contract does not allow the annuitant to transfer ownership or payments to someone else, the annuity is not a countable resource, although it may be a transfer of assets if purchased within the five (5) year look back period as outlined in this chapter.

2. If periodic payments are not being made, the individual must take all steps necessary to receive periodic payments as outlined in this chapter. If periodic payments are denied but a lump sum payment is possible, the lump sum amount is a countable resource.

D. Payments Produced by Annuities (Applies Regardless of Purchase Date)

1. Annuity payments paid to the annuitant are countable income regardless of whether the annuity itself is countable as an asset or treated as a disqualifying transfer. Certain conditions apply to the frequency and amount of the payments required in order for an annuity to avoid being treated as a transfer of assets, as described within this chapter.

E. Non-Annuitized Annuity (or any portion thereof) (Applies Regardless of Purchase Date)

1. The equity value of an annuity that is not annuitized or any part of an annuity that is not annuitized is counted as a countable resource. Verification is needed to make a determination.

Source: Social Security Act §1917 (c) and (d); Omnibus Reconciliation Act of 1993 (OBRA-93) § 13611(Rev. 1993); Deficit Reduction Act of 2005 §6011 and §6016 (Rev. 2006).

History: Revised eff. 11/01/2014.

Rule 6.2: Treatment of Annuities Purchased prior to 2/8/2006.

A. An annuity purchased before February 8, 2006, by or for an individual using that individual's assets will be considered a transfer of assets unless both of the following are met:

   1. The annuity produces a net annual return of at least 6% of its equity value; and

   2. Pays out principal and interest in equal monthly installments (no balloon payments) to the individual in sufficient amounts that the principal is paid out within the actuarial life expectancy of the individual seeking long term care services, including HCBS services.

B. An annuity that meets the criteria above will be excluded as a resource and the income paid by the annuity counted as income to the annuitant.

C. An annuity that does not meet the required conditions is a transfer of assets if purchased during the look back period. The income produced by the annuity counts as income to the annuitant during the transfer penalty period and the full payment period of the annuity.

Source: Social Security Act §1917(d); Omnibus Reconciliation Act of 1993 (OBRA-93) § 13611(Rev. 1993).

History: Revised eff. 11/01/2014.

Rule 6.3: Calculating the Uncompensated Value of Annuities Purchased prior to 02/08/2006.

The transfer penalty period for the purchase of an annuity prior to 02/08/2006 is calculated based on the value of the payments that would be beyond the actuarial life expectancy of the annuitant.

A. Divide the purchase price of the annuity by the number of payout years. This equals the annual rate.

B. Use the life expectancy tables published by the Office of the Actuary of the Social Security Administration to determine the number of years the individual is expected to live.

C. Subtract the number of years from the number of payout years.

D. Multiply the difference by the annual rate. This is the uncompensated value.

Source: Social Security Act §1917(c); Omnibus Reconciliation Act of 1993 (OBRA-93) § 13611(Rev. 1993).

History: Revised eff. 11/01/2014.

Rule 6.4: Treatment of Annuities Purchased on or after 2/8/2006.

The Deficit Reduction Act of 2005 (DRA), P.L. 109-171 adds new requirements to the Medicaid statute with respect to the treatment of annuities purchased on or after the date of enactment, February 8, 2006, by or on behalf of an annuitant who has applied for Medicaid for nursing

facility services or other long-term care services. The DRA requirements also apply to certain other transactions involving annuities that take place on or after the date of enactment that are described below.

A. Disclosure Requirement

1. At each application and annual review for Medicaid eligibility, all long-term care applicants or beneficiaries are required to disclose any interest the applicant/beneficiary or community spouse may have in an annuity or similar financial instrument. Parents of a minor child must report any annuities in which the child may have an interest.

2. This disclosure is a condition for Medicaid eligibility for long-term care services, including nursing facility services and home and community-based waiver services (HCBS) and applies regardless of whether or not an annuity is irrevocable or is treated as a resource.

3. Refusal to disclose sufficient information related to any annuity will result in denial or termination of Medicaid eligibility, based on the applicant or beneficiary's failure to cooperate in accordance with existing Medicaid policies.

4. When an unreported annuity is discovered after eligibility has been established and after payment for long-term care services has been made, appropriate steps to terminate payment for long-term care services will be taken, including allowing for rebuttal and advance notice.

B. Annuity-Related Transactions Other than Purchases Made on or after February 8, 2006.

1. In addition to purchases of annuities, certain related transactions which occur to annuities on or after February 8, 2006, make an annuity, including one purchased before that date, subject to all provisions of the DRA that went into effect on February 8, 2006.

2. Any action taken on or after February 8, 2006, by the individual that changes the course of payment to be made by the annuity or the treatment of the income or principal of the annuity result in the annuity being treated as if purchased on or after February 8, 2006. These actions include:

   a) Additions of principal,

   b) Elective withdrawals,

   c) Requests to change the distribution of the annuity, and

   d) Elections to annuitize the contract and similar actions.

3. For annuities purchased prior to February 8, 2006, routine changes and automatic events that do not require any action or decision after the effective date are not considered

transactions that would subject the annuity to treatment under the DRA provisions. Routine changes could be notification of an address change or death or divorce of a remainder beneficiary and similar circumstances.

4. Changes which occur based on the terms of the annuity which existed prior to February 8, 2006, and which do not require a decision, election or action to take effect are also not subject to the DRA.

C. Requirement to Name the Division of Medicaid as Remainder Beneficiary on Annuities

1. The purchase of an annuity within the five (5) year look back-period and in all subsequent months will be treated as a transfer of assets unless the Division of Medicaid is named as a remainder beneficiary in the correct position as described herein.

   a) This requirement applies to annuities purchased by the applicant or spouse and to certain annuity-related transactions other than purchases made by the applicant or spouse.

   b) An annuity must name the Division of Medicaid as the remainder beneficiary in the first position for the total amount of Medicaid assistance paid on behalf of the institutionalized beneficiary who is the annuitant unless there is a community spouse and/or a minor or disabled child.

   c) If there is a community spouse and/or minor or disabled child, the Division of Medicaid may be named in the next position after those individuals.

   d) If the Division of Medicaid is named beneficiary after a community spouse and/or minor or disabled child, and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than fair market value, the Division of Medicaid must then be named in the first position.

   e) If verification is not provided which reflects the Division of Medicaid as remainder beneficiary in the correct position on annuities purchased by the institutionalized spouse or community spouse, the purchase of the annuity will be considered a transfer for less than fair market value. The full purchase value of the annuity will be considered the amount transferred.

2. An annuity purchased prior to the five (5) year look-back period is treated as a resource and/or income source, depending on the terms of the annuity as outlined in Miss. Admin Part 103, Rule 6.1.

D. Information Provided by the Division of Medicaid to Issuer

1. For any annuity disclosed for the applicant or community spouse, the Division of Medicaid must inform the issuer of the annuity of the Division of Medicaid's right to be named as a preferred remainder beneficiary and may require the issuer to notify the

Division of Medicaid regarding any changes in amount of income or principal being withdrawn from the annuity.

2. The issuer of the annuity may disclose information about the Division of Medicaid's position as remainder beneficiary to others who have a remainder interest in the annuity.

E. Treatment of Annuities in Determining Eligibility for Long-Term Care

1. In addition to the requirement for the Division of Medicaid to be named as a remainder beneficiary for an annuity purchased by the institutionalized spouse or community spouse within the five (5) year look-back period and in all subsequent months, an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility or other long-term care services will not be treated as a transfer of assets if purchased within the five (5) year look-back period or any subsequent month if certain conditions are met which are described below.

2. The annuity meets one of the following conditions for employment-related annuities that are treated as retirement funds:

   a) It is an individual retirement annuity according to (b) or (q) of section 408 of the Internal Revenue Code (IRC) of 1986, or,

   b) The annuity is purchased with proceeds from an account or trust described in subsection (a), (c) or (p) of section 408 of the IRC, or,

   c) The annuity is purchased with proceeds from a simplified employee pension within the meaning of section 408 of the IRC, or,

   d) The annuity is purchased with the proceeds from a Roth Individual Retirement Account (IRA) described in section 408A of the IRC.

3. The purchase of an annuity not described in Miss. Admin. Code Part 103, Rule 6.4.E.2. above will be considered a transfer of assets unless it meets all of the following requirements for every month in which eligibility is being considered:

   a) The annuity is irrevocable and non-assignable, and,

   b) The annuity is actuarially sound as outlined in Miss. Admin. Code Part 103, Rule 6.5., and

   c) The annuity is providing payments in equal amounts during the term of the annuity with no deferred or balloon payments, and

   d) The annuity is issued by a business licensed and approved to issue commercial annuities in the state in which the annuity was purchased; and

e) The Division of Medicaid has been named as beneficiary of the annuity in the correct position as outlined in Miss. Admin. Code Part 103, Rule 6.4.C. above.

4. The purchase of a single-premium life insurance policy, endowment policy or similar instrument which has no cash value, and for which the individual receives no valuable consideration will be considered a transfer of assets if purchased within the five (5) year look-back period or any subsequent month.

5. To determine that an annuity is established under any of the various provisions of the IRC referenced above and/or meets all of the conditions required to be excluded from a transfer of assets penalty or counted as a resource, rely on verification from the financial institution, employer or employer association that issued the annuity. The burden of proof is on the individual or representative to produce needed documentation. The individual or representative must produce the annuity contract in order to evaluate the annuity. Without documentation, the purchase of an annuity will be considered a transfer of assets subject to a transfer penalty in the amount of the full purchase value of the annuity.

6. An annuity that does not meet the conditions cited above, or an annuity that is not changed to meet the necessary requirements and/or documentation that is not provided relating to an annuity will result in the annuity being treated as a transfer of assets if purchased within the five (5) year look-back period or any subsequent month using the full purchase value as the amount transferred.

7. Even if an annuity is determined to meet the requirements above and the purchase is not treated as a transfer, if the annuity or income stream from the annuity is transferred, that transfer may be subject to a penalty with the exception of transfers to a spouse or to another individual for the sole benefit of the spouse, to a minor or disabled child or to a Special Needs Trust.

F. Consideration of Income from an Annuity

1. An annuity that does not comply with the requirements described in this chapter will be treated as a transfer of assets. During the penalty period, the income produced by the annuity counts as income to the individual or spouse, as appropriate, in determining eligibility and post-eligibility cost of care and spousal allocation, as applicable.

2. The income produced by an annuity that complies with the requirements in this chapter counts as income to the individual or spouse, as appropriate, in determining eligibility and post-eligibility cost of care and spousal allocation, as applicable.

G. Requirements for the Community Spouse

1. Annuities purchased by the community spouse on or after February 8, 2006, must name the Division of Medicaid as the preferred remainder beneficiary.

2. The institutionalized spouse may not be named as a beneficiary ahead of the Division of Medicaid.

3. However, if there is a minor or disabled child, the child may be named as first beneficiary and the Division of Medicaid must be named in the next position after those individuals.

4. It does not matter if the community spouse's annuity is actuarially sound or provides payments in approximately equal amounts with no deferred or balloon payments. These provisions apply only to annuities purchased by or on behalf of the individual who has applied for medical assistance, not a community spouse.

H. Estate Recovery

1. Annuities purchased on or after February 8, 2006, will be subject to estate recovery.

2. The rules for the institutional spouse and the community spouse are the same for annuities purchased prior to February 8, 2006.

Source: 42 U.S.C. § 1396p; Miss. Code Ann. § 43-13-121.

History: Revised to correspond to SPA 16-0009 (eff. 01/01/2016) eff. 01/01/2017; Revised eff. 11/01/2014.

Rule 6.5: Determining Whether an Annuity (Purchased After 02/08/2006) is Actuarially Sound

A determination must be made on whether the purchase of annuities, other than qualifying IRS annuities, is treated as a transfer of assets for less than fair market value.

A. If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the annuitant, the annuity can be deemed actuarially sound. The life expectancy tables published by the Office of the Actuary of the Security Administration are used.

B. The average number of years of expected life remaining for the individual must coincide with the life of the annuity. If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value of the annuity based on the projected return.

C. If this is the case, the annuity is not actuarially sound and a transfer of assets for less than fair market value has taken place, subjecting the individual to a penalty.

D. The penalty is assessed based on a transfer of assets that is considered to have occurred at the time the annuity was purchased, using the full purchase price as the amount transferred.

Source: Social Security Act §1917(c); Deficit Reduction Act of 2005 §6011 and §6016 (Rev. 2006).

History: Revised eff. 11/01/2014.

Part 103 Chapter 7: OBRA-93 and DRA Transfer Policy

Rule 7.1: OBRA-93 and DRA Transfer Policy Principles.

A. General.

1. Section 13611 of the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66), herein referred to as OBRA-93, amended Section 1917(c)(1) of the Social Security Act to revise transfer of assets policy previously described in the Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360). Assets disposed of on or before the enactment of OBRA-93, which was August 10, 1993, will be evaluated under MCCA policy discussed in Miss. Admin. Code Part 103, Chapter 11. Assets disposed of on or after August 11, 1993, will be evaluated under policy mandated by OBRA-93 and revised by the Deficit Reduction Act of 2005, effective February 8, 2006.

B. Definitions Applicable to OBRA and DRA Transfers and Trusts.

1. OBRA-93 added and amended the following definitions of terms used in conjunction with transfer and trust policy:

   a) Individual.

      1) As used in this instruction, the term "individual" includes the individual himself or herself, as well as:

         (a) The individual's spouse, where the spouse is acting in the place or on behalf of the individual;

         (b) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse, and

         (c) Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

   b) Spouses.

      1) This is a person who is considered legally married to an individual under the laws of Mississippi.

   c) Assets.

      1) For purposes of this section, assets include all income and resources of the individual and of the individual's spouse. This includes income or resources

which the individual or the individual's spouse is entitled to but does not receive because of any action taken to direct the assets elsewhere by:

(a) The individual or the individual's spouse;

(b) A person, including a court or administrative body, with legal authority to act in place or on behalf of the individual or the individual's spouse, or

(c) Any person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

d) For purposes of this section, the term "assets an individual or spouse is entitled to" includes assets to which the individual is entitled or would be entitled if action had not been taken to avoid receiving the assets. The following are examples of actions which would cause income or resources not be received:

1) Irrevocably waiving pension income;

2) Waiving the right to receive an inheritance;

3) Not accepting or accessing injury settlements;

4) Tort settlements which are diverted by the defendant into a trust or similar device to be held for the benefit of an individual who is plaintiff; and

5) Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony.

(a) The above actions could result in an uncompensated transfer of assets. However, the specific circumstances of each case must be examined in order to determine if a transfer has occurred.

e) Resources.

1) For purposes of this section, the definition of resources is the same definition used by the Supplemental Security Income (SSI) program, except that home property loses its exclusion if home property is transferred or ownership interest is reduced for institutionalized individuals, as addressed in transfer of assets rules.

2) In determining whether a transfer of assets or a trust involves an SSI-countable resource, use those resource exclusions and disregards used by the SSI program, except for the exclusion of the home for institutionalized individuals. Income, for purposes of this section, is the same definition used by the SSI program. In determining whether a transfer of assets involves SSI- countable income, take into account those income exclusions and disregards used by the SSI program. This is discussed in more detail in the chapter on income.

f) For the Sole Benefit of.

1) A transfer is considered to be for the sole benefit of a spouse, blind or disabled child or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child or disabled individual can benefit from the assets transferred in anyway, whether at the time of the transfer or at any time in the future.

g) For the Sole Benefit Of.

1) Similarly, a trust is considered to be established for the sole benefit of a spouse, blind or disabled child, or disabled individual if the trust benefits no one but that individual, whether at the time the trust is established or any time in the future. However, the trust may provide for reasonable compensation for a trustee or trustees to manage the trust, as well as for reasonable cost associated with investing or otherwise managing the funds or property in the trust.

(a) A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is not the spouse, blind or disabled child or disabled individual is not considered to be established for the sole benefit of one of these individuals

(b) In order for a transfer or trust to be considered to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the funds involved for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual involved.

(c) When the instrument or document does not so provide, any potential exemption from penalty consideration for eligibility purposes is void.

(d) An exception to this requirement exists for trusts discussed in "Exemptions to Treatment of Trusts." Under these exceptions, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the Division of Medicaid, up to the amount of Medicaid benefits paid on the individual's behalf. When these exceptions require that the trust be for the sole benefit of an individual, the restriction discussed in the previous paragraph does not apply when the trust instrument designates the Division of Medicaid as the recipient of funds from the trust.

(e) Also, the trust may provide for disbursal of funds to other beneficiaries, provided the trust does not permit such disbursals until the State's claim is satisfied.

C. Transfer Penalty Definitions.

1. General.

   a) Under the transfer of assets provisions in Section 1917(c) of the Act, as amended by OBRA 1993, coverage of certain Medicaid services to otherwise eligible institutionalized individuals who transfer (or whose spouses transfer) assets for less than fair market value must be denied. This same transfer prohibition is applicable to HCBS individuals and their spouses.

2. Definitions.

   a) The following definitions apply to transfers of assets.

      1) Fair Market Value.

         (a) Fair market value is an estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred. Value is based on criteria used in appraising the value of assets for the purpose of determining Medicaid eligibility.

         (b) For an asset to be considered transferred for fair market value or to be considered to be transferred for valuable consideration, the compensation received for the asset must be in a tangible form with intrinsic value.

         (c) A transfer for love and consideration, for example, is not considered a transfer for fair market value. Also, while relatives and family members legitimately can be paid for care they provide to the individual under an acceptable personal services contract, Medicaid presumes that services provided for free at the time were intended to be provided without compensation. Refer to the full discussion of personal services contracts. Thus, a transfer to a relative for care provided for free in the past is a transfer of assets for less than fair market value. However, an individual can rebut this presumption with tangible evidence that is acceptable, such as a written repayment schedule agreed to at the time services were provided.

      2) Valuable Consideration.

         (a) Valuable consideration means that an individual receives in exchange for his or her right or interest in an asset some act, object, service or other benefit which has a tangible and/or intrinsic value to the individual that is roughly equivalent to or greater than the value of the transferred asset.

      3) Uncompensated Value.

(a) The uncompensated value is the difference between the fair market at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the asset) and the amount received for the asset.

4) Institutionalized Individual.

(a) An institutionalized individual is an individual who is:

(1) An inpatient in a nursing facility;

(2) An inpatient in a medical institution for who payment is based on a level of care provided in a nursing facility; or

(3) An inpatient in an ICF-MR facility.

5) HCBS Individual.

(a) A participant in a long-term care alternative program. Although not institutionalized, this individual is considered to be receiving long-term care services. The eligibility criteria for the HCBS individual are the same as those for the institutionalized person, including application of transfer policy.

D. Transfer of Asset Rules.

1. Transfer of asset rules apply to the following:

a) Resources.

1) Any real or personal property, annuity, liquid resource, or funds owned by the individual and his spouse that is given away, sold for less than fair market value, or used to purchase a promissory note, loan, mortgage, or life estate, waiving the right to receive any potential future resource that the individual might be entitled.

b) Income.

1) Any earned or unearned income (including lump sum) of the individual and his or her spouse that is transferred to another individual in the month of receipt, waiving the right to receive any potential future income that the individual might be entitled.

E. Effective Date of OBRA-93 Transfer Policy.

1. All transfers made on or after August 11, 1993, are treated under OBRA-93 rules with DRA amendments effective February 8, 2006.

2. Transfers made before August 11, 1993, are treated under policy in effect prior to OBRA-93.

3. While this section applies to transfers made on or after August 11, 1993, penalties for transfers for less than fair market value under OBRA-93 cannot be applied to services provided before October 1, 1993.

4. Apply pre-OBRA-1993 rules regarding transfers of assets to transfers made on or after August 11, 1993, and before October 1, 1993.

5. As indicated above, the effective date of all DRA changes is February 8, 2006. Assets disposed of on or after February 8, 2006, will be evaluated under OBRA-93 and any changes mandated by the DRA. The DRA changes are noted.

F. Individuals to Whom Transfer of Assets Applies.

1. Apply these provisions when an institutionalized individual, HCBS waiver individual or the individual's spouse disposes of assets for less than fair market value on or after the look-back date explained below.

2. For purposes of this section, assets transferred by a parent, guardian, court or administrative body, or anyone acting in place of or on behalf of or at the request or direction of the individual or spouse are considered to be transferred by the individual or spouse.

G. Verification and Documentation.

1. In addition to the initial application, look for a transfer of assets at the time of review, when a transfer is reported, or when there is a request for a change to institutional or HCBS coverage. When there has been a transfer of assets during the look-back period, the following documentation must be obtained:

   a) A description of the asset transferred (the home, other real property, life estate, cash, lump sum, car, stocks, bank account, certificate of deposit, etc.).

   b) The name of the person who transferred the asset (client, spouse, legal representative.)

   c) The name of the person(s) to whom the asset was transferred.

   d) The client's relationship to the individual to whom the asset was transferred.

   e) The countable value of the asset at the time of the transfer and the compensation (money or other benefit) received or expected to be received from the transferred asset.

f) The date the asset was transferred.

g) Whether the applicant was the sole owner of the asset at the time of the transfer if not the name of any co-owners.

h) If applicable, documentary evidence that the individual intended to dispose of an asset at fair market value or information from knowledgeable sources to support the value (if any) at which the asset was disposed.

H. Look Back Period.

1. The Deficit Reduction Act of 2005 changed the look back period to five (5) years sixty (60) months effective for institutional applications filed on or after February 8, 2006.

2. The sixty (60) month rule applies to any type of asset transferred including assets placed in a trust. Transfers that took place during the five (5) year look back period, but prior to February 8, 2006, will be evaluated using previous transfer of assets policy and the penalty period is calculated under the rules in effect at the time of the transfer.

3. Application of the DRA transfer rules is being phased in over the sixty (60) month period starting February 8, 2006. Because the DRA implementation date will not change, the length of the look back period to evaluate transfers under DRA rules will increase each month by one month until it reaches sixty (60) months in February 2011.

4. Under OBRA-93, the look-back period for transfers other than transfers to a trust is a date that is thirty-six (36) months from the date the individual both is an institutionalized individual and has applied for Medicaid.

I. Applying the Transfer Penalty.

1. Denial of coverage or services because assets were transferred for less than Fair Market Value is known as a transfer penalty.

2. Under the DRA, transfer penalties are applied differently to institutionalized individuals and those applying for, or receiving, Home and Community Based Services.

a) The penalty period for an institutionalized applicant begins when the individual is receiving an institutional level of care for which he/she would be eligible if not for imposition of the transfer penalty. If the individual is otherwise eligible for Medicaid, he/she may receive Medicaid for all services except:

1) Nursing facility services;

2) Nursing facility services provided in an institution that is equivalent to that of nursing facility services;

b) An application for Home and Community Based Services (HCBS) cannot trigger the start of a transfer penalty period. As indicated, a penalty can only start when an individual is receiving an institutional level of care for which he/she would be eligible if not for imposition of the transfer penalty.

1) The transfer penalty does not allow an individual to enter into an HCBS waiver program; therefore, the start date for the penalty cannot be triggered and the individual remains ineligible as long as the transfer is within the five (5) year look back period.

3. If an individual or his/her spouse has a penalty as the result of a transfer, the penalty is imposed as follows:

a) Nursing Home Assistance:

1) Vendor payment (room and board) is denied or terminated for the duration of the penalty period; and

2) Medicaid is approved for all other services.

b) Home and Community Based Services

1) If Medicaid eligibility is dependent on participating in the waiver, the application is denied or the case is closed until the transfer is outside the five (5) year look back period;

2) The individual can be approved in a Medicare Savings Program (QMB, SLMB, QI) if all other criteria are met.

J. Multiple Periods of Institutionalization and Multiple Applications.

1. When an individual has multiple periods of institutionalization or has made multiple applications for Medicaid (unless the application was withdrawn), the look-back date is based on a baseline date that is the first date upon which the individual has both applied for Medicaid and is institutionalized.

a) Each individual has only one look-back date, regardless of the number of periods of institutionalization, applications for Medicaid (the exception is a withdrawn application), or periods of eligibility or transfers of assets.

K. Calculation and Imposition of the Transfer Penalty

1. Effective 02/08/06, the date of the penalty will begin with the later of the first day of a month during which assets have been transferred for less than fair market value; or

2. The date on which the individual is eligible for medical assistance based on all factors of eligibility being met and is receiving institutional level of care services (based on an approved application for such services) that, were it not for the imposition of the penalty period would be covered by Medicaid.

3. Recipients are prohibited from transferring resources after approval.

   a) For transfers discovered after approval, the penalty is imposed beginning with the month following the advance notice and rebuttal period.

4. An improper payment report will be prepared for any ineligible months before the penalty is imposed. If the penalty period has ended, the improper payment would cover all months of the penalty period.

5. For applications on or after 2-8-06~~,~~ handled under DRA rules, the penalty will begin the month that Long Term Care services are requested if the individual is otherwise eligible for Medicaid.

6. For application prior to 02/08/06, transfers are considered under the provisions of OBRA-93. The date of the penalty period is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not occur in any other periods of ineligibility under this policy.

7. The number of months of ineligibility for an institutionalized individual shall be equal to:

   a) The total, cumulative uncompensated value (UV) of all assets transferred by the individual (or individual's spouse) on or after the look back period divided by:

   b) The average monthly cost to a private pay patient for nursing facility services in Mississippi at the time of application for new applicants. For active recipients, the average cost to a private pay patient at the time the penalty is being calculated is used.

   c) The average monthly cost referenced in b) above shall be calculated annually based on the average daily per diem rate from the Division of Medicaid cost reports for the previous year. Each annual calculation shall be made and distributed to Division of Medicaid staff by July 1 of each year.

8. Under the DRA, when the amount of the transfer is less than the average monthly cost of nursing facility care, a penalty is imposed for less than a full month. This is called a partial month penalty.

9. Rounding down or otherwise disregarding any fractional part of an ineligibility period when determining the penalty period is not allowed effective 02/08/06.

10. Effective 02/08/06, the average daily per diem applicable to the transfer is used in determining the partial month penalty period. The average daily per diem is calculated using the average daily cost to a private pay patient as described in 6.above for the procedures used to determine the average monthly cost.

L. HCBS and the Partial Month Penalty

1. If a transfer is discovered in an ongoing waiver case, the penalty period will be calculated the same as nursing home cases with the exception of the partial month.

2. The penalty begins the month the transfer occurred; however, the "partial month' is extended to the end of the month for HCBS cases.

3. If the penalty period has not expired, the case will be closed and an improper payment report will be completed for the prior ineligible months.

4. If the penalty period has expired, an improper payment will be completed for the transfer penalty period and the case will remain open. The client must be given the opportunity for rebuttal prior to preparing the improper payment report.

M. Determining the Penalty When Penalty Periods Overlap.

1. All countable transfers occurring during the look-back period are totaled and the penalty period determined by dividing the total UV by the average private pay rate.

   a) The first month of the transfer penalty period is the month in which the first countable transfer occurred.

2. Transfers that occur after a penalty period is in effect are added in full to the end of the penalty period currently in effect.

3. There is no limit on the number of months a transfer penalty can be imposed.

4. The penalty period is always determined by the total UV calculated during the look back period.

N. Determining the Penalty When Penalty Periods Do Not Overlap

1. When multiple transfers are made so that the penalty periods for each do not overlap, treat each transfer as a separate event with its own penalty period.

2. An exception is consecutive transfers that occur on a regular basis must be calculated together.

O. Types of Transfer of Assets

1. Transfer of Income.

    a) Income, in addition to resources, is considered to be an asset for transfer (and trust) purposes.

        1) When an individual's income is given or assigned in some manner to another person, such a gift or assignment can be considered a transfer of assets for less than fair market value.

        2) There must be a determination as to whether amounts of regularly scheduled income or lump sum payments, which the individual received or would otherwise have received, have been transferred.

        3) When a single lump sum payment is transferred, the penalty period is calculated on the basis of the value of the lump sum payment.

        4) When a stream of income, (i.e., income received in a regular basis, such as a pension) is transferred over multiple months, calculate the penalty period by adding the income payments together and begin the penalty period on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

        5) When the transfer involves a right to income ~~(~~such as when a private pension is placed in a trust) determine ~~of~~ the total amount of income expected to be transferred during the individual's life, based on an actuarial projection of the individual's life expectancy, and calculate the penalty on the basis of the projected total income.

2. Conveyance for Less than Fair Market Value.

    a) Giving away or conveying an asset for less than fair market value within the look back period for an institutionalized or HCBS individual may be considered a transfer of assets.

3. Waiving an Inheritance or Other Entitled Benefit.

    a) Refusal to accept an inheritance or refusal to take legal action to obtain benefits an individual is entitled to receive may be considered a transfer of assets.

4. Annuities When Expected Returns Are less than Cost of Annuity.

    a) Establishing or purchasing annuities in which anticipated payments based on life expectancy of the individual are less than the cost of the annuity. The policy on annuities is explained in detail in Miss. Admin. Code Part 103, Chapter 6.

5. Irrevocable Burial Contracts Under Certain Circumstances.

a) An irrevocable burial contract or similar device established by the funeral home/director is considered a transfer of assets if the cost to the individual or spouse exceeds the value of the merchandise and/or services.

b) An itemized statement must be obtained to assist in determining whether the costs are commensurate with the value of the merchandise and/or services.

6. Transfers by a Spouse. Transfers made by the Community Spouse (CS) will create a penalty for the Institutionalized Spouse (IS).

   a) Transfers by the CS after the IS has been determined eligible will also create a penalty for the IS.

   b) If the CS becomes institutionalized and applies for Medicaid during the penalty period, the penalty must be apportioned between both spouses.

   c) If the IS has already served the penalty in full, it will not be applied a second time.

   d) If one member of the couple should leave the facility or die, the remaining portion of the penalty must be served by the remaining institutionalized spouse.

7. Transfers of Jointly-Held Assets

   a) In the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person that reduces or eliminates such individual's ownership or control of such asset.

   b) If placing another person's name on the account or asset actually limits the individual's right to sell or otherwise dispose of the assist (e.g., the addition of another person's name requires that the person agree to the sale or disposal of the asset where no such agreement was necessary before), such placement constitutes a transfer of assets.

   c) Regular Medicaid rules are used to determine what portion of a jointly held asset is presumed to belong to an applicant or recipient. This portion is subject to a transfer penalty if it is withdrawn by a joint owner.

8. Personal Service Contracts.

   a) A personal service contract should be a written contract between the recipient/applicant and the personal services provider.

b) The contract should be executed prior to the date any payments have been made to the provider.

c) If payments have been made prior to the date of the contract these payments should be considered as transfers.

d) Once an individual begins receipt of Medicaid Long Term Care (LTC) services, the individual's personal and medical needs are considered to be met by the LTC provider.

e) Payments to other individuals for services received after the individual enters LTC are considered an uncompensated transfer for Medicaid purposes.

f) The contract should be very specific as to services to be provided and the payment to be paid for the services.

g) Each service/duty should be listed with the number of hours for each service with the amount charged for each service.

h) If the contract calls for a payment of a specific amount per hour, this amount should be reasonable.

1) Example: Nursing charges will not be allowed for non-nurses and CPA charges will not be allowed for persons who are not CPA's. Documentation of the services performed and the number of hours for each service should be submitted.

2) All charges will be evaluated based on usual and customary charges for services in the community.

3) The contract must not provide for payment of compensation for future services. All payments should be made only as the services are actually rendered.

4) Any payments made for future service should be considered as transfers Contracts indicating a prior date but no payments have ever been made should be questioned as to why the payments for services were not made when the services were performed.

5) This type of arrangement indicates services were provided for free. Services provided for free are not under obligation to be paid at a future unknown date.

9. Purchase of a Life Estate in Another Individual's Home

The purchase of a life estate interest in another individual's home is considered a transfer of assets unless the purchaser resides in the home for a period of at least one (1) year after the date of purchase.

10. Promissory Notes, Loans or Mortgages

The term "assets" includes funds used to purchase a promissory note, loan or mortgage unless such note, loan or mortgage is determined to be actuarially sound, provides for payments to be made in equal amounts during the term of the loan, with no deferral or balloon payments, and prohibits the cancellation of the balance upon the death of the lender. A note, loan or mortgage not meeting these requirements is a transfer of assets in the amount of the outstanding balance due as of the date of the individual's application.

P. Exceptions

1. Home Property

a) The transfer penalty will not apply to the transfer of home property by an institutionalized individual to the following family members of such individual:

(1) The individual's spouse or child under age twenty-one (21) or a disabled or blind adult child (Disability must be established and age verified); or

(2) A sibling who is part owner of the home who lived in the home for one (1) year prior to the individual entering a nursing facility; or

(3) A child who lived in the home for two (2) years before the individual entered a nursing facility and provided care to the individual which permitted the individual to remain at home.

(a) Sufficient documentary information must be provided to make a determination that:

(i) The child resided in the home for the required length of time. (This may include statements from knowledgeable individuals when other verification is not available.)

(ii) Whether the child provided care which enabled the parent to remain at home.

(iii) If the child was employed outside the home, the arrangements for care while the child was away must be determined.

2. Non-Home Property

a) The transfer penalty will not apply to the transfer of any type of non-home asset in the following situations:

(1) Assets transferred to the individual's spouse or to another for the sole benefit of the individual's spouse.

(2) Assets transferred from the individual's spouse to another for the sole benefit of the individual's spouse;

(3) Assets transferred to the individual's child under age twenty-one (21) or a disabled adult child or the individual's spouse; or blind adult child. If the disabled adult child is not receiving a social security disability payment, a disability determination is required;

(4) Assets transferred to a Special Needs Trust established solely for the benefit of a disabled applicant less than sixty-five (65) years of age.

(5) The resource was excluded under ongoing policy at the time of transfer.

b) In determining whether an asset was transferred for the sole benefit of a spouse, child, or disabled individual, ensure that the transfer was accomplished via a written instrument of transfer (e.g., a trust document) which legally binds the parties to a specified course of action and which clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer.

(1) A transfer without such a document cannot be said to have been made for the sole benefit of the spouse, child, or disabled individual, since there is no way to establish, without a document, that only the specified individuals will benefit from the transfer.

3. An individual shall not be ineligible for medical assistance if an acceptable rebuttal is submitted and a satisfactory showing is made to the Division of Medicaid that:

a) The individual intended to dispose of the assets either at fair market value or for other valuable consideration;

b) The assets were transferred exclusively for a purpose other than to qualify for medical assistance;

c) All assets transferred for less than fair market value have been returned to the individual; or

d) The Division of Medicaid determines that denial of eligibility would work an undue hardship on the individual.

(1) The transfer penalty will not apply if undue hardship exists. Undue hardship exists when:

(a) Application of the transfer penalty would deprive the individual of medical care such that his/her health or his/her life would be endangered.

(b) Application of the transfer penalty would deprive the individual of food, clothing shelter, or other necessities of life and cause severe deprivation.

(c) The applicant or spouse or representative has exhausted all legal action to have the transferred assets that caused the penalty returned.

e) Undue hardship does not exist when:

(1) Application of the application of the transfer of assets provision merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him her at risk of serious deprivation.

(2) The assets were transferred to community spouse and the community spouse refuses to cooperate in making the resource available to the institutional spouse.

(3) The resource was transferred to a person (spouse, child, or other person who was handling the financial affairs of the client or to the spouse or children of a person handling the financial affairs of the client unless it is established that the transferred funds cannot be recovered even through exhaustive legal measures.

f) Each case situation must be reviewed individually to determine if Undue Hardship exists. Generally, this provision is limited to financially and medically needy individuals with no possible means of recovering the transferred assets.

g) A hardship waiver may be requested by a facility. Effective February 8, 2006, an undue hardship waiver may be requested by the facility in which the person resides on behalf of the individual if the facility has the individual's consent, or their person representative's consent.

(1) The hardship waiver is for the recipient, not the hardship of the facility.

(2) The agency provides that, while an application for an undue hardship waiver is pending in the case of an individual, who is a resident of a nursing facility, payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed thirty (30) days.

4. Exception for Transfers to Community Spouse or Third Party.

a) Section 1924 of the Act sets forth the requirements for treatment of income and resources where there is an individual in a medical institution with a spouse still living in the community.

b) This section of the Act provides for apportioning income and resources between the institutional spouse and the community spouse so that the community spouse does not become impoverished because the individual is in a medical institution.

c) The exceptions to the transfer of assets penalties regarding inter-spousal transfers and transfers to a third party for the sole benefit of a spouse apply even under the spousal impoverishment provisions.

d) The institutional spouse can transfer unlimited assets to the community when transfers between spouses are involved.

e) The unlimited transfer exception should have little effect on the eligibility determination, primarily because resources belonging to both spouses are combined in determining eligibility for the institutionalized spouse.

f) Resources transferred to a community spouse are still considered available to the institutionalized spouse for eligibility purposes.

g) The exception for transfers to a third party for the sole benefit of the spouse may have greater impact on eligibility because resources may potentially be placed beyond the reach of either spouse and thus cannot be counted for eligibility purposes.

h) For the exception to be applicable, the definition of what is for the sole benefit of the spouse must be fully met.

i) This definition is fairly restrictive, in that it requires that any transferred funds spent for the benefit of the spouse within a time-frame actuarially commensurate with the spouse's life expectancy.

j) If this requirement is not met, this exemption is void, and a transfer to a third party may then be subject to a transfer penalty.

Q. Transfer of Assets Notification

1. The applicant/client will be notified regarding countable transfers and the penalty period.

2. The transfer and the penalty must be clearly indicated.

3. The notice should allow the client or representative time to present evidence to show that the transfer should not count.

   a) Evidence should include a written rebuttal plus any pertinent documentary evidence.

   b) If no rebuttal is offered, the penalty will be applied and the appropriate adverse action notice.

4. Individuals in nursing homes remain eligible for all other Medicaid services if the transfer penalty is the only factor of ineligibility; therefore, payment of nursing home services only will be denied or terminated.

5. If the individual is ineligible on other factors as well as the transfer, the application or case must be denied or terminated.

6. If Medicaid eligibility is dependent on participating in the HCBS waiver program, the application is denied or the case is closed until the transfer is outside the five (5) year look back period;

   a) These individuals can be approved in a Medicare Savings Program (QMB, SLMB, QI) if all other criteria are met.

R. Rebuttal Process

1. Written rebuttals require State Office review and approval of the action to be taken.

S. Return of a Transferred Resource

1. If a transferred resource is returned to, or if compensation is received by, the institutionalized individual, the UV is no longer an issue or is reduced as of the date of the return.

2. The resource or compensation is evaluated according to normal resource rules in the month of return. Any portion of a transferred resource that is not returned continues to count as UV which means the penalty period must be re-evaluated.

T. Recalculation of a Penalty Period

1. A penalty period must be recalculated from the month a portion of the resource is returned or additional compensation is received. If the resource is returned, normal resource rules apply in determining Medicaid eligibility.

U. Transfer Penalty Involving SSI Months

1. The transfer penalty can be imposed during months that an individual receives SSI or is SSI eligible in a nursing home.

2. Notices for SSI eligibles must not be sent verifying eligibility for nursing facility services until the possibility of any transfers have been developed.

Source: Miss. Code Ann. § 43-13-121.1; Social Security Act §1917(c); Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360); Omnibus Reconciliation Act (OBRA-93) of 1993 §13611 (Rev. 1993); Deficit Reduction Act of 2005 §6011 and §6016 (Rev. 2006).

History: Revised eff. 11/01/2014.

Part 103 Chapter 8: Medicaid Qualifying Trusts (MQT)

Rule 8.1 Treatment of Medicaid Qualifying Trusts (MQT).

A. The provisions in this section are applicable to any trust or similar legal device established on or after March 1, 1987, through August 10, 1993, that meet MQT criteria. If MQT criteria are not met, defer to Standard Trust policy.

1. A Medicaid Qualifying Trust is a trust or similar device, which:

a) Is established (other than by will) with the applicant/recipient's own funds, by the applicant/recipient (or spouse);

b) Names the applicant/recipient as the trust beneficiary for all or part of the payments from the trus; and

c) Permits the trustee to exercise any discretion with respect to the distribution of such payments to the individual.

2. The MQT provision is applied without regard to whether or not:

a) The MQT is revocable or irrevocable; or

b) The MQT is established for purposes other than to qualify for Medicaid; or

c) The discretion of the trustee is actually exercised.

3. In determining whether an MQT exists, look for 3 main components:

a) The grantor is the Medicaid client or his representative (e.g., spouse, parent, guardian, conservator or anyone holding power of attorney for the client);

b) The trust was established with property belonging to the client; and

c) The client is at least one of the beneficiaries of the trust.

4. In addition, the following principles must be considered:

a) The client is considered the grantor even if the trust was established pursuant to court order issued upon the petition of the client or his representative. In this situation, the court acts as the client's agent in establishing the trust.

b) It is not necessary that there be a trust agreement, as defined by state law, for MQT trust policies to apply. MQT trust policies apply to "similar legal devices" or arrangements having all of the characteristics of an MQT, except there is no actual trust instrument.

1) Examples are:

(a) Escrow accounts;

(b) Savings accounts;

(c) Pension funds;

(d) Annuities;

(e) Investment accounts; and

(f) Other accounts managed by agent with fiduciary obligations, such as conservatorships or guardianships.

c) The MQT provision does not apply to trust agreements established by will. These trusts are treated as standard trusts. However, if a client inherits resources and in turn establishes a trust, the MQT provision could apply.

5. Each trust document must be reviewed individually to determine the resource treatment of the trust, but in general use the following criteria to determine resource treatment:

a) Revocable MQT.

1) The entire corpus of the trust is an available resource to the client. Resources comprising the corpus are subject to individual resource exclusions, if applicable, since the client can access these resources. An exception is exclusion of the home for institutionalized recipients. Home property loses its excluded status when transferred into an MQT.

b) Irrevocable MQT.

1) The countable amount of the corpus is the maximum amount the trustee can disburse to (or for the benefit of) the client, using his full discretionary power under the terms of the trust. Resources transferred to an irrevocable MQT lose individual resource consideration.

(a) Example: Home property transferred to such a trust can no longer be excluded as home property but is included in the value of the corpus.

2) If the trustee has unrestricted access to the corpus and has discretionary power to disburse the entire corpus to the client (or to use it for the client's benefit), then the entire corpus is an available resource to the client.

3) If the trust does not specify an amount for distribution from the corpus of the trust or from income produced by the corpus, but the trustee has access to and

use of both corpus and income, the entire amount is an available resource to the client.

4) If the trust permits a specified amount of trust income to be distributed to the client (or to be used for his benefit), but these distributions are not made, then client's countable resources increase cumulatively by the undistributed amount.

6. In general use the following criteria to determine treatment of income from an MQT:

a) Amounts of trust income distributed to the client are counted as income when distributed.

b) Amounts of trust income distributed to third parties for the client's benefit (including payments for medical services) are countable income when distributed.

c) Exculpatory Clauses which limit the authority of the trustee to distribute funds from a trust if such distribution would jeopardize eligibility for government programs are ignored for MQT purposes if the language explicitly or implicitly links the trustee's discretion to Medicaid requirements.

7. Handle a transfer of assets under this policy as follows:

a) If the MQT is irrevocable, a transfer of assets has occurred if the resources are no longer available to the client.

1) Resources rendered unavailable are subject to the transfer penalty based on the value of the unavailable resources without consideration of whether the resource would have been excluded under ongoing policy.

8. The MQT provision may be waived if an undue hardship is determined to exist: .

a) This means Medicaid should not be denied to an individual under this provision if the individual would be forced to go without life-sustaining services because the trust funds cannot be released.

1) This does not include situations where the trustee simple chooses not to make the trust funds available.

Source: Social Security Act §1917(c); Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360).

Part 103 Chapter 9: Standard Trusts

Rule 9.1 Treatment of Standard Trusts.

A. Standard trust policy is applicable to trusts or conservatorships established prior to March 1, 1987, and/or trusts that do not meet the criteria of OBRA-93 or MQT trusts, regardless of the date established. Testamentary trusts where the Medicaid client is the beneficiary are also standard trusts.

B. In all situations discussed under this rule, a copy of the trust agreement or court documents must be obtained for review.

C. Whether the trust is counted as a resource depends on the client's role as beneficiary or trustee and the specific terms of the trust.

1. Treatment When the Medicaid Client is Trustee.

a) Generally, a person appointed as a trustee cannot use any of the funds in the trust forhis/her own benefit.

b) Thus, an individual can be a trustee of a valuable trust and not be able to receive money from the trust since he/she has no access to the funds for personal use.

c) When the trustee has no access to the funds for personal use, the trust is not a resource to the client who is the trustee.

d) However, under certain circumstances the trust is a countable resource to the client who is the trustee. Count the trust as a resource, regardless of whose funds were originally deposited into the trust, if the client:

1) Is the trustee, and

2) Has the legal ability to revoke the trust and

3) Use the money for his own benefit.

e) Also, consider the trust a resource to the client if either the client or living-with spouse (eligible or ineligible) is the person who created the trust and has the right to dissolve it and use the funds for his own benefit.

f) Where trust principal is considered a resource to the trustee, count the total value of the trust and count any interest or distributions as a resource the month following the month of receipt.

g) Do not count as income any withdrawals made from the trust by the trustee since the funds have already been counted as a resource.

2. Treatment When Medicaid Client is Beneficiary.

a) Any payments made to, or on behalf of, the client are counted as income unless the trustee states the client has unrestricted access to use of the trust funds; in which case, the funds are a countable resource.

1) Restricted Access to Principal.

(a) If the client is the beneficiary of the trust and the client's access to the trust principal is restricted, meaning only the trustee or the court can invade the principal, the principal of the trust does not count as a resource to the client. Count all payments made to, or on behalf of, the client from a restricted trust as income.

2) Unrestricted Access to Principal.

(a) Count the trust as a resource if the client is trust beneficiary and has unrestricted access to the principal of the trust. In this situation payments from the trust to the beneficiary are not counted as income since the funds have already been counted as a resource. The payments from the trust are conversion of a resource.

3. Authority for Discretion by Trustee.

a) The authority for discretion by the trustee in the use of trust funds, including invasion of the principal for support and maintenance of the beneficiary, does not mean that the principal is available to the client and, as such, it should not be counted as a resource. Only the income or resource(s) that is available to the client via the trustee's discretion count for purposes of determining eligibility.

1) In cases where the trustee has "full discretion" in the use of trust funds, the trustee must specify, by way of a written and signed statement for the case record, what arrangements exist or will be made to release funds or resources for the client's use.

Source: 42 CFR § 435.601(b) (Rev 1994); CMS Transmittal 64, State Medicaid Manual §3257-3259.

Part 103 Chapter 10: Conservatorships Prior to 3/1/1987

Rule 10.1 Treatment of Conservatorships Prior to 03/01/1987.

A. Conservators and legal guardians are court appointed and are usually court controlled. These types of legal arrangements are initiated when the competence of an individual is at issue. Technically, a legal guardian is appointed to serve over an individual and the individual's resources, whereas a conservator is appointed only to handle an individual's resources. Regardless of the legal term used, an application or active case involving a conservator or legal guardian is handled as outlined below.

1. In the absence of evidence to the contrary, conserved liquid and non-liquid resources held by a guardian or conservator on behalf of a Medicaid applicant or recipient are countable resources to that client.

    a) The fact that the guardian/conservator manages and controls the funds, (e.g., makes the actual (withdrawals), does not alter the attribution of the resource to the client. Since the guardian/conservator legally acts on behalf of the incompetent individual, it is the same as if the individual is controlling or managing the resource.

    b) "Evidence to the contrary" that may indicate a client does not have total access to conserved resources held by a guardian or conservator is a court order which specifies the disbursement of funds and/or disposal of assets.

        1) If the court order or decree specifies the amount and frequency of funds which may be disbursed or restricts the disposal of resources, the court's decision in such matters determines the client's access.

        2) However, a "silent" court order, which does not specify disposition and/or availability of conserved resources, is not considered evidence to the contrary. Therefore, conserved funds controlled by a silent court order are considered available to the client.

2. The fact that a guardian/conservator must first petition the court in order to dispose of resources or disburse funds does not constitute "evidence to the contrary".

    a) State law requires such a petition in guardian/conservator cases making petitioning a standard practice.

    b) In all cases where petitioning is required, the conserved resources are considered available to the client unless or until the court is petitioned and rules as to the availability/disposition of assets.

    c) When a signed and dated petition is presented as evidence that a court has been petitioned for disbursement of funds and/or disposal of resources, the petition is sufficient to exclude the resources in question until the court renders a decision in the matter.

3. Eligibility Determinations Involving Conservatorship.

    a) To determine how to handle a case involving a legal guardian or conservator, it is necessary to obtain a copy of the original decree appointing an individual as guardian or conservator and any legal documents which may subsequently have been issued by the court to amend or change the original decree, if any. If a guardianship or conservatorship is in the process of being established, the client's resources are considered available until court documents are presented as outlined below:

1) If the court order specifies disbursement of funds, any payments made to or on behalf of the client count as unearned income to the client.

2) If the court order does not specify the disbursement of any non-liquid resources conserved by the court, consider the funds as a countable resource.

3) If the court order specifies that conserved non-liquid resources, such as property, may be disposed of for the benefit of the client, consider the property, etc., as a countable resource.

4) If the court order is silent on the subject of disposal of non-liquid resources, consider the resources countable unless or until the court is petitioned for disposal.

5) A court order may specify the disbursement of liquid resources and not mention disposal of any conserved non-liquid resources or vice versa.

   (a) In such a case, abide by the court's decision regarding the disbursement or disposal issue specified and count as a resource the unspecified resource.

      (i) Example: A conservatorship court order specifies the release of $100 per month from a savings account with a $5000 balance and fails to mention the disposal of 50 acres of property owned by the client. The $100 is counted as income while the balance of the account is excluded as a resource. The property is countable until the court is petitioned for the purpose of disposing of the property.

6) Court orders that are not specific on the availability of conserved resources result in the availability of the conserved resource to the client until the month the court is petitioned for use of the conserved funds or resources.

   (a) A valid petition will exclude the resource provided the petition requests the court to rule as to the disposal and/or disbursement of conserved resources. The exclusion will apply until the court rules in the matter at which time the case must be reviewed in light of the court decision.

Source: 42 CFR § 435.601(b) (Rev 1994); CMS Transmittal 64, State Medicaid Manual §3257-3259.

Part 103 Chapter 11: Medicare Catastrophic Coverage Act Transfer Policy

Rule 11.1 Treatment of Medicare Catastrophic Coverage Act Transfer Policy.

A. The Medicare Catastrophic Coverage Act of 1988 (MCAA) repealed the transfer of resources penalty for non-institutionalized individuals.

1. New transfer of resources policy created under the MCAA applies only to institutionalized individuals as defined below, who transfer resources on or after July 1, 1988 through August 10, 1993.

2. Transfers that occur after August 10, 1993, are evaluated under OBRA-93 transfer policy.

B. Under this rule, an institutionalized individual is defined as an individual who is:

1. A nursing facility inpatient,

2. An inpatient at a medical institution receiving a nursing facility level of care, or

3. A recipient of home and community-based waiver services.

a) ICF-MR residents are not included in this definition.

b) The transfer penalty resulting in ineligibility, as defined below, applies to nursing facility services and medical institution services where the level of care provided is equivalent to nursing facility care.

c) An institutionalized individual remains eligible for all other Medicaid services while a transfer penalty is in effect, provided eligibility is met on all other factors.

C. An institutionalized individual, who, at any time during the 30-month period immediately before the individual's application for medical assistance, disposed of resources for less than fair market value shall be ineligible for nursing facility services beginning with the month in which resources were transferred.

1. An institutionalized individual is also prohibited from transferring resources during the period of institutionalization, unless an exception applies.

2. Effective October 1, 1989, the transfer penalty also applies to a community spouse who transfers resources within the 30-month period preceding application and/or during the time his-her spouse remains institutionalized.

a) A transfer of resources by a community spouse to another individual will result in a transfer penalty applying to the institutionalized spouse.

D. The following describes the period of ineligibility and application of the transfer penalty:

1. The transfer penalty is equal to 30 months, or

a) The 30-month period is calculated using the month of a transfer as the first month continuing through the 30th consecutive month, provided the transfer occurred on or after July 1, 1988.

b) The 30-month period of ineligibility is imposed unless the uncompensated value/private-pay calculation results in a period of ineligibility less than 30 months.

2. The transfer penalty is the number of months required to deplete the uncompensated value (UV) based on the total UV of the transferred resources divided by the average monthly cost of nursing facility services to a private pay patient if less than 30 months.

   a) The private pay calculation is based on a statewide average private pay cost of $1,456.00 per month.

   b) In calculating the period of ineligibility, divide the UV by $1,456.00 to determine the number of month that an individual will be ineligible for nursing home services.

   c) All calculations are rounded down to the nearest whole dollar.

      1) Example: If the total UV is $20,000, then $20,000 divided by $1,456 = 13.73. Rounding down, the period of ineligibility would be 13 months, which is less than the 30-month penalty.

3. In determining the penalty period, the month of the transfer is always "month one" of the period of ineligibility. As a result, the penalty period may be expired or near expiration as of the month of the application.

   a) Example: A transfer with UV of $5,000 occurs 7/5/88. Using the private pay calculation, the period of ineligibility for nursing facility services is 3 months, July through September. If the application is filed on or after October 1, 1988, the penalty period will have expired, although eligibility for all other Medicaid services is possible in the retroactive period. If the UV does not result in ineligibility for at least one month, the transfer will not count.

   b) Example: If the transfer is for $1,000, which is less than the average private pay rate, no penalty applies for the month of the transfer. Each transfer is evaluated based on the month the transfer occurred. If more than one transfer occurs in the same month, the UV is combined and the penalty period calculated on total UV for a particular month. If transfers crossover into different months, each transfer is evaluated separately and UV is not combined. The possible results would be overlapping penalty periods.

4. The transfer penalty will not apply to the transfer of home property by an institutionalized individual to the following family members:

   a) The individual's spouse or child under age 21 **or** a disabled or blind adult child; or

   b) A sibling who is part owner of the home who lived in the home for one (1) year before the individual entered the nursing facility; or

c) A child who lived in the home for up to two (2) years before the individual entered a nursing facility and provided care to the individual which permitted the individual to remain at home.

5. The transfer penalty will not apply to the transfer of any type of resource in the following situations:

a) Resources are transferred to or from the individual's spouse.

1) Effective October 1, 1989, a transfer of assets from a community spouse to another individual will result in a penalty charged to the institutionalized spouse.

b) Resources are transferred to the institutionalized individual's child who is disabled or blind.

c) Satisfactory evidence is required to show that the individual intended to dispose of the resource(s) either at fair market value or for other valuable consideration, or, that resource(s) were transferred exclusively for a purpose other than to qualify for Medicaid.

d) Denial of eligibility would result in undue hardship.

e) The resource was excluded under ongoing policy at the time for the transfer.

f) The resource was transferred by an individual other than the institutionalized applicant/recipient and that person had no legal authorization to act in the applicant's or recipient's behalf at the time of the transfer.

E. Notification of Transfer Penalty and Rebuttal.

1. The client will be notified of countable transfers and the penalty period.

2. The client or representative is allowed 10 days to present evidence to show that the transfer should not count.

a) Evidence should include a written rebuttal plus any pertinent documentary evidence.

b) If no rebuttal is offered, the penalty will be applied and the appropriate adverse action notice issued to deny or terminate payment of nursing home services only.

c) The individual remains eligible for all other Medicaid services if the transfer penalty is the only factor of ineligibility.

d) If the individual is ineligible on other factors as well as the transfer, the application or case must be denied or terminated.

3. Factors which may indicate that a transfer was made for some purpose other than establishing Medicaid eligibility are listed below. The presence of one or more of the following factors may result in an acceptable rebuttal:

   a) The occurrence after a transfer of resources of one or more of the following:

      1) Traumatic onset (e.g., traffic accident of disability or blindness;

      2) Diagnosis of previously undetected disabling condition;

      3) Unexpected loss of other resources which would have precluded Medicaid eligibility;

      4) Unexpected loss of income (including deemed income) which would have precluded Medicaid eligibility.

      5) In general, if the client was healthy and/or financially secure at the time of the transfer, with no expectation of future Medicaid need, then an acceptable rebuttal may be established.

      6) Total countable resources that would have been below the resource limit at all times from the month of transfer through the present month even if the transferred resource had been retained;

      7) Court-ordered transfer;

      8) Resource(s) sold at less than current market value in order to obtain cash quickly to meet expenses or repay a legal debt.

F. The transfer penalty can be waived if a period of ineligibility would result in undue hardship for the institutionalized individual.

   1. Undue hardship exists if a Medicaid denial of nursing home care would result in the individual's inability to obtain medical care.

   2. Each case situation must be reviewed individually to determine if undue hardship exists but the provision is geared toward financially and medically needy individuals with no possible means of recovering their transferred resource(s).

G. If a transferred resource is returned to or if compensation is received by the institutionalized individual, the UV is no longer an issue or is reduced as of the date of return.

   1. The resource of compensation is evaluated according to normal resource rules in the month of the return.

2. Any portion of a transferred resource that is not returned continues to count as UV which means the penalty period must be re-evaluated.

3. A penalty period must be recalculated from the month a portion of the resource is returned or additional compensation is received.

   a) Example: A transfer of $10,000 occurred in 10/88 resulting in a 6-month penalty period, or October 1988 – March 1989. In January 1989, $5,000 is returned to the institutionalized client. The penalty period is then recalculated using UV of $5,000 transferred in 10/88 which results in a revised period of ineligibility of 3 months or October 1988 – December 1988. If the full resource is returned, normal resource rules apply the month of the transfer.

H. The transfer penalty can be imposed during months that an individual receives SSA or is SSI-eligible in a nursing home.

   1. Example, an ABD application is filed in December 1988 and a transfer is discovered during the application process. The applicant had entered the nursing home in October 1988 as an SSI eligible and SSI eligibility continued until 12/31/88. The transfer results in a 4-month penalty period. The penalty can be imposed for October 1988 – January 1989 even though SSI eligibility existed October 1988 – December 1988.

      a) This would mean no vendor payment would be authorized for the 4-month penalty period; and

      b) As a result, notices regarding ABD eligibility based on SSI will be postponed until eligibility for ABD is determined which excludes any transfers for the SSI months.

Source: Social Security Act §1917(c); Medicare Catastrophic Coverage Act (MCCA) of 1988 (P.L. 100-360); Omnibus Reconciliation Act of 1993 (OBRA-93) §13611 (Rev. 1993); Miss. Code Ann. §43-13-121.1 (Rev. 2005).

Part 103 Chapter 12: Encumbrance of a Liquid Resource

Rule 12.1 Treatment of the Encumbrance of a Liquid Resource.

A. An encumbrance is defined as a legal obligation to pay a debt.

   1. If an applicant/recipient's combined resources exceed the resource limit, the amount of any encumbrances is deducted from the Current Market Value (CMV) to determine the equity value of a resource.

   2. The equity value is countable toward the resource limit.

B. Under SSI policy, an encumbrance may occur when the applicant/recipient in an SSI-related coverage group has alleged a check has been written from a bank account, and it has not yet

cleared the bank. If the individual has alleged a check has been written from a bank account and it has not cleared:

1. Examine evidence that the check was written, therefore legally obligating the funds from the bank account.

2. Verification must be obtained before allowing a reduced equity value of the bank account. Once verification, is received, the equity value of the bank account can be established by deducting the amount of the check written.

3. Verifications needed are a paid receipt, cancelled check, etc.

   a) Example: Mr. Timmons' bank statement shows a checking account balance of $1,250 as of May 1, which combined with other countable resources, exceeds $2000 as of the first day of the month. Mr. Timmons alleges that the balance includes his rent check of $500 which he wrote and gave to the landlord on April 25, but his landlord has not yet cashed the check.

      The specialist examines Mr. Timmons' check register and finds an annotation for check number 1345 written on 4/25 for $500. He also notes that check 1346 has already cleared the bank and has been deducted from his account according to the bank statement. Next the specialist notes Mr. Timmons has written a $500 check to his landlord for rent on or around the 25th of each month for the last six months.

      Since there is evidence that Mr. Timmons has written the check and legally obligated those funds in his account, and his records provide a complete and consistent picture of the account, the specialist can deduct the amount of the uncashed check from the 5/1 first of the month balance. The uncashed check can be deducted because SSI equity value rules state that in determining equity value, we deduct encumbrances from the CMV. The new balance of $850 permits eligibility on resources.

C. Under liberalized resource policy, an encumbrance may occur when the applicant/recipient has alleged a check has been written from a bank account, and it has not yet cleared the bank. If the individual has alleged a check has been written from a bank account and it has not cleared:

1. Examine evidence that the check was written, therefore legally obligating the funds from the bank account.

2. Verification must be obtained before allowing a reduced equity value of the bank account. Once verification, is received, the equity value of the bank account can be established by deducting the amount of the check written.

3. Verifications needed are a paid receipt, cancelled check, etc.

a) Example: Mr. Jon Doe applied for Medicaid on January 4. As of January 31, Mr. Doe's bank statement shows a checking account balance of $2,350, which combined with other countable resources, exceeds $4000. Mr. Doe alleges that the balance includes his rent check of $500 which he wrote and gave to the landlord on January 22, but his landlord has not yet cashed the check.

b) The specialist examines Mr. Doe's check register and finds an annotation for check number 1345 written on January 22 for $500. Since there is evidence Mr. Doe has written the check from the account, the specialist can deduct the amount of the uncashed check since it is an encumbrance.

c) In determining equity value of the bank account, the encumbrance of $500 is deducted from the $2,350 in the bank account. Eligibility can be established for Mr. Doe for January if he is otherwise eligible.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Part 103 Chapter 13: Resource Spenddown (Liberalized Policy)

Rule 13.1 Treatment of Resource Spenddown Under Liberalized Policy.

A. Effective October 1, 1989, eligibility can exist for an entire month when an individual or couple, subject to liberalized resource policy, meets the resource test during the month.

B. The applicant is allowed to "spenddown" resources in a month to become eligible for that month.

C. Under the liberalized spenddown provisions, resources can be reduced within the applicable limit and as long as resources remain within the limit for that month, eligibility can be established. The following are considered in making the determination:

1. Do not allow payment of expenses that will be returned, refunded or reimbursed as legitimate spenddown expenses when calculating resources for a given month. Client-owned resources spent for reimbursable expenses count as an available resource in the month paid.

2. Allow outstanding checks/payments as an expense if proof is provided that the payment was authorized during the spenddown month and the expense is non-reimbursable.

3. The spenddown provision implies that an individual spends down to the resource limit and remains at or below the limit for the remainder of the month. When determining eligibility for a prior period and reviewing the resource situation for a full month, the individual or couple must have depleted resources to acceptable level and remained eligible for that month for a true spenddown to have occurred.

a) Example: An individual had $5,000 in a bank account on the first of the month and spent $3,000 on a pre-paid burial contract on the 5th of the month. However, on the 20th, he sold his car, which was excluded as a resource for $2,500. The $2,500 then becomes a resource (conversion of a resource) in the same month and unless the individual spends the excess $2,500 by the end of the month, eligibility cannot be established for that month.

D. Under liberalized resource policy, if excess liquid resources are earmarked for payment of private pay expenses for month(s) prior to a month of Medicaid eligibility, these excess resources can be excluded as a resource for any potential Medicaid months since the funds are obligated. If Medicaid will cover any months that have been paid as private pay by the client, the amount subject to reimbursement is a resource in the month paid.

1. Example: A LTC applicant enters a nursing home in June and applies for Medicaid in August. The applicant's bank account is $6,000, but $4,500 is earmarked for private pay for June/July. Medicaid is needed for August 1. Since the $4,500 is obligated for months prior to Medicaid eligibility, it can be excluded as a resource in determining eligibility for August forward, provided the earmarked funds are used to pay for the intended private pay expenses.

E. Under liberalized resource policy, income that accumulates while a Medicaid application is in process and that is obligated for payment of Medicaid income for months that will be covered by Medicaid can be excluded as a resource if excess resources result from accumulating income.

1. Example: A LTC applicant enters a nursing home in August and applies for Medicaid in October requesting benefits retroactive to August. The client's income is $1,200 per month. In November when the case is being worked up, the bank balance is $5,000. Medicaid Income for September and October would be $2,312 ($1,200 - $44 = $1,156 x 2).

2. November's income of $1,200 can be backed out of the balance plus the $2,312 obligated for September and October Medicaid Income, thus leaving $1,488 as a countable resource for November.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Part 103 Chapter 14: Deeming of Resources

Rule 14.1 Treatment of Resource Deeming.

A. For SSI and Medicaid purposes, an individual's resources are deemed to include any resources of an ineligible spouse or ineligible parent(s).

1. Resources are deemed whether or not they are actually available.

2. Deeming only applies in household situations, i.e., it only applies to an eligible with an ineligible spouse or parent(s).

   a) In deeming resources from one spouse to the other, consider only the resources of those two individuals.

   b) In deeming resources from a parent to a child, consider only the resources of the parent.

   c) Where there is more than one eligible child, the resources available for deeming are shared equally among the children.

      1) Eample: If there are two eligible children and $500 in parental resources must be deemed, deem $250 to each child.

   d) Do not include the resources of a stepparent who is not legally liable for support of the child under state law in the deeming process.

B. Effective September 1, 1987, pension funds owned by an ineligible spouse or parent(s) are excluded from resources for deeming purposes.

   1. This exclusion applies in order for an ineligible spouse or parent(s) to provide for their own future support.

   2. Pension funds are defined as monies held in a retirement fund under a plan administered by an employer or union, or an individual retirement account (IRA) or Keogh account as described by Internal Revenue Code.

C. When deeming spouse to spouse:

   1. The ineligible spouse's resources must be verified and documented as required for the eligible spouse.

   2. Total countable resources are the combination of the resources of the eligible individual and ineligible spouse after all applicable resource exclusions are applied.

   3. Total countable resources are compared to the resource limit for a couple.

   4. If the amount of the resources does not exceed the limit, the applicant/recipient meets the resource eligibility requirement.

   5. If countable resources exceed the limit for a couple, the applicant/recipient is ineligible.

   6. Eligible Spouses Not Living Together.

a) If an eligible individual and eligible spouse are not living together, the resources of both members (whether owned separately by each or jointly by both) are combined only for the month of separation.

b) Each member of the couple is treated as an eligible individual beginning with the month after the month of separation, i.e., no longer living in the same household, and the resource limit for each is the individual resource limit.

7. When a change occurs in marital status, a new resource limit is established and a new resource determination is made for the first month in which the new resource limit (individual or couple) is effective as a result of the change.

   a) Make a new resource determination for the first month in which a new resource limit (individual or couple) is effective as a result of the change in marital status.

      1) Example: If two eligible individuals marry in February, a new resource determination would be required for March since the individuals became a couple effective on the first day of March as a result of the marriage. For SSI or Medicaid purposes, the marital relationship of a couple can be ended by death, divorce or annulment:

         (a) If a marriage ends by death, divorce or annulment in the same month the marriage begins, treat the marriage as though it had not occurred.

         (b) Beginning with the month following the month of the death of one member of a couple, the surviving member will be an eligible individual if all other eligibility criteria are met.

         (c) If the marital relationship of a couple terminates by divorce or annulment, each member of the couple should be treated as an individual effective the first day of the month following the month the couple no longer lives in the same household.

D. When deeming from Parent to Child to determine elgibility for a child under age 18 (or under 21, if a student), who lives with his parent(s):

1. The resources of the child include the value of the countable resources of the parent(s) or parent/stepparent to the extent that the resources of the parent(s) or parent/stepparent exceed the resource limit of:

   a) An individual, if one parent lives in the household; or

   b) A couple, if two parents live in the household.

2. The following should be considered:

   a) Do not include the resources of the stepparent in the deeming process.

b) The value of parental resources is subject to deeming whether or not those resources are available to the child.

c) If there is more than one eligible child under 18 or (under 21, if a student) in the household, equally divide the value of the deemed resources among those children.

1) If an eligible child is later determined ineligible for any reason or is no longer subject to deeming (e.g., after attainment of age 18), divide the value of the deemed resources among the remaining eligible children effective with the first month the child is ineligible or no longer subject to deeming.

3. A child's total countable resources are the combination of the value of the deemed resources and the non-excluded resources of the child. A child's countable resources are compared with the resource limit for an individual with no spouse. If the resources do not exceed the limit, the child meets the resource eligibility requirement. If countable resources exceed the limit, the child is ineligible because of the excess resources.

4. When more than one eligible individual lives in the same household and there is a parent-child relationship, a multiple deeming situation may exist:

a) If a child under age 18 (or under 21, if a student) lives in the same household with a parent(s) applying for Medicaid or an eligible parent(s), determine the countable resources of the parent(s).

b) If the parent(s) meets the resource eligibility requirement, do not deem the value of any parental resources to the child.

c) If the parent(s) do not meet the resource eligibility requirements, follow the usual parent-to-child resource deeming rules to determine the value of the deemed parental resources.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Part 103 Chapter 15: General Verification Requirements

Rule 15.1 General Verification Requirements.

A. Generally, resources must be verified for any month for which you must determine eligibility. For the following types of action, verify as follows:

1. Applications.

a) Specifically, for initial applications, verify the value of resources for the month of application and each month(s) of possible retroactive eligibility. Verify months subsequent to the month of application as necessary.

2. Redeterminations.

   a) For redeterminations, verify, as needed, the value of resources for up to 3 months prior to the review month. It is permissible for resources to be developed as of the most recent month for which verification is available for regular reviews, rather than requiring resource balances for the review month.

3. Appeals.

   a) If a client appeals a denial related to a particular resource, the evidence in the file must clearly establish the value of that resource. If must do so even if the issue under appeal is not the value itself (e.g., when the issue under appeal is ownership). This requirement ensures that at each level in the appeals process, the file contains complete documentation of the resource in question.

B. There are some exceptions to the above. Do not verify the value of resources for a given month if:

   1. The resource is totally excluded, regardless of its value;

   2. The alleged value of total countable resources exceed the applicable limit for that month; or

   3. The individual is ineligible that month for reasons other than excess resources

C. Develop the equity value of a resource (liquid or nonliquid) when an individual alleges a debt against it and the difference between equity and CMV could mean the difference between eligibility and ineligibility:

   1. Verify, at a minimum, the outstanding principal balance (payoff), the rate of interest and the schedule and amount of payments (to permit the projection of increases in equity); and

   2. Obtain a copy of the agreement or note that establishes the debt. If this does not provide all the information needed, use other records of the individual, the creditor or both.

D. At a minimum, resources owned by a client are verified at the time of application and at each regular review scheduled annually. However, circumstances may warrant re-verification of resource(s) at shorter intervals. The following describes situations which mandate re-verification of resources at shorter intervals than annually, but it is not an all-inclusive list. Any reported changes in resources or discovery of changes in resources may warrant verification or re-verification.

   1. Individuals/couples determined eligible for Medicaid who own countable resources valued within $100 of the applicable limit must have resources renewed/verified every six months, rather than annually.

a) The purpose of the 6-month special review will be to verify the value of countable resources in order to determine if the individual/couple remains eligible based on resources.

b) A tickler must be utilized to control the timing of the required special review of cases with countable resources close to the resource limit.

2. Client cases, especially long term care cases that receive excess VA income that is not countable as income must be monitored closely for excess resources.

   a) The amount of the monthly income that is not counted will determine the frequency review/re-verification is deemed necessary.

   b) Long Term Care Recipients in Medicare Beds. Individuals who are placed in Medicare-certified nursing facilities are not required to pay any of their income toward the cost of their care which means that income may be allowed to accumulate and result in excess resources during the first 100 days of possible Medicare coverage.

      This means it is necessary to re-verify resources during the period of Medicare coverage to check for possible excess resources.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994); Miss. Code Ann. §43-13-121.1 (Rev. 2005).

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid

Part 104

Income

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Title 23: Division of Medicaid, Office of the Governor

Part 104: Income

Part 104 Chapter 1: Introduction to Income – ABD Programs

Rule 1.1: Income Rules.

A. Chapters 1 – 10 discuss sources and treatment of income in the Aged, Blind and Disabled (ABD) programs. Eligibility for the ABD Medicaid programs is based on the rules used to decide eligibility for Supplemental Security Income (SSI). In accordance with 42 CFR 435.601, Medicaid is required to use SSI financial eligibility requirements unless a subsequently issued Medicaid statute or regulation supersedes SSI policy. In addition, 1902(r)(2) of the Social Security Act allows states to apply income rules to certain Medicaid categories that are more liberal than the SSI program.

B. The following income rules are based on SSI income policy:

    1. Income is counted on a monthly basis.

    2. An individual who has too much income in a particular month is not eligible for Medicaid for that month.

    3. Income may include more or less than is actually received. For example:

        a) Expenses of obtaining income (less);

        b) Garnishment (more); or

        c) Gross earnings before any deductions (more).

    4. Not all income counts in determining eligibility.

C. The following rules are based on liberalized income policy:

    1. Certain liberalized income policies apply to the following categories of eligibility:

        a) Qualified Medicare Beneficiaries (QMB);

        b) Specified Low-Income Medicare Beneficiaries (SLMB);

        c) Qualifying Individuals (QI);

        d) Working Disabled (WD); and

        e) Healthier Mississippi Waiver (HMW).

2. The following income liberalizations are applicable to the five categories of eligibility listed above:

   a) The value of in-kind support and maintenance (ISM) is excluded.

   b) The $20 general exclusion is raised to a $50 general exclusion.

   c) The SSI budgeting practice that requires an individual who is married to an ineligible spouse to be eligible as both an individual and as a member of a couple is replaced with one test in which the couple's income is combined after allocating to the ineligible children from the ineligible spouse's income. The couple's countable income is then tested against the couple limit appropriate to the coverage group.

   d) Interest, dividend and royalty income that does not exceed $5 per month per individual is excluded.

   e) Couples living together are budgeted separately when one member is enrolled in a HCBS Waiver Program and evaluated for eligibility using institutional financial criteria and the other member of a couple is applying under an at-home category.

   f) Annual cost of living increases in federal benefits (such as VA, Railroad Retirement, Civil Service, etc.,) that are in addition to Title II benefits are disregarded in determining income through the month following the month in which the annual Federal Poverty Level (FPL) update is published.

   g) Annual cost of living increases in federal benefits (Title II benefits, VA, Civil Service, and Railroad Retirement) are disregarded when the Federal Poverty Level (FPL) update fails to increase at an equal or greater rate than the federal cost of Living (COL) increase during the same year. The disregard of the COL increase in federal benefits will apply to increase(s) received by the eligible individual, couple and/or ineligible spouse. The COL increase will be disregarded as income until such time as the FPL increase is greater than the previous COL increase.

   h) For the Working Disabled coverage group, unearned income between the SSI limit and 135% of the federal poverty limit is disregarded.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).).

Part 104 Chapter 2: What is Income

Rule 2.1: Definition of Income.

A. Income is defined as any item an individual receives in cash (or in some cases in-kind) that can be used to meet his/her needs for food or shelter.

   1. Effective March 9, 2005, clothing is no longer considered a basic need for SSI purposes.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.2: Relationship of Income to Resources.

A. The following must be considered in determining the relationship of income to resources:

1. Anything received in a month, from any source is income to an individual, subject to the SSI definition of income.

2. Anything the individual owned prior to the month under consideration is subject to resource counting rules.

3. The same item cannot be counted as both a resource and income in the same month. An item received for the current month is income for the current month only. If held by the individual until the following month, that item is subject to resource counting rules. Any exceptions are noted in the discussion of the particular type of income involved.

   a) Example: Mr. Jones receives his Social Security check in March. It is directly deposited into his checking account. Count the Social Security check as income in March and subtract the deposit from the checking account to determine how much he has in resources for March. If Mr. Jones carries all or part of the check into April, the remaining amount is counted as a resource.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.3: Types of Income.

A. Income is either earned or unearned.

B. Different rules apply to each type of income.

C. Some examples of the types of income are listed below:

1. Earned income consists of the following types of payments:

   a) Wages;

   b) Net earnings from self-employment (NESE);

   c) Payments for services performed in a sheltered workshop or work activities center;

   d) Royalties earned by an individual in connection with any publication of his work and any honoraria received for services rendered.

2. Unearned income consists of the following types of payments:

a) Annuities, pensions, and other periodic payments;

b) Alimony and support payments;

c) Dividends, Interest and royalties (except for royalties mentioned above);

d) Rents;

e) Benefits received as the result of another's death to the extent that the total amount exceeds expenses of the deceased last illness and burial paid by the beneficiary;

f) Prizes and awards;

g) In-kind support and maintenance.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.4: Forms of Income.

A. Whether earned or unearned, income may be received in either of two forms:

1. Cash, which is currency, checks, money orders or Electronic Funds Transfers (EFTs), such as:

   a) Social Security;

   b) Unemployment Compensation;

   c) Wages.

2. In-kind items, such as:

   a) Shelter;

   b) Food;

   c) Clothing (Before March 9, 2005);

   d) Non-cash wages (such as room and board as compensation for employment).

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.5: The Effect of Garnishment or Seizure.

A. A garnishment or seizure is a withholding of an amount from earned or unearned income in

order to satisfy a debt or legal obligation. Amounts withheld from earned or unearned income to satisfy a debt or legal obligation are income for Medicaid purposes.

1. Example: Ms. Jones' wages are being garnished to repay a delinquent debt. The amount withheld for the garnishment is countable income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.6: When Income is Counted.

A. Generally, count income in the earliest month it is:

1. Received by the individual;

2. Credited to an individual's account; or

3. Set aside for an individual's use.

B. For Medicaid eligibility purposes, all income is determined monthly and counted in the month the income is received.

1. However, for institutional clients, income that varies in amount or frequency is averaged to determine Medicaid Income, provided the client is income-eligible for Medicaid in the month the payment is received without averaging.

C. There are exceptions to counting income in the month of receipt:

1. Occasionally, a periodic payment (like wages, Title II or VA benefits) is received in a month other than the month of normal receipt. As long as there is no intent to interrupt the regular payment schedule, the funds are considered to be income in the normal month of receipt.

a) The most common types of situations where this would apply are:

1) Advance Dated Checks. When the payer advance dates a check because the regular payment date falls on a weekend or holiday, there is no intent to change the normal delivery date. When this occurs, consider the check income in the normal month of receipt.

2) Electronic Funds Transfer. When an individual's money goes to a bank by direct deposit, the funds may be posted to an account before or after the month they are payable. When this occurs, treat the electronically transferred funds as income in the month of normal receipt.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.7: Income Determinations Involving Agents.

A. Monies received by an individual in his capacity as an agent on another's behalf (such as a representative payee) are not income to him. However, monies a person receives for his own use (not paid on behalf of another) must be evaluated under regular income rules.

1. Example: Mr. Jones is receiving a Social Security check as the payee for his disabled child. This check is counted as income for the child, not Mr. Jones.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.8: Income Derived from Joint Bank Accounts.

A. The following explains how to charge income in situations involving joint bank accounts held by Medicaid applicants/recipients with other individuals:

1. Eligible with Ineligible. When an applicant/recipient and an ineligible individual hold a joint bank account, the full amount of any deposit, regardless of the source of the deposit, is income to the applicant/recipient unless:

   a) The ineligible individual is a deemor (parent or spouse) for income and/or resource purposes. In which case the deposits are income to the person actually receiving them, but the ineligible's income or resources will be deemed to the eligible.

   b) The ineligible is a legal guardian, or conservator of the eligible, and legal documents allow deposits to be treated otherwise.

   c) The deposit can be excluded under some other provision.

   d) Spousal impoverishment rules apply.

2. Eligible with Other Eligibles. When Medicaid-eligibles are joint account holders, a deposit by one Medicaid-eligible is not income to the other eligible person. Deposits are counted as income to the eligible person actually receiving the benefit or entitled to the payment. Interest payments are allocated equally among the joint holders.

B. Rebuttal Situations.

1. If an eligible individual or deemor has successfully rebutted ownership of a portion of the funds in a joint bank account, deposits made by the other account holders will not be counted as income and interest will be charged in proportion to the amount funds in the account which are owned by the eligible individual or deemor.

2. If an eligible individual or deemor has successfully rebutted ownership of all of the funds held in a joint bank account, no deposits by other account holders or interest credited to the account are counted as income to the eligible individual or deemor.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 2.9: Income from Trusts and Conservatorships.

A. Generally, if the client has a right to the income from the principal of a trust or conservatorship, it is income to him as it becomes available.

B. If the client has no right to the income from the trust/conserved funds, then only the payments actually paid from the trust would be income.

C. The income/resource rules that apply to a trust or conservatorship depend on when the trust or conservatorship was established. Refer to Part 103, Chapter 5, for a complete discussion of applicable income/resource rules.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Part 104 Chapter 3: What is Not Income

Rule 3.1: Items Not Considered Income for Medicaid Purposes.

A. Some items received by an individual are not income because they do not meet the definition of income. Other items are income by definition, but are excluded from an individual's income by federal statute. Only those items specifically listed in the law and regulations can be excluded from income. The items in this section are not considered income for Medicaid purposes, as follows:

1. Medical and Social Services. These services are not income for Medicaid purposes. Under the circumstances specified in this section, cash and in-kind items received in conjunction with medical and social services are also not income.

a) Medical services are those services which are directed toward diagnostic, preventive, therapeutic or palliative treatment of a medical condition and which are performed, directed or supervised by a state licensed health professional.

1) The term "medical services" includes any room and board (i.e., food or shelter) provided during a medical confinement, as well as in-kind medical items such as prescription drugs, eyeglasses, prosthetics and their maintenance, electric wheelchairs, modified scooters and specially trained animals, such as seeing eye dogs, and their maintenance. Transportation to and from medical treatment is also considered a medical service.

b) A social service is any service (other than medical) which is intended to assist a

handicapped or socially disadvantaged individual to function in society on a level comparable to that of an individual who does not have such a handicap or disadvantage.

1) Some frequently encountered social services programs are programs funded under Title IV-B of the Social Security Act, Child Welfare Services; Title V of the Social Security Act, Maternal and Child Health and Crippled Children's Services and the Rehabilitation Act of 1973.

2) Education is not generally considered to be a social service, nor is vocational training that is not part of a vocational rehabilitation program.

3) Government income maintenance programs such as TANF or Bureau of Indian Affairs General Assistance and Child Welfare Assistance are also not social services.

c) When cash is received in conjunction with medical or social services, handle as follows:

1) Any cash provided by a governmental medical or social services program is not income.

2) Any cash from a nongovernmental medical or social services organization is not income when:

(a) The cash is for medical or social services already received by the individual and approved by the organization; however, if the individual receives an amount in excess of the expense of the medical or social services, the excess cash is unearned income; or

(b) The cash is a payment restricted to the future purchase of a medical or social service, or related excludable in-kind items.

3) Cash from any insurance policy which pays "loss of time" benefits to the recipient and restricts payment to periods of hospital confinement is treated as a third party resource, not income. However, cash payments considered to be an income supplementation for lost income due to a disability are income. This includes weekly disability policies without regard to hospital confinement.

d) When in-kind items are is received in conjunction with medical or social services, handle as follows:

1) In-kind items which meet the definition of medical services are not income regardless of their source.

2) Room and board (food and shelter) provided during a medical confinement is not

income. A medical confinement exists when an individual receives treatment in a medical treatment facility.

3) Any in-kind items (including food and shelter) provided by a governmental medical or social services program are not income.

4) In-kind items (other than food or shelter) provided by a nongovernmental medical or social services organization for medical or social services purposes are not income.

e) Cash payments for medical or social services that are not income are also not a resource for one calendar month following the month of receipt.

2. Personal Services. A personal service performed for an individual is not income.

a) Examples of personal services for an individual which are not income are:

1) Mowing the lawn;

2) Doing housecleaning;

3) Going to the grocery store; and

4) Babysitting.

3. Conversion or Sale of a Resource. Receipts from the sale, exchange or replacement of a resource are not income, but are resources that have changed their form. This includes any cash or in-kind item that is provided to replace or repair a resource that has been lost, damaged or stolen.

a) Example: Jerry sells his 1999 Buick for $1000. The money he receives is not income, but a resource which has been converted from one form (a car) to another form (cash).

4. Rebates and Refunds. When an individual receives a rebate, refund or other return of money he has already paid, the money returned is not income.

a) The key idea in applying this policy is the return of an individual's own money.

1) Some rebates do not fit that category. If the rebate is a return on an investment, for example, the rebate would be treated as a dividend.

5. Income Tax Refunds. Any amount of income tax refunded to an individual is not income. Amounts withheld or paid as income tax during the course of a taxable year are included in the definition of income; therefore, any later refund of income taxes by a federal, state, or local taxing authority is not again treated as income, but it is treated as a resource. This

is so even if the income from which the tax was withheld or paid was received in a period prior to the Medicaid application.

a) The Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010 provides that federal tax refunds received from January 1, 2010, through December 31, 2012, are not counted income or as a resource to the recipient or any person to whom the funds are given for a period of 12 months following receipt.

   1) Through December 31, 2012, any of these funds which are transferred are not subject to penalty.

   2) If placed in a trust, the funds are not subject to Medicaid trust provisions.

6. Credit Life and Credit Disability Insurance Payments. These payments are issued to or on behalf of borrowers to cover payments on loan, mortgages, etc., in the event of the borrower's death or disability.

   a) Both types of insurance may be administered under group or individual policies.

   b) The insurance payments are made directly to loan or mortgage companies, and are not available to the individual, either directly or by sale or conversion, for purposes of meeting his basic needs.

   c) These payments made on behalf of an individual under credit life or credit disability policies are not income.

7. Other Insurance Payments. Each insurance policy must be examined to determine the type of benefit it provides and the purposes for which is can be used. Cash payments should be treated as follows:

   a) Cash payments from any insurance policy made directly to the provider are not income since the beneficiary does not receive the payment. Any amounts paid to a facility for purposes other than medical care may be considered income if the facility actually pays the amount to the individual.

   b) Cash payments from any insurance policy which are restricted for purchase or reimbursement of medical services covered under the policy are a third party resource, not income.

   c) Cash payments from policies that restrict payments to periods of hospital confinement are a third party resource, not income.

   d) Cash payments from specialized policies, such as cancer or dismemberment polices, are reimbursements, not a third party resource.

   e) Cash payments from any insurance policy intended for income supplementation for

lost income due to a disability are considered income. This includes weekly disability payments without regard to hospital confinement.

f) Long term care insurance policies may be paid directly to the individual or to the nursing facility.

1) If payments are made directly to the individual, consider them countable unearned income.

2) If paid directly to the nursing facility, consider them a third party resource.

8. Bills Paid by a Third Party. When someone other than the eligible individual or couple makes a payment directly to a vendor, the payment is not income to the Medicaid recipient because the individual does not receive the payment itself.

a) However, a third party vendor payment is a means by which an individual may receive unearned in-kind income if food or shelter is received.

9. Replacement of Income already Received. If an individual's income is lost, stolen or destroyed and the individual receives a replacement, the replacement is not income. This is because once a payment has been issued and treated as income in determining an individual's eligibility, the reissuance of that same payment is not counted as income

10. Return of Erroneous Payments. A payment is not income when the individual is aware the he is not due the money and returns the check uncashed or otherwise refunds all of the erroneously received money in the month of receipt or the following month.

a) When the return is timely, accept the client’s statement the money was returned and do not count it as income.

b) However, if there is a delay in return of the erroneous payment beyond the month following the month of receipt, verify return of the full payment and document the reason for the delay and any other relevant facts.

11. Weatherization Assistance. This type of assistance (insulation, storm doors, windows, etc.) is not income.

12. Receipt of Certain Non-Cash Items. The value of any noncash items (other than an item of food or shelter) is not income if the item would become a partially or totally excluded nonliquid resource if retained into the month after the month of receipt.

a) Such non-income items may include, but are not limited to, specially equipped vehicles, automobiles, household goods, and property essential to self-support.

b) Consider these non-income items solely under resource rules.

13. Wage-Related Payments. The following payments by an employer are not income unless the funds for them are deducted from the employee's salary:

    a) Funds the employer uses to purchase qualified benefits under a cafeteria plan;

    b) Employer contributions to a health insurance or retirement fund;

    c) The employer's share of FICA taxes or unemployment compensation taxes, in all cases;

    d) The employee's share of FICA taxes or unemployment taxes paid by the employer on wages for domestic service in the private home of the employer or for agricultural labor only; to the extent the employee does not reimburse the employer.

14. Proceeds of a Loan. Refer to Part 103, Chapter 3, Rule 3.3, for a complete discussion of the definitions associated with loans. For income purposes, the proceeds of a loan are treated as follows:

    a) The proceeds of a bona fide loan are not income to the borrower because of the borrower's obligation to repay. Money received as repayment of the principal of a bona fide loan is not income to the lender; however, the interest received on money loaned is income to the lender.

    b) If the loan is not bona fide, the proceeds received in the transaction are unearned income to the borrower in the month received. If the loan is not bona fide, payments toward principal and interest are unearned income to the lender. As indicated above, the interest received by the lender on money loaned is unearned income whether the loan is bona fide or not.

15. Promissory Notes and Property Agreements. Refer to Part 103, Chapter 3, Rule 3.3, for a complete discussion of the definitions associated with promissory notes and property agreements. For income purposes, they are treated as follows:

    a) Treatment for the borrower is as follows:

        1) Under both SSI and liberalized policy, for the Medicaid client who is the borrower, cash paid by the lender to the borrower is not income if a promissory note or property agreement is bona fide. However, any reserve may be a resource the following month;

        2) Under both policies, if the agreement is non-bona fide or non-negotiable, cash paid by the lender to the borrower is income in the month received by the borrower and any retained cash (or property received) may be a resource the following month.

    b) Under SSI policy, treatment for the lender is as follows:

1) A bona fide, negotiable promissory note or property agreement is a resource.

(a) The goods or money represented in the agreement are not a resource because they are not accessible.

(b) The interest portion of the payment on a bona fide, negotiable agreement received by the Medicaid client who is the lender is unearned income.

2) If the agreement is non-bona fide or non-negotiable, both principal and interest paid to the lender are income.

c) For coverage groups subject to liberalized resource policy, treatment for the lender is as follows:

1) A bona fide, non-negotiable promissory note or agreement can be excluded as a resource if it produces at least a 6% net annual return of the principal balance.

(a) For this exclusion to apply to the non-institutionalized client, the income must be received by the client/spouse and counted as income.

(b) For all institutionalized individuals in either SSI or liberalized programs, the agreement may be excluded as a resource if it produces at least a 6% net annual return of the principal balance and meets all of the following criteria:

(i) The repayment terms of the note or agreement are actuarially sound;

(ii) The institutional client must reasonably expect to receive full payoff of the note or agreement during his lifetime. The average number of years of life expectancy remaining based on the Annuity Life Expectancy charts, compiled by the Office of Actuary of the Social Security Administration and applicable to the decision, must coincide with the payout of the note or agreement;

(iii) Principal and interest portions of payments are of uniform rate, with no deferred or balloon payments and

(iv) The agreement prohibits cancellation of the debt upon death of the lender.

16. Fund Raising Proceeds. Benefits received through fund raising are a potential third party liability source. The applicant/recipient must report all sources of income from fund raising to the regional office. The regional office will inform the Third Party Liability unit of the availability of any source of payment for medical services.

a) Donated funds for the purpose of payment of medical services are considered a third party source. In order for donated funds to be excluded as income, the following

criteria must be met:

1) Prior to accepting donations, the applicant/recipient (or family of a child) must make arrangements to place donations in a trust fund or special account;

2) The trust fund or special account must be managed by an administrator (someone outside the family);

3) The funds must never be mixed with personal or family money;

4) The applicant/recipient should not have direct access to the trust funds or special account; and

5) The applicant/recipient or administrator must be able to produce documentation of how the funds were spent.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994); Miss. Code Ann. §43-13-121.1 (Rev. 2005).

Part 104 Chapter 4: Exclusions for Earned and Unearned Income

Rule 4.1: Exclusions that Apply to both Earned and Unearned Income.

A. An exclusion is an amount of income which does not count in determining eligibility and payment amount.

B. Exclusions never reduce income below zero.

C. There are three statutory exclusions that apply to both earned and unearned income, as follows:

1. General Exclusion;

2. Infrequent and Irregular Income Exclusion; and

3. Plan for Achieving Self-Support (PASS) Exclusion.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.2: General Income Exclusion.

A. A general income exclusion of either $50 or $20 per month is applied based on whether the program operates under liberalized or strict SSI income policy.

1. Under liberalized income policy, the general exclusion is $50 for the following programs:

a) Qualified Medicare Beneficiaries (QMB);

b) Specified Low-Income Medicare Beneficiaries (SLMB);

c) Qualifying Individuals (QI);

d) Working Disabled (WD); and

e) Healthier Mississippi Waiver.

2. Under SSI income policy, the general exclusion is $20 for the following programs:

a) SSI Retro;

b) Disabled Child Living at Home;

c) Qualified Working Disabled (QWDI);

3. Also under SSI policy, the following programs use the $20 general exclusion; however, in addition, these categories of eligibility are allowed other income disregards specific to the coverage group:

a) Disabled Adult Child (DAC);

b) Cost of Living (COL);

c) OBRA Widow/Widowers; and

d) HR-1.

B. The general exclusion is applied to unearned income first. Any remainder is then applied to any earned income. If there is no unearned income, apply the full general exclusion to earnings before excluding $65 plus one-half of the remaining earned income.

C. The following principles must be considered in regard to the $50/$20 per month general exclusion:

1. The general exclusion applies to the individual applicant's or recipient's own income, which includes income which has been deemed to them.

2. Only one general exclusion can be applied to the combined income of any couple. A spouse deemor is not allowed a separate deduction from his/her income.

3. In parent to child deeming situations, the $20 SSI disregard is applied to income of a single parent or combined parental income when a two-parent household is involved.

4. No other unused unearned income exclusion, except the general exclusion, may be applied to earned income.

5. The general exclusion is not applied to Income Based on Need (IBON).

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.3: Infrequent and Irregular Income Exclusion.

A. For this exclusion to apply, the earned or unearned income must be received infrequently or irregularly, as defined below. This provision does not apply to unearned income that is subject to other exclusions, i.e., infrequent or irregular child support, subject to the one-third child support exclusion.

   1. Infrequent Income. Effective September 8, 2006, income is considered to be received infrequently if an individual receives it only once during a calendar quarter from a single source and the individual did not receive that type of income in the month immediately preceding that month or in the month immediately subsequent to that month, regardless of whether these payments occur in different calendar quarters.

   2. Irregular Income. Income is considered to be received irregularly if an individual cannot reasonably expect to receive it.

B. To apply the exclusion, exclude the following amount which is received either infrequently or irregularly:

   1. The first $30 per calendar quarter of earned income; and

   2. The first $60 per calendar quarter of unearned income.

      a) The exclusion can apply to both earned and unearned income in the same month, provided the total does not exceed the limits stated above. Thus, it is possible to exclude as much as $90 in a quarter under this provision when applicable.

C. The following considerations must also be taken when applying this exclusion:

   1. A single source of earned income is defined as an employer, trade or a business.

   2. A single source of unearned income is defined as an individual, a household, an organization or an investment.

   3. The exclusion is applicable to income received infrequently or irregularly by an eligible, individual, eligible or ineligible spouse, ineligible parent(s) and ineligible children.

   4. The dollar amount of the exclusion does not increase, even if both an eligible individual and spouse (eligible or ineligible) have infrequent or irregular income.

5. Effective September 8, 2006, if an individual begins receiving a recurring payment (like a Social Security check) in the third month of a quarter, the payment does not meet the definition of infrequent because it will be received in the following month, even though the following month is in another quarter. The same would be true if the recurring payment ended in the first month of a quarter, but had been received in the prior month in another quarter.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 4.4: Plan for Achieving Self-Support (PASS) Exclusion.

A. The Social Security Act permits the exclusion of income and resources of a person who is blind or disabled if the person needs such income to fulfill a Plan for Achieving Self-Support under an approved plan.

   1. This exclusion applies to a blind or disabled individual under age 65, or age 65 or older if the individual was receiving SSI, disability or blind payments, for the month before he became age 65.

B. The income of a blind or disabled recipient, whether earned or unearned, may be excluded under an approved PASS when the income is set aside for a planned expenditure determined necessary to achieve the individual's occupational objective.

   1. To be eligible for this income exclusion for Medicaid, the individual plan must be submitted to state office for approval. The plan submitted must:

      a) Include the objective and time period for achieving it;

      b) Include the amount of money involved; and

      c) Be currently in use by the individual.

C. With the implementation of the Working Disabled Program with higher income and resource limits, PASS income and resource exclusions are rare.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Part 104 Chapter 5: Earned Income Exclusions

Rule 5.1: Applying the Exclusions.

A. While the source and amount of all earned income must be determined, not all earned income counts when determining Medicaid eligibility.

   1. First, any earned income excluded by federal law must be disregarded.

2. Then the applicable income exclusions discussed in this section are applied in the following order to the rest of the earned income in the month:

   a) Earned income tax credit payments (EITC) and child tax credit (CTC) payments;

   b) Up to $30 of earned income in a calendar quarter if it is infrequent or irregular;

   c) Student Earned Income Exclusion (SEIE);

   d) Any portion of the $50/$20 general income exclusion which has not been excluded from unearned income in that same month

   e) $65 of earned income in a month (applied only once to a couple, even when both members, whether eligible or ineligible, have earned income);

   f) Earned income of disabled individuals used to pay impairment-related expenses (IRWE);

   g) One-half of the remaining earned income in a month;

   h) Earned income of blind individuals used to meet work needs (BWE);

   i) Any earned income used to fulfill an approved plan to achieve self-support (PASS);

   j) An unused earned income exclusion is never applied to unearned income and cannot be carried over for use in subsequent months.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 5.2: Exclusion of Earned Income Tax Credit (EITC) and Child Tax Credit (CTC) Payments.

A. The EITC is a special tax credit that reduces the federal tax liability and results in a payment to the low-income taxpayer, either as advance from the employer or a refund from IRS. Exclude the EITC received either as an advance or as a refund.

B. The CTC is a special refundable federal tax credit that is available to parents, step-parents, grandparents and foster parents and provides a refund to individuals even if they do not owe any tax. There is no advance payment with the CTC. Exclude CTC refund payments from income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 5.3: Student Earned Income Exclusion (SEIE).

A. Effective April 1, 2005, the Student Earned Income Exclusion was extended to all individuals

who are working students under the age of 22, not just those who meet the SSI definition of a child.

1. The SEIE will apply to earnings deemed from an ineligible spouse or parent(s) and it will apply to the joint earned income of eligible couples when both members are under age 22 and are working students.

B. The SEIE allows an individual under age 22 and regularly attending school to have earnings up to the monthly maximum, but not more than the annual maximum, both of which are adjusted annually based on increases in the cost of living index.

1. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 5.4: $65 Plus One-Half of Remainder Earned Income Exclusion.

A. $65 per month of earned income plus one-half of the remaining earned income in the month is excluded in the order listed in Rule 5.1.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 5.5: Impairment-Related Work Expenses (IRWE) Exclusion.

A. IRWE expenses are for items or services which are directly related to enabling a person with a disability (other than blindness) to work and which are necessarily incurred by that individual because of a physical or mental impairment.

B. Any earned income of a person who is disabled (but not blind) that is used to meet any reasonable, non-reimbursable impairment-related work expenses is not counted.

C. The IRWE exclusion may be applied to the earnings of a disabled person who is under age 65, or is age 65 or older and received SSI and Medicaid or a disability payment for the month prior to attaining age 65.

D. The IRWE exclusion applies only to earned income and is applied in the order discussed in Rule 5.1.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 5.6: Blind Work Expenses (BWE) Exclusion.

A. BWE represents any earned income of a blind person which is used to meet any expenses reasonably attributable to earning the income.

B. Exclude BWE from earned income if the blind person is under age 65, or is age 65 or older and received SSI and Medicaid or disability payments for the month before attaining age 65.

C. The BWE exclusion applies to earned income only and in the order discussed in Rule 5.1.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Part 104 Chapter 6: Unearned Income – General Provisions

Rule 6.1: Definition of Unearned Income.

A. Unearned income is all income that is not earned income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 6.2: When to Count Unearned Income.

A. Unearned income is counted as income in the earliest month it is:

1. Received by the individual;

2. Credited to the individual's account; or

3. Set aside for the individual's use.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 6.3: Unearned Income Exclusions.

A. An exclusion is an amount of income that does not count in determining eligibility and payment amount.

1. Except for the $50/$20 general exclusion, no other unused unearned income exclusion may be applied to earned income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 6.4: Expenses Incurred to Obtain Unearned Income.

A. The amount of unearned income which must be counted in determining eligibility for Medicaid is the gross amount due the client; however, the gross amount of unearned income may be reduced by certain expenses that are an essential factor in obtaining a particular payment(s).

B. Unearned income does not include that part of a payment that is for an essential expense incurred in getting the payment. For example:

1. From a payment received for damages in connection with an accident, subtract legal, medical and other expenses connected with the accident; or

2. From a retroactive check from a benefit program other than SSI, subtract legal fees connected with that claim.

C. The following fees are considered essential to obtaining income and are allowed as deductions:

1. Document fees to acquire documentation to establish that an individual has a right to certain income are an essential expense and reduce the amount of unearned income which is countable.

   a) Examples include fees for obtaining birth or death certificates, legal papers, medical examinations, filing fees, etc.

2. Guardianship fees are essential expense only if the presence of a guardian is a requirement for receiving the income.

D. The following criteria must be used when deducting expenses essential to obtaining the unearned income:

1. Expenses are deducted from the first and any subsequent amount(s) of related income until the expense is completely offset.

2. Excludable expenses can be offset against the income when it is actually or constructively received.

3. Allow any verified expenses which were paid by the recipient prior to the receipt of the income (e.g., a partial payment to an attorney made from an individual's savings account) as long as they are essential to obtaining the income.

4. Proof of having incurred the expense (bills, canceled checks, money orders, etc.) is required. If an expense has been incurred, but not paid, assume the individual will pay the expense.

5. The remainder is unearned income subject to the general rules pertaining to income and income exclusions.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 6.5: Overpayment Recovery from Unearned Income.

A. Unearned income includes that part of a benefit that has been withheld to recover a previous overpayment.

B. However, the amount withheld to reduce a prior overpayment is not included as income if double counting would result.

1. Double counting (counting the unearned income twice) would result if:

   a) The individual received both SSI and the other benefit (or deemed income using the other benefit) at the time the overpayment of the other benefit occurred; and

   b) The overpaid amount was included in figuring the SSI payment (and resulting Medicaid eligibility) at the time.

C. This policy applies to the following types of benefits:

1. Annuities and pensions;

2. Retirement or disability benefits (including veteran's pensions and compensation);

3. Workers' Compensation;

4. Social Security benefits;

5. Railroad Retirement benefits;

6. Unemployment benefits; and

7. Black Lung benefits.

D. Overpayment means "overpayment as defined by the entity paying the benefit" and may include overpayments made to someone other than the person whose benefits are withheld.

1. Example: Joe Jones started receiving RSDI benefits and SSI in January 2010. His SSI terminated in December 2010. In January 2011, he received a notice explaining that he was overpaid $150 in RSDI benefits from April 2010 through August 2010 and $30 will be withheld from his RSDI benefit from March 2011 through July 2011 to recover the overpayment. Since the overpaid amount was used to determine his SSI payment from April 2010 through August 2010, the $30 a month overpayment recovery is not included in the determination of his countable unearned income for March through July 2011.

E. This exception does not apply if the individual was determined ineligible for SSI based on countable income that included the overpayment and no SSI payment was received for the months the overpayment occurred.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 6.6: Garnishment or Other Withholdings.

A. Unearned income includes amounts withheld because of a garnishment or to make certain other payments (such as Medicare premiums).

B. Unearned income includes amounts withheld whether the withholding is:

1. Purely voluntary;

2. To repay a debt; or

3. To meet a legal obligation.

C. This policy does not apply to amounts withheld to pay the expenses of obtaining the income since such amounts are not income.

D. The following are types of items for which amounts may be withheld, but withheld amounts are considered income received:

1. Federal, state or local income taxes;

2. Supplementary Medical Insurance (SMI), Medicare Part B;

3. Loan payments;

4. Child support;

5. Life or health insurance premiums;

6. Union dues;

7. Bank charges; or

8. Garnishments.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 6.7: Return of Previously Deducted Money.

A. If any of the types of deductions listed in Rule 6.6 above are later returned to the individual by the original source, agency or organization which received the deduction (e.g., refund of Medicare premiums), the refunded amounts cannot again be income.

B. Refunded amounts can be available resources when received and would be counted if retained into the following month.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 6.8: Payments in Foreign Currency.

A. Occasionally, an individual receives income tendered in a monetary unit other than US dollars, usually in the form of a check or a direct deposit to a bank.

B. The US dollar value of a payment made in foreign currency, less expenses, is income.

1. Foreign currency payments are counted as income when received unless the individual can establish that the payment was received too late in the month for conversion prior to the following month.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 6.9: Deemed Income.

A. Deemed income is unearned income attributed to an applicant or recipient for Medicaid eligibility from an ineligible spouse or parent.

1. Deeming only applies in household situations.

2. There is no deeming of income in any month of institutionalization and deemed income is not used in determining Medicaid Income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.602(a) (Rev 1994).

Rule 6.10: Income Based on Need (IBON).

A. Income based on need is assistance which is:

1. Provided under a program which uses income as a factor eligibility; and

2. Funded wholly or partially by the federal government or a nongovernmental agency (e.g., Catholic Charities or Salvation Army) for the purpose of meeting basic needs.

B. IBON is unearned income that is not subject to the $50/$20 general exclusion.

1. If received by a client, IBON is counted in its entirety.

2. However, if IBON is received by an ineligible spouse, parent or child, it is not deemed to a client.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 6.11: Assistance Based on Need (ABON).

A. Assistance based on need is assistance which is:

1. Provided under a program which uses income as a factor of eligibility; and

2. Funded wholly by a state, a political subdivision of a state or a combination of such jurisdictions.

B. Assistance based on need is excluded from income.

1. If a program uses income to determine payment amount, but not eligibility, it is not ABON, e.g., some crime victim compensation programs.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Part 104 Chapter 7: Sources and Treatment of Unearned Income

Rule 7.1: Annuities, Pensions, Retirement and Disability Payments.

A. These types of income are defined as follows:

1. An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer.

2. Pensions and retirement benefits are payments to a worker following retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company or other entity.

3. Disability benefits are payments made because of injury or disability.

B. These types of income are treated as follows:

1. Annuities, pensions, retirement benefits and disability benefits are counted as unearned income.

   a) An exception is certain accident disability benefits paid within the first 6 months after the month an employee last worked are treated as earned income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.2: Title II, Retirement, Survivors and Disability Insurance (RSDI) Payments.

A. This type of income is defined as follows:

1. Retirement, Survivors and Disability Insurance are monthly Social Security benefits which are counted as unearned income.

a) Special age 72 benefits, also known as Prouty benefits, are also counted as unearned income.

B. This type of income is treated as follows:

1. Title II benefits are counted as unearned income, considering the following:

a) The amount of premiums deducted from RSDI for the optional Supplemental Medical Insurance (SMI) premium under Medicare are counted as unearned income.

b) The amounts deducted for Medicare Part D are countable unearned income.

c) SMI/Medicare Part D premiums that are refunded to the individual are not counted.

d) A Title II benefit is reduced dollar for dollar in the amount of any monthly Workers' Compensation paid.

1) If a monthly benefit payment has been reduced because of a Workers' Compensation offset, the net amount of the benefit received (plus any SMI, Medicare Part D premium withheld) is unearned income.

e) Overpayments recovered from SSA benefits are included unless the overpayment occurred when the person was receiving SSI and the overpaid amount was included in at that time. In this instance, the amount deducted for an overpayment is not included in calculating countable Title II income.

f) Refund of recovered monies based on a waiver approval is not income if the money was previously withheld to recover a Title II overpayment, both SSI and Title II benefits were received at the time of the overpayment and the overpaid amount was included in figuring the SSI payment at that time.

g) If a monthly Title II benefit payment has been reduced because of a garnishment, the gross amount of the benefit received (plus any SMI premium withheld) is counted as unearned income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.3: Treatment of Retroactive Benefits.

A. Retroactive RSDI benefits, whether paid in a lump sum or by installment, are treated as unearned income in the month received, with the following exceptions:

1. Retroactive RSDI benefits must be paid in installments when paid to representative payees of persons who are eligible because of Drug Addiction or Alcoholism (DAA).

a) The total of retroactive RSDI benefits paid in installments is treated as if paid in a lump sum in the usual manner.

b) The total of such benefits paid in installments is considered unearned income in the month in which the first installment is made.

2. Retroactive RSDI benefits paid for a month for which a person also received an SSI payment (i.e., an offset month) have been reduced by an amount equal to the amount of SSI that would not have been paid had the RSDI benefits been paid when due.

a) The balance of these retroactive RSDI benefits is considered income not when received, but rather in the month regularly due.

1) The award letter issued to the recipient will specify the offset amount.

2) Any payment over and above this amount is income in the month received.

b) Retroactive RSDI benefits paid for periods outside of an offset period are not subject to reduction and are considered income when received.

3. In certain situations, SSA will agree at the recipient's request to pay by installment retroactive RSDI benefits that would otherwise be paid in one lump sum.

a) In such cases, the total of retroactive RSDI benefits (except for amounts considered paid in a windfall offset as discussed above) is counted as unearned income in the month the benefits were set aside for the person's use.

B. Retroactive SSI and RSDI benefits are defined as follows:

1. Retroactive SSI benefits are SSI benefits issued in any month after the calendar month for which they are paid.

a) SSI benefits for January that are issued in February are retroactive.

2. Retroactive RSDI benefits are those issued in any month that is more than a month after the calendar month for which they are paid.

a) RSDI benefits for January that are issued in February are not retroactive; however, RSDI benefits for January that are issued in March are retroactive.

C. The unspent portion of retroactive SSI and RSDI benefits is excluded from resources for 9 calendar months following the month the individual receives the benefits.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.4: Mandatory State Supplement (MSS) Benefits.

A. This type of income is defined as follows:

1. Aged, blind and disabled individuals converted from state welfare rolls are deemed to have filed for SSI beginning January 1, 1974. These converted recipients receive SSI and a Mandatory State Supplement to maintain the 12/73 income levels of former assistance recipients and protect them from suffering a loss of income under the SSI Program. In addition, certain recipients may receive MSS without an SSI payment.

2. The Social Security Administration (SSA) administers MSS payments in Mississippi. MSS payments are included with SSI benefits each month or paid separately if the individual does not receive SSI.

B. This type of income is treated as follows:

1. MSS payments are treated as Income Based on Need (IBON) for income purposes. Note: Currently, there are no remaining state supplement cases in the state.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.5: Black Lung (BL) Benefits.

A. This type of income is defined as follows:

1. Black Lung benefits are paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act (FMSHA).

2. Under the Black Lung Consolidation of Administrative Responsibilities Act, benefits under Part B and Part C of the FMSHA are paid by the Department of Labor (DOL).

B. This type of income is treated as follows:

1. BL benefit payments are counted as unearned income.

a) Both Part B and Part C BL benefits are subject to offsets (like Workers' Compensation) and can be reduced due to the recovery of an overpayment

1) The amount of the BL benefit to charge as income is the amount paid after application of an offset (like Workers' Compensation), but before the collection of any obligations of the recipient.

b) In addition, Part C benefits may be reduced because of liens imposed by other federal agencies such as the Internal Revenue Service (IRS).

1) The amount deducted from a Part C BL benefit because of garnishment (such as liens imposed by other federal agencies) is counted as unearned income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.6: Civil Service and Federal Employee Retirement Payments.

A. This type of income is defined as follows:

1. The Office of Personnel Management (OPM) makes US Civil Service and Federal Employee Retirement System (FERS) payments because of disability, retirement or death.

B. This type of income is treated as follows:

1. US Civil Service payments and FERS payments are counted as unearned income to the entitled retiree or individual survivor even when additional monies for other family members are included in the payment.

2. However, certain disability benefits paid within the first six (6) months after an employee last worked are treated as earned income.

3. OPM provides annuitants under the Retired Health Benefits (RHB) program free coverage under Part B of Medicare. All annuitants covered by the RHB program retired before 7/1/1960.

   a) At the employee's option, the Part B premium may instead be paid to another health insurance plan or paid directly to the annuitant for use in purchasing health insurance coverage privately.

   b) The RHB payment is shown as a positive amount (addition) on the health benefits line of the OPM notice. RHB payments to annuitants are not income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.7: Other Government Pensions and Retirement Plans.

A. This type of income is defined as follows:

1. Payments made to former employees, their dependent(s) or survivor(s) by state, local (or foreign) governments.

   a) Examples include State and Municipal retirement.

B. This type of income is treated as follows:

1. The full amount of benefits the recipient is entitled to receive is counted as unearned income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.8: MS State Retirement 13th Check.

A. This income is defined as follows:

1. Certain state retirees (including those drawing benefits from a deceased spouse's record) are eligible to receive a 13th check each year in addition to their regular monthly check.

2. The 13th check is sometimes referred to as a bonus check. The bonus check, which is usually issued each December 15th, is computed on a percentage basis multiplied by the number of years retired and annual income received.

B. This income is treated as follows:

1. Institutionalized clients, who receive a 13th check and are subject to Income Trust provisions, are required to have the bonus check averaged over the 12-month period as a condition of eligibility.

   a) Institutional clients who are eligible for December based on receipt of the bonus check will have the bonus payment averaged in the Medicaid Income computation.

2. For all other recipients, the 13th check is counted as income each December to determine eligibility for the month of December.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994); Miss. Code Ann. §43-13-121.1 (Rev. 1995).

Rule 7.9: Railroad Retirement Benefits.

A. There are three basic categories of payments made by the Railroad Retirement Board (RRB):

1. Life and Survivor annuities.

2. Title II benefits certified by RRB.

3. Unemployment, sickness and strike benefits.

B. These types of payments are treated as follows:

1. RRB payments are counted as unearned income.

   a) The amount deducted from a RRB benefit for Medicare is counted as income.

   b) The amount of the RRB annuity to charge as income is the amount before collection of any obligations of the annuitant.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.10: Military Pensions.

A. The Air Force, Army, Marine Corps, Navy and Coast Guard pay military pensions to military retirees and survivors normally on the first day of the month.

B. There are three categories of beneficiaries who may be entitled to military payments:

1. Retiree. A person with 20 years of service who meet the requirements for entitlement.

2. Annuitant. A Survivor who is designated by the retiree to receive benefits upon the death of the retiree under the Retired Serviceman's Family Protection Plan (RSFPP), Survivor's Benefit Plan (SBP) or both;

3. Allottee. Anyone other than an annuitant of the RSFPP or SBP who is designated to receive money out of the service member's or retiree's check.

a) Entitlement as an allottee terminates upon the death of the retiree. However, an allottee can become an annuitant when the retiree dies.

C. The RSFPP and SBP annuitant programs pay money to surviving spouse(s) and children. The SBP program also pays:

1. "Insurable interest" persons, i.e., someone other than a surviving spouse or child that a service member designates to receive survivor benefits based on monies withheld from his/her retirement payment under the provisions of the SBP program; and

2. Minimum income level widows (MIW) who are certified by the VA as having low income and are referred by the Department of Defense (DOD).

D. This type of income is treated as follows:

1. Military pensions are counted as unearned income.

2. Payments to Minimum Income Widows are counted as income based on need (IBON) not subject to the $50/$20 general income exclusion.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.11: Department of Veterans Affairs (VA) Benefits.

A. This type of income is defined as follows:

1. The Department of Veterans Affairs (VA) has numerous programs that make payments to

recipients and their families. The most common types of VA payments discussed in this section are:

a) Pensions;

b) Compensation;

c) Educational Assistance;

d) Aid and Attendance Allowance;

e) Housebound Allowance;

f) Clothing Allowance;

g) Payment Adjustment for Unusual Medical Expenses;

h) Payments to Vietnam Veterans' children with Spina Bifida; and

i) Insurance Payments.

B. The Utilization of Benefits provision applies to most VA income.

1. VA Aid and Attendance (A&A) is not a required benefit under the Utilization of Benefits Provision. The potentially-eligible client must be advised to apply for A&A, but there is no penalty for failing to apply when it is the only benefit involved.

C. Treatment of VA payments for SSI/Medicaid purposes depends on the nature of the payments and is included in the discussion of each type of VA income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.12: VA Pension Payments.

A. The following is information about VA pensions:

1. Pension payments are based on a combination of service, an age of 65 or over and a nonservice-connected disability or death.

2 All VA pension payments are based on need, except those noted later under this rule.

3. VA may consider dependents' needs in determining a pension; however, normally VA will not make a pension payment directly to a dependent during the lifetime of the veteran. Instead, the amount of the veteran's basic pension is increased if the veteran has dependents.

4. When computing some needs-based pension payments, VA deducts unusual medical expenses from any countable income.

    a) This computation may result in an increase in a pension payment or in an extra payment.

        1) An increase or extra payment resulting from this computation is not income.

5. Assume that a VA pension is partially or entirely needs-based unless there is evidence to the contrary. As such, these payments are unearned income and the $50/$20 general income exclusion is not applied.

    a) The exceptions to IBON designation are:

        1) VA Aid and Attendance and Housebound Allowances are not income. All or part of a VA pension may be subject to this rule.

        2) VA payments resulting from unusual medical expenses are not income. All or part of a VA pension payment may be subject to this rule.

        3) Pensions paid to veterans and their dependents on the basis of a Medal of Honor or special act of Congress, are not needs-based. These pensions are unearned income and the $50/$20 general exclusion does apply.

6. The Veterans and Survivors Pension Improvement Act (VA Improved Pension), signed into law October 1978 and effective January 1979, changed the method of determining the pension payable. The new rates of payment are not automatic; therefore, the veteran or survivor must file an application with VA to establish entitlement under the improved pension. Recipients who receive benefits under the old VA law must file for the improved pension as a factor of eligibility under the Utilization of Other Benefits provision.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.13: VA Compensation Payments.

A. Compensation payments are based on service-connected disability or death and may be based on need.

B. The following are types of compensation payments and their treatment:

1. Death Compensation and Dependency and Indemnity Compensation (DIC) payments to a surviving parent of a veteran are counted an unearned income. Since these payments are determined by the parent's income, they are income based on need and the general income exclusion does not apply.

2. Compensation payments resulting from unusual medical expenses, aid and attendance allowances and housebound allowances are not counted as income.

3. Compensation payments to a veteran, spouse, child or widow(er) are counted as unearned income subject to the $50/$20 general exclusion.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.14: VA Educational Benefits.

A. VA provides educational assistance under a number of different programs, including vocational rehabilitation. Veterans, dependents and survivors of veterans may be eligible for educational benefits. Depending on the nature of the program, different SSI/Medicaid income and resource policies apply.

B. The following are not considered in determining VA income:

1. Vocational Rehabilitation. Payments made as part of a VA program of vocational rehabilitation are not income, including any augmentation for dependents.

2. Withdrawal of Contributions. Any portion of a VA educational benefit that is a withdrawal of the veteran's own contributions is conversion of a resource and is not income.

C. VA educational income is treated as follows:

1. Any VA educational benefit payment or portion of such a payment funded by the government that is not part of a program of vocational rehabilitation is unearned income.

2. Any portion of the VA educational benefit used to pay for tuition, books, fees, tutorial services, or other necessary educational expenses is excluded from income.

   a) For SSI/Medicaid purposes, only the portion of an educational payment that is income to the veteran obtaining the education is subject to the educational expenses exclusion.

   b) The augmented portion is not subject to the educational expenses exclusion.

3. The $50/$20 general income exclusion applies to countable VA educational assistance and these payments are subject to deeming.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.15: VA Benefits for Dependents.

A. VA often considers the existence of dependents when determining a veteran's or veteran's surviving spouse's eligibility for pension, compensation and educational benefits by the following:

1. Apportionment. This is direct payment of the dependent's portion of VA benefits to a dependent spouse or child.

   a) The portion of a VA benefit paid by apportionment to a dependent spouse or child is VA income to the dependent spouse or child. It is not a support payment from the designated VA beneficiary.

2. Augmentation. An augmented payment includes a designated VA beneficiary's portion and one or more dependent portions.

   a) The designated beneficiary's portion is that part of an augmented benefit that is attributable to the veteran or the veteran's surviving spouse and it VA income to the designated beneficiary, i.e., veteran or veteran's surviving spouse.

   b) The dependent's portion is VA income to the dependent, provided the dependent resides with the designated beneficiary. The dependent's portion is not a support payment from the designated beneficiary.

   c) An absent dependent's portion of an augmented VA benefit is not VA income to either the dependent or the designated beneficiary.

      1) This is true even if the designated beneficiary continues to receive the absent dependent's portion.

      2) The dependent's portion of a VA benefit is not VA income to an absent dependent unless he receives it directly as an apportioned payment.

      3) Any portion of the absent dependent's augmented benefit that is retained by the designated beneficiary is a countable resource.

      4) Any payment made from the designated beneficiary directly to an absent dependent is unearned income in the form of a gift, a support payment, or other income, not VA income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.16: VA Clothing Allowance.

A. A VA clothing allowance is not income for eligibility or Medicaid Income purposes.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.17: Payments to Veterans' Children with Certain Birth Defects.

A. These VA payments are made to, or on behalf of, the natural children of veterans, regardless of age or marital status, who are in the following categories:

   1. Vietnam veterans' children for any disability resulting from spina bifida;

   2. Korea service veterans' children for any disability resulting from spina bifida;

   3. Women Vietnam veterans' children for certain birth defects.

B. The payments are treated as follows:

   1. They are excluded from income and resources.

   2. The interest earned on unspent funds is excluded effective July 2004.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.18: VA Aid and Attendance and Housebound Allowances.

A. VA Aid and Attendance and Housebound Allowances are not counted as income for eligibility purposes and must be excluded from the total VA payment when determining eligibility.

   1. In addition, these payments are not considered third party payments.

B. Anyone in a nursing home who receives VA is potentially eligible for VA Aid and Attendance, except:

   1. Individuals drawing a "child's" benefit, i.e., those who became disabled prior to age 18 and draw a child's benefit into adult years, are not eligible for Aid and Attendance.

   2. Someone drawing only VA Insurance benefits is not eligible for Aid and Attendance.

      a) Individuals who draw a VA Insurance benefit usually also receive a DIC benefit and are potentially eligible for Aid and Attendance.

      b) However, it is possible for someone to draw only the VA Insurance payment. If the person draws only VA Insurance benefits, that person is not eligible for Aid and Attendance.

C. A nursing home applicant potentially eligible for VA Aid and Attendance must be advised in writing to apply for the payment. However, the penalty for failure to apply for the benefit is not applicable when the only benefit involved is VA Aid and Attendance.

D. The income of an ineligible spouse or parent who receives income based on need is not deemed to an eligible in an at-home case. Needs-based pension and compensation payments are not deemable along with any other income of the ineligible.

1. However, if an ineligible spouse or child receives a VA payment that is attributed solely to A&A, the receipt of the payment will result in deeming of the remaining income of the ineligible to the eligible.

   a) Example: If an ineligible spouse receives Social Security and VA that is attributed solely to A&A, the ineligible's Social Security would be deemable to the eligible. However, if the ineligible receives a VA needs-based pension or needs-based compensation payment in addition to payment for A&A, all income of the ineligible is non-deemable to the eligible person

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.19: VA Payment Adjustments for Unusual Medical Expenses (UME).

A. VA considers unusual medical expenses when determining some needs-based pension and compensation payments.

B. These VA payments resulting from unusual medical expenses are treated as follows:

1. They are not income for eligibility or Medicaid Income purposes.

2. These payments are considered as reimbursements for medical expenses or services that are excluded in the definition of income.

3. Any unspent VA payments resulting from unusual medical expenses are resources if retained into the calendar month following the month of receipt.

4. Prior to July 1, 1994, any VA increase or extra payment resulting from unusual medical expenses was income. The client was required to claim UME as part of the VA Improved Pension application process if UME would result in a higher benefit whether the client lived at home or in a nursing facility as part of the Utilization of Other Benefits provision.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.20: Deeming VA Income.

A. Under the deeming provision, the income of an ineligible spouse or parent who receives income based on need is not deemed to an eligible spouse or child in at-home cases.

B. The needs-based pension and needs-based compensation payments are non-deemable along with any other income of the ineligible.

C. However, if an ineligible spouse or parent receives a VA payment that is solely attributed to UME or A & A, the receipt of such payment will result in deeming the remaining income of the ineligible to the eligible.

D. Example: If an ineligible spouse receives Social Security and VA that is attributed solely to UME, the ineligible's Social Security would be deemable to the eligible. However, if the ineligible receives a VA needs-based pension or needs-based compensation payment in addition to payment for UME, all income of the ineligible, including the Social Security payment, is non-deemable to the eligible person.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.21: Treatment of Institutional Cases involving UME or A & A.

A. If the institutional client (IS) with a community spouse (CS) receives non-countable income from UME or A&A, the CS will be allowed to receive the IS' payment attributable to UME or A&A in addition to the CS allocation amount computed in the Medicaid Income computation.

   1. If the CS is not entitled to Medicaid, the extra income will have no impact.

   2. However, if the CS is Medicaid-eligible at home, the income that represents the UME (or A&A) payable to the IS is income to the CS.

      a) UME (and A&A) is disregarded as income only to the one entitled to the payment.

      b) When it becomes income available to the CS, it is income to the CS.

         1) If the income is given to anyone else, the possibility of a transfer of resources exists.

B. If the CS does not receive the income attributed to UME (or A&A), the possibility of excess resources building up for the IS exists. In this case, resources must be monitored closely.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.22: Treatment of VA Income in Income Trust Cases.

A. Only basic VA benefits (as verified by VA) are counted as an Income Trust client's total income available to fund the Income Trust.

   1. Any UME (or A&A), which is not counted as income, can be retained by the client and/or spouse, as discussed in the above rule.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.23: Treatment of VA Contract Patients in Nursing Facilities.

A. Certain veterans qualify for VA contract payments which cover nursing home care for one to six months; however, veterans with a service-connected disability may not be subject to the six-month limit.

B. Treatment of these individuals is as follows:

1. Eligibility for Medicaid benefits other than nursing home reimbursement can begin prior to the date a VA contract expires, depending on the date the application is filed and provided the individual is eligible on all other factors.

2. Reimbursement cannot begin until the date the VA contract expires.

3. The VA money paid to the nursing home is not counted as income to the Medicaid applicant.

   a) Although a VA contract payment is a third party medical payment, it is not a payment subject to recovery by Medicaid.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.24: Reduced VA Pension for Veterans and Surviving Spouses in Nursing Homes.

A. Federal law limits the maximum pension that can be paid to or for veterans, who have neither a spouse nor a child, or surviving spouses (widows or widowers) without children who are covered by Medicaid for services furnished by a nursing facility to a maximum of $90.

1. The reduced pension of $90 or less is VA Aid and Attendance in all cases, and is not income for eligibility purposes.

2. Federal law also prohibits counting the reduced pension toward the veteran's cost of care (Medicaid Income); therefore, the Personal Needs Allowance (PNA) for all clients receiving a reduced pension is equal to the pension payment received to ensure that no part of the reduced pension is counted as income.

3. When a client who is eligible for long term care nursing home coverage under an Income Trust becomes entitled to the $90 reduced pension and the client continues to need the Income Trust to remain eligible, the $90 reduced pension is not counted as income to the Income Trust client.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994); Miss. Code Ann. §43-13-121.1 (Rev. 2005).

Rule 7.25: Treatment of VA Benefits Allocated to Spouse Receiving IBON.

A. When the spouse of an applicant or recipient receives Income Based on Need (IBON), the source of the IBON may count a portion of the VA benefit as income to the spouse receiving the IBON. This amount counted by the IBON source will be deducted from the countable VA benefit verified by VA for Medicaid eligibility.

1. Example: An applicant receives a VA pension and his spouse receives SSI. SSI verifies $50 of the VA pension is the spouse's income in the SSI computation; therefore, $50 is deducted from the client's verified VA pension in determining countable income for Medicaid.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.26: Determining the Amount of VA Payments.

A. The following must be considered in determining the amount of VA payments:

1. The type of VA payment being made and the policy in effect in the month of payment.

2. Overpayments recovered from VA benefits are included as income in determining eligibility and Medicaid Income.

3. In cases where VA "suspends" VA Improved Pension benefits for failure to verify medical expenses, the benefit in effect prior to the suspension date continues to count as income because the recipient remains entitled to the VA benefit.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.27: Unemployment Insurance Benefits.

A. This type of income is defined as follows:

1. Unemployment insurance benefits, also known as unemployment compensation, means payments received under a state or federal unemployment law and additional amounts paid by unions or employers as unemployment benefits.

B. This type of income is treated as follows:

1. Unemployment compensation is unearned income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.28: Workers' Compensation Payments.

A. This type of income is defined as follows:

1. Workers' Compensation (WC) payments are awarded to an injured employee and his/her survivor(s) under federal and state WC laws, such as the Longshoremen and Harbor Workers' Compensation Act and may be made by a federal or state agency, an insurance company or an employer.

B. This type of income is treated as follows:

1. The WC payment less any expenses incurred in obtaining the payment is counted as unearned income.

   a) Any portion of a WC payment or award that the authorizing or paying agency designates for medical, legal or other expenses attributable to obtaining the WC award is not income.

   b) If an individual alleges having incurred expenses that exceed the amounts designated for expenses, or to which no amount was designated, the normal rules pertaining to the expenses of obtaining income apply.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.29: Temporary Assistance for Needy Families (TANF).

A. This type of income is defined as follows:

1. TANF provides a monetary grant to families under a program that uses income as a factor of eligibility and is partially funded by federal block grants.

B. This type of income is treated as follows:

1. TANF payments are considered income based on need (IBON).

2. If a Medicaid client is included in the TANF family unit, the client's share of the TANF grant is counted dollar for dollar as income and the $50/$20 general income exclusion does not apply.

3. TANF incentive payments, additional payments made as a reward for compliance with program requirements, are also IBON and the $50/$20 general income exclusion does not apply.

4 Participation allowances for the TANF program, such as those for transportation, are reimbursements.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.30: Bureau of Indian General Assistance (BIA GA).

A. This type of income is defined as follows:

1. Bureau of Indian Affairs General Assistance (BIA GA) is a federally funded program administered by the Bureau of Indian Affairs (BIA) through its local agency or a tribe. The program makes periodic payments to needy Indians.

B. This type of income is treated as follows:

1. BIA GA payments are federally funded income based on need and, therefore, count as income on a dollar-for-dollar basis regardless of whether they are paid in cash or in kind. The $50/$20 per month general income exclusion does not apply.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.31: Foster Care and Adoption Assistance.

A. These types of income are defined as follows:

1. Foster Care. An individual (adult or child) is considered to be in foster care when:

   a) A public or private nonprofit agency places the individual under a specific placement program; and

   b) The placement is in a home or facility which is licensed or otherwise approved by the state to provide care; and

   c) The placing agency retains responsibility for continuing supervision of the need for such placement and the care provided.

B. Adoption Assistance.

1. Adoption assistance programs provide payments and/or services for children for whom unassisted adoption is unlikely because of age, ethnic background, disability, etc. The income of the adoptive parent, the adopted child or both may be considered in determining the payment.

C. These types of income are treated as follows:

1. Treatment of both types of payments depends on the funding source of the payment, the purpose of the payment and whether the Medicaid recipient is the provider or beneficiary of the care as follows:

   a) Funded by Title IV-E.

1) Title IV-E foster care payments are income based on need (IBON) to the individual in care. This income is not subject to the $50/$20 general income exclusion. Amounts paid to the provider in excess of the foster care payment, e.g., incentive or service payments, which are not intended to support the child, and are in addition to the foster care payment are counted as income to the provider.

(a) Foster care payments made under Section 477 of Title IV-E, Independent Living Initiatives, are cash assistance from a governmental social services program and do not count as income.

2) Adoption assistance cash payments made to adoptive parents under Title IV-E are federally-funded income based on need (IBON) to the adopted child. This income is not subject to the $50/$20 general income exclusion. The total payment is considered cash income to the adopted child and is counted dollar for dollar. Social services may be provided to the adoptive parents under Title IV-E, but they are not counted as income.

b) Funded by Titles IV-B or Title XX.

1) Foster care payments and adoption assistance through Title IV-B or Title XX are not income. Payments are considered social services.

c) Funded by Other Sources.

1) Other payments for foster care and adoption assistance are unearned income subject to general policy pertaining to income and income exclusions. The adoption assistance may be income to the parent of the child depending on the type of assistance received.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.32: Support Payments – Spousal Support, Alimony.

A. These types of income are defined as follows:

1. Alimony and support payments are both cash contributions intended to meet some and all of a person's needs for food and shelter.

a) Support payments may be made voluntarily or because of a court order.

b) Alimony, sometimes called "maintenance" is an allowance made by a court from the funds of one spouse to the other spouse in connection with a suit for separation or divorce.

B. These types of income are treated as follows:

1. Alimony and spousal support payments are counted as unearned income to the recipient.

2. The income used to make court-ordered alimony or spousal support payments by an ineligible spouse, ineligible parent or ineligible child is excluded from the deemor's income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.33: Support Payments – Child Support.

A. Child support is defined as follows:

1. A child support payment is payment from an absent parent to or for a child to meet the child's needs for food and shelter.

2. Child support can be voluntary or court-ordered.

B. Child support payments from an absent parent are treated as follows:

1. Treat child support payments (including arrearage payments) as unearned income to the child.

   a) An arrearage payment is one that was due, but not paid timely and is being paid to comply with an unfulfilled past obligation.

2. One-third of the amount of the child support payment made to or for an eligible child by an absent parent is excluded.

   a) The one-third exclusion of a child support payment applies to the eligible child only.

   b) The disregard is not applied when an ineligible child receives child support payments which are considered in a deeming computation.

   c) The income used to make court-ordered or Title IV-D support payments by an ineligible spouse, ineligible parent or ineligible child is excluded when deeming.

3. Child support payments being made for adult children are treated as follows:

   a) Child support payments (excluding arrearages) received by a parent after an adult child stops meeting the definition of a "child" are income to the adult child, whether or not the adult child lives with the parent or receives any of the child support from the parent.

      1) These payments are not subject to the one-third reduction.

   b) When a parent receives child support arrearage payments on behalf of an adult child:

1) Any portion of the arrearage payment that the parent receives and does not give to the adult child is income to the parent.

2) Any amount of the arrearage payment that the parent gives to the adult child is income to the adult child in the month given, not income to the parent.

(a) The one-third reduction does not apply.

3) When an adult child receives an arrearage payment directly from the absent parent, the arrearage payment is income to the adult child.

(a) The one-third reduction does not apply.

c) Child support payments and arrearages received by a parent on behalf of a deceased child or adult child are income to the parent who receives them.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.34: Rental Income.

A. Rental income is defined as follows:

1. Rent is payment that a person receives for the use of real or personal property, such as land, housing or machinery.

B. Rental income is treated as follows:

1. In determining Medicaid eligibility for at-home and institutional categories, consider net rental income.

2. Net rental income is gross less the ordinary and necessary expenses paid in the same taxable year.

a) Net rental income is counted as unearned income unless it is earned income from self-employment (such as someone in the business of renting properties).

b) Ordinary and necessary expenses are those necessary for the production or collection of rental income and generally include:

1) Interest on debts;

2) State and local taxes on real and personal property and on motor fuel;

3) General sales tax;

4) Expenses of managing or maintaining the property.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.35: Dividends and Interest.

A. This type of income is defined as follows:

1. Dividends and interest are returns on capital investments such as stocks, bond or savings accounts.

   a) Account service fees or penalties for early withdrawal do not reduce the amount of interest or dividend income.

B. This type of income is treated as follows:

1. Count dividends or interest as income or excluded income based on the following criteria:

   a) When the source of the dividends or interest is a countable resource, the dividends or interest generated is excluded income for programs with an asset test.

      1) The Medicare Cost Sharing programs (QMB, SLMB, and QI) do not have an asset test so the exclusion does not apply to them.

   b) When the source of the dividends or interest is a resource which is excluded under federal statute, the dividends or interest generated is excluded income.

      1) Examples are: Agent Orange payments, Austrian Social Insurance payments, Japanese-American and Aleutian Restitution payments, Radiation Exposure Compensation Trust Fund payments, Ricky Ray Hemophilia Relief funds, payments to Veterans' Children with Certain Birth Defects, etc.

   c) When the source of the dividends or interest is a resource excluded by the Social Security Act, dividends or interest generated on the excluded resource may or may not be excluded. Treatment is specific to the excluded resource.

      1) Examples are: burial funds and burial spaces, relocation assistance, PASS funds, gifts to children with life-threatening diseases, victim's compensation, grants, scholarships, fellowships and gifts, etc.

   d) Under liberalized income policy, interest, dividend and royalty income or any combination that does not exceed $5 per month per individual is excluded.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.36: Royalties.

A. This type of income is defined as follows:

1. Royalties include compensation paid to the owner for the use of property, usually copyrighted material, e.g., books, music or art, or natural resources, e.g., minerals, oil, gravel or timber.

   a) Royalty compensation may be expressed as a percentage of receipts from using the property or as an amount per unit produced. To be considered royalties, payments for the use of natural resources also must be received:

      1) Under a formal or informal agreement whereby the owner authorizes another individual to manage and extract a product (like timber or oil) and

      2) In an amount that is dependent on the amount of the product actually extracted.

B. This type of income is treated as follows:

1. Royalties are counted as unearned income unless they are:

   a) Received as part of a trade or business; or

   b) Received by an individual in connection with any publication of his work.

      1) Royalties earned by an individual in connection with any publication of his work are earned income (for example, publication of a manuscript, magazine article or artwork).

2. Under liberalized income policy, interest, dividend and royalty income that does not exceed $5 per month per individual is excluded. The exclusion applies to either income type or a combination of the three types up to the $5 maximum.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.37: Awards.

A. This type of income is defined as follows:

1. An award is something received as the result of a decision by a court, board of arbitration or the like.

B. This type of income is treated as follows:

1. An award is counted as unearned income subject to the general rules pertaining to income and income exclusions.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.38: Gifts.

A. This type of income is defined as follows:

1. A gift is something a person receives which is not repayment for goods or services the person provided and is not given because of a legal obligation on the giver's part.

2. A gift is something that is given irrevocably, i.e., the giver relinquishes all control.

B. This type of income is treated as follows:

1. A gift is unearned income subject to general rules pertaining to income and income exclusions. Determine the nature of the gift and apply appropriate policy.

C. Gifts used to pay tuition, fees or other necessary educational expenses are treated as follows:

1. Effective June 1, 2004, gifts (or a portion of a gift) used to pay for tuition, fees or other necessary educational expenses at any educational institution, including vocational and technical education, are excluded from income.

2. They are also excluded from resources for the 9-month period beginning the month after the month the gift was received.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.39: Gifts of Travel Tickets.

A. Domestic travel is defined as follows:

1. Domestic travel is travel in or between the 50 states, the District of Columbia, Puerto Rico, the US Virgin Islands, Guam, American Samoa and the Northern Mariana Islands.

B. A gift of a domestic travel ticket is treated as follows:

1. A domestic ticket received as a gift is treated an unearned income in the month the ticket was converted to cash.

2. The value of a ticket for domestic travel received by an individual, his spouse or parent whose income is subject to deeming is excluded from income if the ticket is received as a gift and was used for transportation or retained and has not been converted to cash (e.g., cashed in or sold, etc.).

C. A gift of a non-domestic travel ticket is treated as follows:

1. The gift of a non-domestic travel ticket that cannot be converted to cash (non-refundable)

or used to obtain food or shelter is not considered income even if the ticket was used for transportation.

2. Travel tickets that can be converted are income and counted as unearned income at the current market value in the month of receipt whether or not the ticket was used for transportation.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.40: Prizes.

A. This type of income is defined as follows:

1. A prize is generally something won in a contest, lottery or game of chance.

B. This type of income is treated as follows:

1. A prize is counted as unearned income subject to the general rules pertaining to income and income exclusions.

   a) Gambling losses are not subtracted from gambling winnings in determining an individual's countable income.

   b) If a person is offered a choice between an in-kind prize and cash, the cash offered is counted as unearned income even if the individual chooses the in-kind item, regardless of the value, if any, of the in-kind item.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.41: Gift Cards and Gift Certificates.

A. This type of income is treated as follows:

1. The value of a gift card or gift certificate is unearned income in the month it is received if the gift card or certificate can be used to purchase food or shelter or can be resold.

   a) Absent evidence to the contrary, presume a gift card or certificate can be resold.

      1) Evidence to the contrary could include a legally enforceable prohibition on resale or transfer of the card/certificate imposed by the card issuer/merchant printed on the card or certificate.

2. The value of the gift card/certificate is subject to general rules pertaining to income and income exclusion, e.g., infrequent or irregular income exclusion policy.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.42: Work-Related Unearned Income.

A. The following work-related payments are counted as unearned income:

1. Certain in-kind items provided as remuneration for employment, e.g., in-kind payments of food or shelter to domestic employees;

2. Money paid to a resident of a public institution when no employer/employee relationship exists;

3. Tips under $20 per month;

4. Jury fees, i.e., fees for services, not expense money;

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.43: Treatment of Sick Pay as Unearned Income.

A. Any payments on account of sickness and accident disability paid more than six full months after work stopped because of that sickness or disability are unearned income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.44: Death Benefits.

A. This type of income is defined as follows:

1. A death benefit is something received as the result of another's death.

   a) Examples include:

      1) Proceeds of life insurance policies received due to death of the insured;

      2) Lump sum death benefits from SSA;

      3) RR burial benefits;

      4) VA burial benefits;

      5) Inheritances in cash or in kind;

      6) Cash or in-kind gifts given by relatives, friends, or a community group to "help out" with expenses related to death.

B. This type of income is treated as follows:

1. Death benefits are counted as income to the extent the total amount exceeds the expenses of the deceased person's last illness and burial paid by the recipient of the benefit.
2. Death benefits that are not income are also not a resource for one calendar month following the month of receipt. If retained into the second month following receipt, they are countable resources.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.45: Inheritances.

A. This type of income is defined as follows:

1. An inheritance is cash, a right or a noncash item(s) received as the result of someone's death. An inheritance is a death benefit.

B. This type of income is treated as follows:

1. Until an item or right has a value (i.e., can be used to meet the heir's need for food or shelter), it is neither income nor a resource.

2. The inheritance is income in the first month it has a value and can be used.

3. An inheritance is not income to a person if the inheritance is something that was considered that person's resource (either as a member of an eligible couple or through deeming of resources) immediately before the death.

   a) The proceeds of a life insurance policy were not a resource before the death.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.46: Choctaw Tribal Bonus.

A. The Choctaw Tribal Bonus is issued as the result of gaming revenues which are distributed to individuals on a per capita basis.

B. For Medicaid eligibility purposes, the bonus is a recurring lump sum payment and is counted as income in the month of receipt.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.47: Educational Assistance.

A. Educational assistance is provided in many forms. Treatment will vary depending on the nature and sometimes the use of the assistance.

B. Educational assistance may be earned or unearned and may be counted or excluded.

1. The following are specific types of educational assistance:

a) VA Educational Benefits, which are discussed in Rule 7.10);

b) Assistance under Title IV of the Higher Education Act (HEA) of 1965 or Bureau of Indian Affairs;

1) All student financial assistance received under HEA or BIA assistance programs is excluded from income and resources, regardless of use.
2) The resource exclusion does not have a time limit, i.e., regardless of how long held, the assistance is excluded from resources.

3) Interest and dividends earned on unspent educational assistance under Title IV HEA and BIA are excluded from income.

c) Grants, Scholarships, Fellowships and Gifts;

1) Grants, scholarships and fellowships are defined as follows:

(a) These are amounts paid by private nonprofit agencies, the US government, instrumentalities or agencies of the US, state and local governments, foreign governments and private concerns, e.g., a private citizen, to enable qualified individuals to further their education and training by scholastic or research work, etc.

2) Gifts are defined as follows:

(a) A gift is something a person receives which is not repayment for goods or services provided and not given by legal obligation on the giver's part. To be a gift, something must be irrevocably given.

3) Any portion of a grant, scholarship, fellowship or gift used for paying tuition, fees, or other necessary educational expenses at any educational institution, including vocational or technical education, is excluded from income.

4) Any portion of such educational assistance that is not used for paying current tuition, fees or other necessary educational expenses but will be used for paying this type of educational expense at a future date is excluded from income in the month of receipt.

(a) This exclusion does not apply to that portion set aside or actually used for food, clothing or shelter.

5) Any portion of grants, scholarships, fellowships, or gifts that is not used or set

aside for paying tuition, fees, or other necessary educational expenses is income in the month received and a resource the month after the month of receipt, if retained.

6) If any portion of grants, scholarships, fellowships or gifts that is excluded from resource because it is set aside to pay for necessary educational expenses is used for some other purpose, the funds are income at the earliest of the following points:

(a) In the month that it is spent; or

(b) The month the individual no longer intends to use the funds to pay necessary educational expense.

7) If the funds set aside for pay for necessary educational expenses are not spent after the 9th month, they are countable resources as of the 10th month following the month of receipt.

(a) Interest and dividends earned on grants, scholarships, fellowships or gifts which are excluded as a resource count as income. Interest and dividends earned on educational assistance which is a countable resource are excluded as income.

d) Educational Payments under AmeriCorps and the National Civilian Community Corps.

1) The National and Community Service Trust Act established the Corporation for National and Community Services (CNCS). Through CNCS, the federal government administers a number of national and community service programs. It is also the federal agency that administers VISTA and the Service Corps, programs formerly administered by the ACTION agency.

2) Effective September 1, 2008, cash or in-kind payments provided by AmeriCorps State and National and AmeriCorps NCCC are excluded from income, even if they meet the definition of wages. Such payments include, but are not limited to:

(a) Living allowance payments;

(b) Stipends;

(c) Food and shelter;

(d) Clothing allowances;

(e) Educational awards and payments in lieu of educational awards.

Source: Social Security Act §1902 (r)(2); 42 CFR §435.601(b) (Rev 1994); P.L. 110-245 §203.

Rule 7.48: Presidentially-Declared Disaster Assistance.

A. This type of assistance is defined as follows:

1. At the request of the state governor, the President may declare a major disaster when the disaster is of such severity and magnitude that effective response is beyond the capabilities of the state and local governments, and federal assistance is needed.

B. This type of assistance is treated as follows:

1. The value of support and maintenance in cash or in-kind is not counted as countable income if:

   a) The individual lived in a household which he or she (or he and another person) maintained as his or their home at the time a catastrophe occurred in the area; and

   b) The President declared the catastrophe a major disaster for purposes of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (formerly the Disaster Relief Act of 1974); and

   c) The individual stopped living in his home because of the catastrophe and began to receive support and maintenance within 30 days after the catastrophe; and

   d) The individual receives support and maintenance while living in a residential facility maintained by another person. A residential facility is to be interpreted broadly, including a private household, a shelter, or any other temporary housing arrangement resorted to because of the disaster.

2. Assistance (other than support and maintenance) received under the Robert T. Stafford Disaster Relief and Emergency Assistance Act or any other Federal statute because of a catastrophe which the President declares to be a major disaster is excluded from countable income.

   a) This includes assistance to repair or replace the individual's own home or other property and disaster unemployment assistance.

   b) Interest earned on the assistance is excluded from income and resources.

   c) If excluded from income, any unspent assistance is permanently excluded from resources.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.49: Federal Emergency Management Agency (FEMA) Emergency Assistance.

A. This type of assistance is defined as follows:

1. Through a national board chaired by the Federal Emergency Management Agency (FEMA) and local boards, funds are provided to private nonprofit organizations and state and local governmental entities for providing emergency food and shelter to needy individuals. The federal funds are not provided to meet ongoing basic needs.

B. This type of assistance is treated as follows:

1. Assistance involving FEMA is subject to general rules pertaining to income and income exclusions.

   a) Assistance involving FEMA is most often provided in-kind by private nonprofit organizations and with state certification will qualify for exclusion as Home Energy Assistance and Support and Maintenance Assistance (HEA/SMA).

2. It is neither IBON nor ABON.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.50: Federal Housing Assistance.

A. This type of assistance is defined as follows:

1. The Federal Government through the Office of Housing and Urban Development (HUD) and the US Department of Agriculture's Rural Housing Service (RHS), formerly the Farmers Home Administration, provides many forms of housing assistance.

2. This assistance may be provided directly by the federal government or through other entities such as local housing authorities or nonprofit organizations.

B. This type of assistance is treated as follows:

1. The value of any assistance paid with respect to a dwelling unit is not counted as income or resources if paid under a program or project in which HUD, i.e., "Section 8", or RHS is involved.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.51: Low Income Energy Assistance.

A. This type of assistance is defined as follows:

1. Through a block grant, the federal government provides funds to states for energy assistance (including weatherization) to low income households. This assistance may be

provided by a variety of agencies (such as state or local welfare offices, community action agencies, special energy offices) and known by a variety of names (for example, HEAP, Project Safe). It is most often provided in a medium other than cash (such as, voucher, two-party check, direct payment to vendor) but may be in cash.

B. This type of assistance is treated as follows:

1. Home energy assistance payments or allowances provided under the Federal Low-Income Home Energy Assistance Program (LIHEAP) are not counted as income or resources.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.52: Home Energy Assistance and Support and Maintenance Assistance (HEA/SMA).

A. This type of assistance is defined as follows:

1. Low income energy assistance discussed in Rule 7.51 is governmental assistance. HEA/SMA is assistance which is the result of charitable efforts by the community to help recipients.

2. Home energy assistance is any assistance related to meeting the costs of heating or cooling a home.

3. Support and maintenance assistance is in-kind support and maintenance or cash provided for the purpose of meeting food, clothing and shelter needs. It includes energy assistance.

B. This type of assistance is treated as follows:

1. Home energy or support and maintenance assistance is not counted as income if it is certified in writing by the appropriate state agency to be both based on need and:

   a) Provided in-kind by a private nonprofit agency (501(c) organization); or

   b) Provided in cash or in-kind by a supplier of home heating oil or gas, a rate-of-return entity (e.g., a utility company) providing home energy, or a municipal utility providing home energy.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.53: Relocation Assistance.

A. This type of assistance is defined as follows:

1. Relocation assistance provided to persons displaced by governmental projects that acquire real property is not income.

B. This type of assistance is treated as follows:

1. Relocation assistance provided under the Uniform Relocation Assistance and Real Property Acquisitions Policies Act is not counted as income.

   a) Federal relocation assistance is permanently excluded from resources.

   b) Interest earned on unspent payments is not excluded from income or resources.

2. Relocation assistance provided to persons displaced by any state, local or state-assisted/locally-assisted project is not counted as income.

   a) Unspent payments are excluded from resources for 9 months.

   b) Interest earned on unspent payments is not excluded from income or resources.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.54: Refugee Cash Assistance (RCA), Cuban and Haitian Entrant Cash Assistance (CHECA).

A. This type of assistance is defined as follows:

1. Refugee Cash Assistance and Cuban and Haitian Entrant Cash Assistance are federally funded programs that make ongoing needs-based payments to refuges during their first 8 months in the United States.

B. This type of assistance is treated as follows:

1. RCA and CHECA payments are federally-funded income based on need and unless excluded under a PASS, are counted dollar for dollar as income under IBON policy. The $50/$20 general income exclusion does not apply.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.55: Refugee Reception and Placement Grants.

A. This type of assistance is defined as follows:

1. Federal funds are provided to national voluntary refugee resettlement agencies such as Catholic Charities or the Hebrew Immigrant Aid Society, which provide services (including food, clothing and shelter) related to initial resettlement of new refugees.

B. This type of assistance is treated as follows:

1. Assistance involving a refugee reception and placement grant or a refugee-matching grant is subject to the general rules pertaining to income and income exclusions.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.56: Community Service Block Grants.

A. This type of assistance is defined as follows:

1. The Department of Health and Human Services makes community service block grants to states to provide a broad range of services and activities to assist low-income individuals and alleviate the causes of poverty in a community. States may subsequently make grants or enter into contracts with private nonprofit organizations or political subdivisions.

B. This type of assistance is treated as follows:

1. Assistance involving community service block grants is subject to the general rules pertaining to income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.57: Work Relief (Workfare) Programs.

A. This type of assistance is defined as follows:

1. Some governmental assistance programs require that certain recipients work in exchange for the assistance provided. Most often the amount of the assistance payment is divided by the minimum wage and the recipient required to perform some service for the resulting number of hours. Usually a participant in such a work program is given money to cover any expenses incurred (e.g., carfare, special clothing, miscellaneous, etc.).

B. This type of assistance is treated as follows:

1. The payment in such situations is an assistance payment and is not earned income. The fact that an individual is required to work in exchange for an income based on need or assistance based on need payment does not change the nature of the payment.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.58: Programs for Older Americans.

A. These programs are defined as follows:

1. The Federal Government through the Administration on Aging is involved in a variety of programs for older Americans. State or local governments or community organizations

may operate the programs.

B. Payments from these programs are treated as follows:

1. A wage or salary paid under Programs for Older Americans is counted as earned income subject to the general policies regarding earned income.

2. Anything provided under the Programs for Older Americans other than a wage or salary is not counted as income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.59: Workforce Investment Act (WIA).

A. This program is defined as follows:

1. The Workforce Investment Act of 1998 (WIA), which became effective July 1, 2000, establishes a national workforce preparation and employment system to meet the needs of businesses, job seekers and those who want to further their careers.

B. Payments from this program are treated as follows:

1. Based on the type, amount and frequency of the income received, e.g., wages, stipends, bonuses, incentive payments, etc., the income will be evaluated under the general rules pertaining to income and income exclusions.

2. Any payments that represent supportive services (child care, transportation, medical care, meals, etc.) which are social services, not income, will be disregarded.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.60: Job Corps.

A. This program is defined as follows:

1. The Job Corps is a Workforce Investment Act (WIA) program.

B. Income from this program is treated as follows:

1. A Job Corps participant who is a student under age 22 qualifies for the student earned income exclusion.

2. The living allowance is wages.

3. The readjustment allowance is income including any amount deducted to pay the participant's share of a dependent's allowance, is wages.

4. Any bonus and incentive payments are also wages.

5. A bi-weekly dependent's allowance may be paid directly to a participant's dependent. This allowance is counted as unearned income to the dependent.

   a) If the participant is a deemor and his dependent is eligible for Medicaid, only one-half of the dependent's allowance is unearned income to the dependent.

6. The clothing allowance is not income.

7. Supportive services such as medical services, transportation to and from medical treatment, counseling, job placement services provided in-kind which are medical or social services are not income.

8. The rules regarding temporary absence for deeming purposes apply to Job Corps participants who reside in a Job Corps Center or who are away at school.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 7.61: Payments for Clinical Trial Participation.

A. These payments are defined as follows:

1. Payments for participation in clinical trials which research and test treatment of rare diseases or conditions, as defined in the Improving Access to Clinical Trials Act of 2009.

B. These payments are treated as follows:

1. As applicable, exclude the first $2,000 of compensation per calendar year received by a Medicaid client, spouse or deemor as compensation for participation in clinical trials.

2. Payments which are reimbursements for expenses incurred while participating in the trial do not reduce the $2,000 calendar year maximum.

3. Apply the exclusion, if applicable. Otherwise, use regular income counting rules.

4. The Act specifies this exclusion will expire on October 5, 2015. Any unspent compensation under this exclusion will count as a resource at that time.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994); Clinical Trials Improvement Act of 2009.

Part 104 Chapter 8: Other Unearned Income Exclusions

Rule 8.1: Agent Orange Settlement Payments.

A. These payments are defined as follows:

1. Payments made in connection with the Agent Orange Product Liability Litigation settlement fund.

B. These payments are treated as follows:

1. Payments from Agent Orange settlement fund or any other fund established pursuant to the settlement in the Agent Orange liability litigation are excluded from both income and resources.

2. Effective July 2004, interest earned by conserved Agent Orange settlement payments is excluded income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994); P. L.101-201; P. L. 101-239 §10405.

Rule 8.2: Austrian Social Insurance Payments.

A. These payments are defined as follows:

1. The nationwide class action lawsuit, Bondy v. Sullivan, involved Austrian social insurance payments based, in whole or in part, on wage credits under Paragraphs 500-506 of the Austrian General Social Insurance Act, which grant credits to person who suffered a loss (imprisoned, unemployed, forced to flee Austria from March 1933 to May 1945 for political, religious or ethnic reasons).

B. These payments are treated as follows:

1. Credits authorized under paragraphs 500-506 of the Austrian General Social Insurance Act are excluded as income.

2. Effective July 2004, interest earned on excluded Austrian social insurance payments retained is excluded from income.

3. Austrian social insurance payments not based on Paragraphs 500-506 are counted as income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.3: Child Care Payments under Child Care and Development Block Grant Act (CCDBGA).

A. These payments are defined as follows:

1. Payments to low-income families or to children with special needs for certain childcare activities, such as early childhood development, before and after school services and services designed to permit a parent to continue working.

B. These payments are treated as follows:

1. Payments to a child's family under the CCDBGA are not counted as income.

2. There are no specific resource exclusions for payments made under CCDBGA.

3. Other types of child care payments are subject to general policy pertaining to income and income exclusions.

4. Payments the child's family makes to the child care provider using the funds is income to the provider.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.4: Department of Defense (DOD) Payments to Certain Persons Captured and Interned by North Vietnam.

A. These payments are defined as follows:

1. Payments made under section 657 of the National Defense Authorization Act to an individual (or if deceased, to the surviving spouse or child of any age) captured and interned by the Democratic Republic of North Vietnam as a result of participation in certain military operations.

B. These payments are treated as follows:

1. These DOD payments are excluded from income and resources.

2. Effective July 2004, interest earned on unspent payments is excluded from income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994); P. L. 105-78 § 606, P. L. 104-201 §657.

Rule 8.5: Energy Employees Occupational Illness Compensation Program Act (EEOICPA).

A. These payments are defined as follows:

1. Lump sum payments for medical and other expenses associated with energy-related occupational illnesses.

B. These payments are treated as follows:

1. Lump sum payments made under EEOICPA, including reimbursement for medical expenses, are excluded from income and resources.

2. Effective July 2004, interest earned on unspent payments is excluded from income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.6: Filipino Veterans Compensation Fund Payments (FVECF).

A. These payments are defined as follows:

1. The American Recovery and Reinvestment Act signed February 17, 2009, established a one-time payment to eligible Filipino veterans (or surviving spouse) who aided American troops during World War II. Must file within one year of enactment.

B. These payments are treated as follows:

1. The one-time FVECF payment is excluded from income.

2. The interest earned on an unspent payment is excluded from income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.7: Food Programs with Federal Involvement.

A. These payments are defined as follows:

1. SNAP;

2. School Lunch Program;

3. Child Nutrition Programs; and

4. Nutrition Programs for Older Americans.

B. These payments are treated as follows:

1. The value of food or assistance offered under these programs is excluded from income and resources.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.8: Gifts to Children with Life Threatening Conditions.

A. These gifts are defined as follows:

1. Any in-kind gift, not converted to cash, and cash gifts that do not exceed $2000 in any calendar year from a 501(c)(3) organization (e.g., Make-a-Wish Foundation, other charities or churches) for the benefit of a child under age 18 with a life threatening condition.

B. These gifts are defined as follows:

1. Such gifts are excluded from income and resources.

2. This exclusion includes a gift to a parent whose income is subject to deeming if the gift is for the benefit of the child and does not exceed the limits discussed above.

3. Interest and dividends earned on funds excluded by this provision are not excluded from income or resources.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.9: HIV and Hemophiliac Settlement Payments.

A. These payments are defined as follows:

1. Payments from Ricky Ray Hemophilia Relief Fund and Susan Walker v. Bayer Corporation, et al, settlement fund.

B. These payments are treated as follows:

1. These payments are excluded from income and resources.

2. The interest earned on retained funds is excluded from income effective July 2004.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.10: Home Produce for Personal Consumption.

A. This produce is defined as follows:

1. Home produce is food which a person catches in the wild or raises.

B. This produce is treated as follows:

1. Home produce is excluded from income if it is consumed by the individual or his household.

2. If home produce is basically raised for home consumption rather than business and the amount of produce traded or sold is small, e.g., extra eggs, home-canned beans, etc.,

assume the production costs equaled the value of what was received; therefore, no income is derived from such a trade or sale.

3. Otherwise, if home produce is sold, but not as a trade or business, the income is unearned. If sold as a trade or business the income is earnings from self-employment.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.11: Individual Interest in Indian Trust or Restricted Lands Exclusion.

A. These payments are defined as follows:

1. Includes certain Tribal per capita payments and other types of Tribal income distributed or held in trust by the Secretary of the Interior and monies received from the lease or sale of natural resources, and rent or lease income resulting from federally-protected rights on excluded Indian property.

B. These payments are treated as follows:

1. All such payments are considered a converted asset rather than income.

2. The $2000 annual income exclusion allowed for eligibles and deemors since January 1, 1994, on monies derived from individual interests in Indian Trust or restricted lands is no longer applicable since all such payments are considered a converted asset.

3. Gaming revenues which are distributed to individuals on a per capita basis are not included in this exclusion. Gaming revenues are countable income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994); American Recovery and Reinvestment Act of 2009 §5009.

Rule 8.12: Japanese American and Aleutian Restitution Payments.

A. These payments are defined as follows:

1. Payments by the US government to individual Japanese-Americans or the spouse or parent of an individual of Japanese ancestry and Aleuts who were interned or relocated during WWII. This exclusion also includes payments made by the Canadian government to Japanese-Canadians interned or relocated during WWII.

B. These payments are treated as follows:

1. These payments are excluded from income and resources.

2. Effective July 2004, interest earned on unspent restitution payments is excluded from income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.13: Nazi Persecution Payments.

A. These payments are defined as follows:
   1. Payments made to individuals because of their status as victims of Nazi persecution include German Reparation payments and payments under provisions of the Nazi Persecution Victims Eligibility Act.

B. These payments are treated as follows:

   1. Payments from any source to individuals because of their status as victims of Nazi persecution are excluded from income and resources.

   2. Interest on unspent payments on victims of Nazi persecution is excluded from income effective July 2004.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.14: Netherlands WUV Payments to Victims of Persecution.

A. These payments are defined as follows:

   1. Payments by the Dutch Government to Dutch/non-Dutch persons in WWII, who were victims of persecution due to religion, race, beliefs or homosexuality and are presently suffering from disabilities and illnesses as a result of that persecution

B. These payments are treated as follows:

   1. WUV payments are excluded from income.

   2. Interest earned on unspent WUV payments is excluded from income effective July 2004.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.15: Radiation Exposure Compensation Trust Fund (RECF).

A. These payments are defined as follows:

   1. Lump sum payments made to individuals who contracted certain diseases after radiation exposure due to nuclear testing and uranium mining.

B. These payments are treated as follows:

   1. Payments from RECF are excluded from income.

2. Interest earned on unspent payments is excluded from income effective July 2004.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.16: Refunds of Taxes Paid on Real Property or Food.

A. These payments are defined as follows:

1. Any amount received from any public agency as a return or refund of taxes paid on real property or on food purchased.

B. These payments are treated as follows:

1. These refunds are excluded from income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 8.17: Victims' Compensation Payments.

A. These payments are defined as follows:

1. Payments received from a fund established by a state to aid crime victims.

B. These payments are treated as follows:

1. Any payment received from a fund established by a state to aid victims of crime is excluded from income.

2. Unspent victims' compensation assistance payments are excluded from resources for 9 months following the month or receipt.

3. Interest earned on unspent victims' compensation payments is not excluded from income or resources.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Part 104 Chapter 9: Sources and Treatment of Earned Income

Rule 9.1: Sick Pay.

A. These payments are defined as follows:

1. Sick pay is a payment made to or on behalf of an employee by an employer or a private third party (such as a union or insurance company) for sickness or accident disability. Sick pay is either wages or unearned income.

2. Payments under a Workers' Compensation law are neither wages nor sick pay. Annual

and sick leave payments are considered a continuation of salary.

B. These payments are treated as follows:

1. When sick pay is received within 6 months after stopping work, and it is not attributable to the employee's own contributions through payroll deduction to a sick pay plan, treat as earned income.

2. When sick pay is received within 6 months of stopping work, and it is attributable to the employee's own contributions through payroll deduction to a sick pay plan, treat any portion of the sick pay received by the employee which, according to the employer is attributable to the employee's own contributions, as unearned income.

3. When sick pay is received more than 6 months after stopping work, treat as unearned income.

   a) To determine the 6-month period after stopping work:

      1) Begin with the first day of non-work.

      2) Include the remainder of the calendar month in which work stops.

      3) Include the next 6 full calendar months.

   b) Example**:** If an individual stops work on May 5, the 6-month periods ends November 30th.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 9.2: Wages and Salaries.

A. These payments are defined as follows:

1. Wages are what an individual receives (before deductions) for working as someone else's employee.

   a) Under certain conditions, services performed as an employee are deemed self-employment rather than wages, e.g., ministers, real estate agents, share farmers, insurance salesmen, etc.

2. Wages may take the form of:

   a) Salaries. Payments (fixed or hourly rate) received for work performed for an employer.

   b) Commissions. Fees paid to an employee for performing a service, i.e., a percentage of

sales.

c) Bonuses. Amounts paid by employers as extra pay for past employment, i.e., outstanding work, length of service, holidays, etc.

d) Severance Pay. Payment made by an employer to an employee whose employment is terminated independently of his wishes.

e) Military Pay. Service member's wage, which is based solely on the member's pay grade and length of service.

f) Special payments because of employment. Items such as vacation pay, advance/deferred wages, etc.

B. These payments are treated as follows:

1. Absent evidence to the contrary, if FICA taxes have been deducted from an item assume it meets the definition of wages.

2. Wages are counted at the earliest date of the following:

a) When received, or

b) When credited to the individual's account, or

c) When set aside for the individual's use.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 9.3: Cafeteria Plans.

A. A Cafeteria Plan is defined as follows:

1. A written benefit plan offered by an employer in which:

a) All participants are employees, and

b) Participants choose cafeteria-style from a menu of two or more cash or qualified benefits.

1) A qualified benefit is not considered part of an employee's gross income.

2) Qualified benefits include, but are not limited to:

(a) Accident and health plans, including medical plans, vision plans, dental plans, accident and disability insurance;

(b) Group term life insurance plans up to $50,000;

(c) Dependent care assistance plans;

(d) Certain stock bonus plans under Section 401(k)(2) of the IRC, but not 401(k)(1) plans.

3) Cash is not a qualified benefit.

B. Employees can participate in Cafeteria Plans in different ways as follows:

1. Salary-Reduction Agreements defined and treated as follows:

a) A salary-reduction agreement is an agreement between the employer and employee whereby the employee, in exchange for the right to participate in a Cafeteria Plan, accepts a lower salary or foregoes a salary increase.

1) The amount of a salary-reduction agreement is not part of gross income and is not subject to Social Security, Medicare or other income taxes.

2) Amounts used to purchase qualified benefits with a salary-reduction agreement are not the employee's wages and are not considered income for Medicaid purposes.

2. Employer Contributions, treated as follows:

a) Amounts an employer contributes to fund basic benefit levels under a Cafeteria Plan, with or without a salary reduction agreement, are not the employee's wages and are not considered income for Medicaid purposes.

3. Payroll deductions, treated as follows:

a) Payroll deductions used to purchase Cafeteria-Plan benefits are the employee's wages and are earned income.

b) Example: Employees who want more than basic benefits contributed by the employer may pay additional costs through payroll deductions. The amounts of those voluntary payroll deductions are the employee's wages and are considered earned income for Medicaid purposes.

1) Unless an exception applies, FICA will be deducted from these payroll deductions.

4. Cash received under a Cafeteria Plan is treated as follows:

a) Cash received under a Cafeteria Plan in lieu of benefits is wages.

b) However, cash received as reimbursement for qualified-benefit expenses, such a child care, is not income.

c) Example: ABC, Inc., contributes $50 per week to fund basic benefits under a cafeteria plan. Mr. White selects insurance that costs $35 per week and opts for a weekly cash payment of $15 in lieu of additional coverage. The $15 cash payment is part of Mr. Brown's countable wages.

C. When a cafeteria plan is involved, countable wages for Medicaid purposes can be less than the gross amount on the check stub. It can be difficult to tell whether paystubs represent payroll deductions, which are part of gross wages, or cafeteria-plan itemizations, which are not.

1. One indicator is when the deduction for Social Security and Medicare taxes is less than the tax rate times the gross wages shown on the checkstub.

2. Example: The June 2010 monthly pay stub reflects gross wages of $999.94, a deduction for FICA/Medicare taxes of $68.85 (does not equal 7.65 percent of the gross wages) and a $160 voluntary deduction for health insurance. The employer confirms the company contributes $100 per month to fund basic benefit levels under a cafeteria plan that offers a variety of insurance coverages. The $100 that the employer contributes toward benefits under a cafeteria plan is not wages. Also, the employer confirms the employee voluntarily pays $60 for additional benefits. The employee's contribution is wages.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 9.4: Wage Advances and Deferred Wages.

A. These payments are defined as follows:

1. Wage advances are payments by an employer to an individual for work to be done in the future.

2. Wages are considered "deferred" if they are received later than their normal payment date.

a) Types of wage payments that may be deferred include vacation pay, dismissal and severance pay, back pay and bonuses.

B. These payments are treated as follows:

1. An advance is wages in the month received.

2. Wages that are deferred due to circumstances beyond the control of the employee are considered earned income when actually received;

3. Wages that are deferred at the employee's request or by mutual agreement with the employer are considered earned income when they would have been received had they not been deferred.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 9.5: Net Earnings from Self Employment (NESE).

A. NESE is defined as follows:

1. NESE is the gross income from any trade or business, less allowable deductions for that trade or business.

   a) Any distributive share (whether distributed or not) of income or loss from a trade or business carried on by a partnership is included in NESE.

   b) NESE also includes any profit or loss in a partnership.

   c) NESE is determined on an annual basis.

B. NESE is treated as follows:

1. NESE is verified whenever an individual is self-employed or has been self-employed during the current taxable year based on the most recent federal income tax return filed with IRS, or if the business is new, based on the individual's business records or the best estimate available.

2. NESE, after any appropriate offsets and deductions, is counted as earned income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 9.6: Payments for Services Performed in a Sheltered Workshop or Work Activities Center.

A. These payments are defined as follows:

1. Payment for services performed in a sheltered workshop or work activities center are what an individual receives for participating in a program designed to help him become self-supporting.

   a) A sheltered workshop is a nonprofit organization or institution whose purpose is:

      1) To carry out a recognized program of rehabilitation for handicapped workers; and/or

      2) To provide such individuals with remunerative employment or other occupational rehabilitating activity of an educational or therapeutic nature.

b) A work activities center is:

1) A sheltered workshop, or

2) A physically separated department of a sheltered workshop having an identifiable program and separate supervision and records.

3) A work activities center is planned and designed exclusively to provide therapeutic activities for handicapped workers whose physical or mental impairment is so severe as to make their productivity capacity inconsequential.

(a) Therapeutic activities are custodial activities such as activities where the focus is on teaching basic living skills and other purposeful activity so long as work production is not the main purpose.

B. These payments are treated as follows:

1. Payments for such services are a type of earned income and are counted when received or when set aside for the person's use.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 9.7: Royalties and Honoraria.

A. These payments are defined as follows:

1. Royalties include compensation paid to the owner for the use of property, usually copyrighted material (e.g., books, music, or art) or natural resources (like minerals, oil, gravel or timber). Royalty compensation may be expressed as a percentage of receipt from using the property or as an amount per unit produced.

   a) To be considered royalties, payments for the use of natural resources also must be received:

      1) Under a formal or informal agreement whereby the owner authorizes another person to manage and extract a product like timber or oil; and

      2) In an amount that is dependent on the amount of the product actually extracted.

2. An honorarium is an honorary or free gift, reward or donation usually provided gratuitously for services rendered (like a guest speaker), for which no compensation can be collected by law. The amount also may include payment for items other than services rendered, e.g., lodging or travel expenses.

B. These payments are treated as follows:

1. Royalties are earned income when they are:

   a) Received as part of a trade or business; or

   b) Received by a person in connection with any publication of his work such as publication of a manuscript, magazine article or artwork.

2. While royalties may involve natural resources, an outright sale of natural resources by the owner of the land or by the owner of rights to use the land constitutes conversion of a resource. Proceeds from the conversion of a resource are not income.

3. Absent evidence to the contrary, assume the amount of any honorarium received is in consideration of the actual services provided by the individual and treat as earned income. Any other payment received in cash or in-kind connected with service is unearned income to the extent it exceeds the individual's expenses.

   a) If the income from royalties/honoraria that are earned income are not allowed. However, such expenses are deductible from royalties/honoraria that are unearned income.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 9.8: Uniformed Services Pay and Allowances.

A. These types of income are broadly defined as follows:

1. Compensation to members of the Uniformed Services takes several forms, chiefly:

   a) Basic or Base Pay;

   b) Special and Incentive Pay; and

   c) Cash Allowances.

B. These types of income are treated as follows:

1. Cash payments for pay and allowances which are paid for service as a member of the uniformed service are treated as earned income, with the exception of the following:

   a) Service members and their families living in on-base housing or privatized military housing may receive a BAH payment or the military may direct a BAH to a housing contractor by way of payroll deduction or allotment. In each case, the BAH is not cash income. However, if service members and their families who live in private housing receive a BAH payment, it is earned income.

b) Hostile fire pay and imminent danger pay (sometimes referred to as "combat pay") are types of special pay to a service member who is subject to hostile fire or explosion of hostile mines or on duty in an area in which he/she is in imminent danger of being exposed to hostile fire or explosion of hostile mines and while on duty in that area, other service members in the same area are subject to, killed, injured or wounded by hostile fire, explosion of a hostile mine or any other hostile action. Hostile fire and imminent danger pay is excluded income. If retained, unspent funds are a resource the following month if not otherwise excluded.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994); Heroes Earnings Assistance and Relief Tax (HEART) Act of 2008.

Rule 9.9: Income of Members of Religious Orders.

A. This type of income is treated as follows:

1. The existence of a vow of poverty is a factor in determining whether cash is considered wages or net earnings from self-employment.

2. The existence of a vow of poverty is also a factor in determining if payments made by a member to the order can be considered contributions for food, clothing, or shelter. The treatment of income to members of religious orders (nuns, monks, priests, etc.) who take a vow of poverty is determined by the source and nature of such income, as follows:

a) Cash or in-kind remuneration for members of religious orders who take a vow of poverty is considered wages if:

1) An individual receives compensation from the order as an active, working member of that order, whether or not the religious order has elected Title II coverage. e.g., an individual works at a hospital owned by the order.

2) An active, working member of a religious order receives compensation for performing services from an agency of the church supervising the order or from an affiliated institution, whether or not the religious order has elected Title II coverage, e.g., an individual teaches at a school which is an affiliate of the order's supervising church.

3) A member of a religious order receives compensation from a third party for services performed as an employee, e.g., an individual works for a private firm as a computer programmer.

b) Remuneration for members of religious orders who take a vow of poverty is considered earnings from self-employment only when a member engages in self-employment activity unrelated to his membership in the order, e.g., an individual writes articles for nature magazines on a free-lance basis.

c) Any income provided by the order to a member who has taken a vow of poverty, which does not fall under one of the above provisions is unearned income to the member even if turned over to the order.

d) Any income or resources turned over by the member to the order are considered to be in fulfillment of the vow of poverty and are not considered contributions for food, clothing, or shelter received from the order.

e) Unearned income received by a member from any source other than the order (such as a Title II or VA benefits) is income to the member even if the member turns it over to the order.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Part 104 Chapter 10: Income Computations and Deeming

Rule 10.1: Income Computations.

A. Countable income is defined as follows:

1. Countable income is what remains after:

a) Eliminating all amounts that are not income; and

2. Applying all appropriate exclusions.

B. Countable income is the sum of a month's countable earned and unearned income, which is subtracted from the appropriate need standard to determine if an individual or couple is eligible for Medicaid.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 10.2: Need Standards.

A. The appropriate need standard used to test income depends on the coverage group for which the client is applying.

B. Medicaid need standards are based on the following:

1. SSI Federal Benefit Rates (FBR) set by SSI policy and subject to increase in January of each year. SSI FBRs are used for SSI-related cases.

a) Countable income cannot equal or exceed the appropriate FBR for Medicaid eligibility.

2. Federal Poverty Levels (FPL**)** set by the federal government and subject to change each

year, usually in February or March. FPLs are used at varying rates (100%, 120%, 135%, 200%, and 250%) depending on the coverage group.

a) Countable income can be equal to, but cannot exceed the appropriate FPL for Medicaid eligibility.

3. 300% of the SSI FBR is the formula required by federal regulation, 42 CFR 435.1005, to set the institutional need standard for all long term care coverage groups. This limit is subject to increase in January of each year when SSI FBRs increase.

a) Countable income cannot be equal to or exceed the institutional limit for Medicaid eligibility.

b) If income does equal or exceed the limit, ineligibility exists for that month unless an Income Trust is in effect.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994); 42 CFR 435.1005.

Rule 10.3: Deemed Income.

A. Deeming is defined as follow:

1. The term "deeming" identifies the process of considering another person's income and resources to be available for meeting a Medicaid client's basic needs.

2. Deemed income and resources are attributed to an eligible individual whether or not they are actually made available, with the following restrictions:

a) Deeming only applies in household situations;

1) Deeming of income is not applied in the eligibility determination for either an institutional or community spouse and deemed income is never included in the Medicaid Income computation post-eligibility.

b) Income is only deemed from an ineligible spouse to an eligible spouse and from ineligible parent(s) to eligible child.

1) Deeming is based on the concept that a husband and wife (including "holding out" couples) and/or parents and child who live together have a responsibility for each other and share income and resources.

2) Both SSI and Medicaid regulations require deeming in household situations.

B. It would not be equitable to deem the entire amount of an ineligible parent's or spouse's income to the eligible individual without some provision to permit the deemor to meet his own needs and those of ineligible children in the household.

1. An allocation is an amount deducted from income subject to deeming which is considered to be set aside for the support of certain individuals other than the eligible individual.

    a) Based on this consideration, allocations are applied for the following:

        1) Ineligible parent(s); and

        2) Ineligible children in the household.

2. Application of these allocations reduces the amount of income available for deeming.

C. For deeming purposes, a child is someone who is neither married nor the head of a household and is:

1. Under age 18 or

2. Under age 22 and a student.

D. For deeming purposes, an eligible child is a natural or adopted child under age 18 who lives in the household with one or both parents, is not married and is eligible for or applying for Medicaid.

1. A child is eligible if the child receives Medicaid from any source (SSI, DHS, etc.).

    a) Deeming no longer applies beginning the month following the month the eligible child attains age 18.

        1) An individual attains a particular age on the day preceding the anniversary of his/her birth.

        2) Deeming applies in the month of attainment of age 18 regardless of whether the application filed that month is filed before or after the day of attainment.

E. For deeming purposes, an ineligible child is either a natural or adopted child of an:

1. Eligible individual or the eligible individual's spouse; or

2. An ineligible parent or the ineligible parent's spouse.

F. In addition to the general definition of a child, an ineligible child must also be unmarried and either:

1. Under age 18; or

2. Under age 22 and a student.

a) Prior to 06/16/08, an ineligible student child could remain a “child” for deeming purposes only until age 21.

G. A parent whose income and resources are subject to deeming is one who lives in the same household with an eligible child and is:

1. A natural parent of the child; or

2. An adoptive parent of the child.

H. A parent’s income and resources are deemed to an eligible child beginning the month:

1. After the month the child come home to live with the parent(s)(e.g., the month following the month the child comes home from the hospital; or

2. Of birth when a child is born in the parent’s home; or

3. After the month of adoption when the month, i.e., the month the adoption become final.

I. Deeming is applied from parent to child when they live together in the same household.

1. When the child lives with a stepparent, the stepparent is not considered a parent or spouse of a parent of the eligible child for deeming purposes.

2. Other relatives or individuals who have legal custody of a child, but are not natural or adoptive parents, are also not considered parents for deeming purposes.

3. An individual whose parental rights have been terminated due to adoption no longer meets the definition of “parent” for Medicaid purposes.

a) This remains true if the adopted child later lives in the same household as the former parent.

J. Parental deeming rules are waived for the following coverage group:

1. Effective July 1, 1998, a child in the Disabled Child Living at Home coverage group is exempt from parental deeming of income and resources.

2. The eligible child’s own income and resources affect Medicaid eligibility in the usual manner.

K. For deeming purposes, a temporary absence exists when an individual (eligible individual or child or ineligible spouse, parent or child) leaves the household but intends to, and does, return in the same month or the following month. If the absence is temporary, deeming continues to apply.

1. A child, away at school (vocational or educational training facility), who returns home on some weekends, holidays, or vacations and is subject to parental control is considered temporarily absent from the parents' household regardless of the duration of the absence.

    a) Evidence which may indicate a child away at school is not subject to parental control includes an existing agreement, court order or signed statements from parents or school authorities. In the absence of such evidence, consider the child subject to parental control.

L. Any item which is not income to an eligible individual is also not income to an ineligible spouse or parent. In addition, the following types of income are excluded from deeming:

1. Exclude income used by an ineligible spouse or ineligible parent (or child) to make support court-ordered payments.

    a) If an ineligible child receives child support payments, do not disregard one-third of the payment as is done for an eligible child.

2. Exclude a stepparent's income from deeming.

    a) The case is treated as a one-parent household, deeming the legal parent's income to the eligible child.

3. Exclude In-Home Supportive Services Payments provided under Title XX or other federal, state or local governmental programs to an eligible individual and paid by the individual to his ineligible spouse, parent or child living in the same household in return for in-home supportive services (chore, attendant, homemaker, etc.).

    a) Such payments made directly to the ineligible spouse, parent or child to provide services to the ineligible are also excluded for deeming purposes.

    b) Retroactive IHSS payments are not a resource for one calendar month following month of receipt.

        1) Any unspent portion becomes a resource if retained into the second calendar month following receipt.

M. Public Income Maintenance Payments (PIM) Received by a Deemor are treated as follows:

1. PIM payments are payments based on need paid under the following:

    a) Temporary Assistance for Needy Families (TANF);

    b) Supplemental Security Income (SSI);

c) The Refugee Act of 1980;

d) The Disaster Relief Act of 1974;

e) General Assistance programs of the Bureau of Indian Affairs;

f) State or local government assistance programs based on need; and

g) VA benefits based on need.

2. In the deeming computation, the PIM payment and any income counted in determining the PIM payment are excluded when received by an ineligible spouse or parent.

   a) Assume all of the income of the person who received the PIM payment was used (counted or excluded) in determining the payment.

   b) There is no deeming allocation given for ineligible spouses, parents or children who receive PIM payments.

   c) Resources continue to be deemed (or combined) from the spouse or parent receiving Income Based on Need.

   d) If the spouse or parent who receives the PIM payments wishes to apply for Medicaid, the PIM payment is counted according to the income rules regarding the specific payment.

   e) As a result of these exclusions from the deeming process, there may be situations advantageous to a couple if the potentially eligible spouse who has non-deemable income does not file.

      1) Example: One spouse has a VA pension of $500. The pension (and any income used to determine the pension payment) is not deemable. The other applicant spouse has no income and would be treated as an individual with zero income. If the spouse who has the pension also files, the $500 would result in a dollar for dollar reduction in the couple FBR or FPL since income based on need is considered income to an eligible individual.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 10.4: In-Kind Income.

A. In-kind income is defined as follows:

1. In-kind income is any income other than cash income.

   a) To meet the definition of income, the in-kind item received by the individual must be:

1) Food or shelter; or

2) Something the individual can sell or convert to obtain food or shelter.

(a) If the in-kind item is neither food nor shelter, and it cannot be sold or converted to cash, then it is not income.

B. In-kind income is treated as follows:

1. In-kind Support and Maintenance (ISM) is unearned income in the form of food or shelter, or both. Receipt of clothing is no longer counted as ISM effective March 9, 2005.

a) ISM is an SSI policy principal that may be applicable to all categories of eligibility as described below:

1) Whenever in-kind payments, as defined above, are received by individuals in SSI-related categories, such as SSI retro cases and former SSI recipient cases, the value of the ISM is determined by one of the three methods discussed below and the ISM is counted as unearned income.

2) For cases associated with the Federal Poverty Level (FPL) or Institutional Income limit, the source of the in-kind payment determines whether the ISM is countable. If the source of the in-kind payment is for the benefit of the client and the in-kind payment is for food or shelter, the actual amount of the ISM is countable unearned income.

(a) Example: The client is the beneficiary of a trust, which is not a resource. A monthly disbursement of $300 is made from the trust to pay his shelter costs. The amount of the disbursement is countable unearned income.

(b) Example: The client's mother pays his rent of $300 to his landlord from her own funds. This third party payment is not countable ISM to the Medicaid recipient.

b) To determine the value of ISM for an eligible individual or couple in an SSI-related category of eligibility, use the lesser of the three values discussed below when the individual or couple:

1) Lives in the household of another,

2) Receives rent free shelter,

3) Has someone else (a third party) pay for goods and services provided to the eligible, or

4) Receives rental subsidies.

c) Current Market Value (CMV). This is the amount for which something can be purchased locally on the open market.

1) Depending on the type of support and maintenance received, the determination of the CMV may be based on various factors such as the assessed value from a knowledgeable source, property owner's statement, and the individual's payment.

d) Actual Value (AV). The current market value is divided by the number of people receiving support and maintenance minus any payment made out of an individual's own funds. If he makes no payment, AV and CMV may be the same amount.

e) Presumed Maximum Value (PMV). This is an amount equivalent to one-third of the applicable Federal Benefit Rate (FBR) plus $20.

1) The PMV rules apply to in-kind support and maintenance that is countable as unearned income. The PMV never applies to earned income.

2) Use of the PMV in determining an individual's countable income is rebuttable by the individual's showing that the AV of the in-kind support and maintenance he receives is less than the PMV.

(a) The lower of these two figures is always used, but never an amount in excess of the PMV, regardless of the number of sources of such income or the variety of living arrangements during any one given period.

3) PMV is not used to determine the value of ISM for individuals in FPL or institutional categories.

f) ISM is counted as income in the month in which the individual has use of the food or shelter item, with the exception that a third party vendor payment received as a gift is income in the month in which the payment is made.

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Rule 10.5: In-Kind Items Received as Remuneration for Employment (SSI Categories Only).

A. In-kind items may be provided as remuneration for employment, as follows:

1. Wages may include the value of food and/or shelter (ISM), or other items received in lieu of cash for individuals in SSI-related categories only.

2. In-kind payment of food or shelter to the following people or under the following conditions is unearned income:

a) Agricultural employees;

b) Domestic employees;

c) Service not in the course of the employer's trade or business;

d) Service by certain home workers;

e) Members of the Uniformed Services;

f) In the form of food and/or shelter which is on the employer's business premises for the employer's convenience and, if shelter, its acceptance by the employee is a condition of employment

Source: Social Security Act §1902 (r)(2); 42 CFR § 435.601(b) (Rev 1994).

Part 104 Chapter 11: Introduction to Income – FCC Programs

Rule 11.1: Income Rules

A. The Affordable Care Act (ACA) requires that state Medicaid programs use modified adjusted gross income or MAGI-based methodology for determining the income of an individual and the individual's household. MAGI methodology and rules are required in determining eligibility for Medicaid or CHIP or an 1115 demonstration that involve FCC covered populations of children, pregnant women and parents and needy caretaker relatives. The ABD population is exempt from MAGI rules.

B. The MAGI methodology is aligned with the process used to determine eligibility for the premium tax credits and cost sharing reductions available to certain individuals purchasing coverage through the federal health insurance marketplace. The requirement that both Medicaid and the marketplace use MAGI-based income methodologies is designed to promote coordination and avoid gaps in coverage, to the extent possible, for individuals that transfer between different types of insurance affordability programs.

C. The use of liberalized income rules under 1902(r)(2) of the Social Security Act is prohibited under MAGI based methodology. This provision is only available to certain ABD covered categories of eligibility.

Source: 42 CFR§ 435.603 (Rev. 2012)

Rule 11.2: MAGI Defined

A. MAGI and household income are defined in section 36B(d)(2)(A) and(B) of the Internal Revenue Code (IRC). The treatment of income is based on IRS tax rules, except for specified exceptions.

B. Modified adjust gross income, as amended by the ACA, has the literal meaning of income that is:

1. Decreased by allowable tax deductions that include trade and business deductions, losses from the sale or exchange of property, deductions attributable to rents or royalties, and deductions for alimony paid. Generally, the same adjustments to income allowable under IRS rules are allowable deductions from countable income for Medicaid and CHIP purposes.

2. Increased by the amount of interest received or accrued that is exempt from tax and foreign earned income that is excludable as taxable income.

Source: Internal Revenue Code § 36B (d)(2)(A) and (B) (Rev. 2011)

Rule 11.3: Household Income

A. MAGI based income rules require that financial eligibility is based on household income for FCC related programs.

B. Household income is the sum of the MAGI-based income of every individual included in the individual's household minus as amount equivalent to five (5) percentage points of the federal poverty level for the applicable family size, with the following exceptions.

1. The MAGI-based income of an individual who is included in the household of his or her natural, adopted or step parent and is not required to file a tax return is not included in the household income whether or not the individual files a tax return.

2. The MAGI-based income of a tax dependent other than a spouse or child and is not required to file a tax return is not included in the household income whether or not the individual files a tax return.

C. No other income disregards are permitted from gross income other than the five (5) percentage points disregard.

Source: 42 CFR § 435.603 (Rev. 2012)

Rule 11.4: Exceptions to IRS Income Rules for MAGI Based Income

A. The following are exceptions to using IRS rules for determining MAGI-based income for a household.

1. Income received in a lump sum, whether recurring or non-recurring, is counted in the month received. Recurring lump sum payments are not averaged.

2. Scholarships, awards or fellowship grants used for education purposes and not for living expenses are excluded from income. Amounts used for room and board are not excluded and count as income.

3. Certain income derived from American Indian and Alaska Native sources are excluded from income. Income that is excluded includes:

   a. Distributions from Alaska Native Corporations and Settlement Trusts;

   b. Distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior;

   c. Distributions and payments from rents, leases, rights of way, royalties, usage rights or natural resource extraction and harvest from rights of ownership or possession in any lands described in above or federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources;

   d. Distributions resulting from real property ownership interests related to natural resources and improvements located on or near a reservation or within the most recent boundaries of a prior federal reservation or resulting from the exercise of federally-protected rights relating to such real property ownership interests;

   e. Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

   f. Student financial assistance provided under the Bureau of Indian Affairs education programs.

4. Social Security benefits that are not taxable income under IRS rules are countable as income for MAGI purposes for all insurance affordability programs, including Medicaid and CHIP.

Source: 42 CFR § 435.603 (Rev. 2012) and Internal Revenue Code, § 36B (d)(2)(iii) (Rev. 2011)

Rule 11.5: When Income Counts

A. Current monthly income counts in determining eligibility for Medicaid and CHIP for new applicants and for recipients at the time of an annual review.

Source: 42 CFR § 435.603 (Rev. 2012)

Part 104 Chapter 12: Income That Does Not Count Under IRS Rules – FCC Programs

Rule 12.1: Income That Does Not Count

A. The following is not an exhaustive list of income that does not count but represents the types more commonly encountered. If not addressed herein, IRS tax rules provide the governing policy.

1. Alimony is deducted from the income of the payer and is therefore a type of non-countable income; however, alimony payments received by an individual count as income.

2. Black Lung benefits are not taxable income and are not counted as income.

3. Child Support benefits are not counted as income to the payee or the child(ren) for whom it is paid; however, Child Support is not a deduction allowable from the income of the payer.

4. VA Benefits are not counted as income. Benefits paid by the Department of Veterans Affairs are not taxable income.

5. Workers' Compensation Benefits are not taxable income and are not counted as income.

6. Life Insurance Proceeds paid due to the death of the insured person are not taxable income and are not counted as income, unless the policy was sold or reassigned for a price.

7. Accelerated Death Benefits paid under a life insurance contract prior to the insured's death are excluded from income if the insured is terminally ill.

8. Public Assistance Benefits, such as SSI, TANF, and the value of assistance from programs such as SNAP and WIC are excluded from income. IV-E Foster Care and Adoption Assistance payments are also excluded from income.

9. Disaster relief income or grants from a qualified disaster relief payment, meaning the payment is to reimburse certain necessary living expenses following a federally declared disaster, are excluded from income.

Source: 42 CFR § 435.603 (Rev. 2012)

Rule 12.2: Excluded Income from Specific Programs Providing Assistance

A. The following are payments excluded from income that originate from a specific program that provides assistance payments.

1. Home Affordable Modification Program (HAMP). Pay-for-Performance Success Payments under the HAMP are not taxable income and are not countable.

2. Hardest Hit Fund and Emergency Homeowners' Loan Program payments. Payments from a State Housing Finance agency that can be used to pay mortgage interest or payments from Housing and Urban Development for an Emergency Homeowners' Loan Program (EHLP) are not countable as income.

3. Mortgage assistance payments under section 235 of the National Housing Act for mortgage assistance are not included in the homeowner's income.

4. Replacement housing payments made under the Uniform Relocation Assistance and Real Property Acquisition Policies Act for Federal and Federally Assisted Programs are not counted as income.

5. Relocation payments and home rehabilitation grants under section 105(a)(11) of the Housing and Community Development Act made by a local jurisdiction to a displaced individual moving from a flood-damaged residence to another residence is not counted as income. Home rehabilitation grants received by low-income homeowners in a defined area under the same act are also not countable as income.

6. Payments to reduce the cost of winter energy made by a state to qualified individuals to reduce their cost of winter energy are not countable as income.

7. Holocaust Victims Restitution. Payments received by a Holocaust victim or the heir of a Holocaust victim and interest earned on the payments are not taxable and are therefore not countable as income.

8. Historic preservation grants. Payments received under the National Historic Preservation Act to preserve a historically significant property are excluded from income.

Source: 42 CFR § 435.603 (Rev. 2012)

Rule 12.3: Income that is Partially Excluded

A. The following income is partially countable and partially excluded under the conditions specified for each type of payment.

1. Foster Care Provider payments received from a state, political subdivision, or qualified foster care placement agency for providing care to qualified foster individuals in an individual's home are not countable as income except in the following situations. A qualified foster individual is someone living in a foster family home who was placed there by an agency of the state or a qualified foster care placement agency.

a) Foster care payments are income to the foster care provider if the individual received payment for more than 5 individuals age 19 or older. Count as income the payment received for foster individuals in excess of the limit.

b) Difficulty-of-care payments are additional payments that are designated by the payer as compensation for providing additional care that is required for the physically, mentally or emotionally handicapped qualified foster individual. These payments count as income if received for more than 10 foster

individuals under age 19 or 5 foster individuals age 19 or older. Count as income the payment received for foster individuals in excess of the limit.

c) If payment is made to maintain space in the home for emergency foster care, the payment is countable as income.

2. Gulf Oil Spill payments. Payment received for lost wages or income are taxable income and are therefore countable as income. Payments received for property damage are non-taxable and not countable as income if the payment does not exceed the basis in the property. Payments received for physical injury or emotional distress is non-taxable and therefore not countable as income.

3. Dependent Care Benefits. If an employer provides dependent care benefits under a qualified plan, benefits can be excluded as follows: the amount to exclude is the lesser of the total amount of benefits received or incurred during the tax year; the individual or spouse's income; or $5,000 annually ($2,500 if married filing separately). Any benefits exceeding the limit are countable as wages.

Source: 42 CFR § 435.603 (Rev. 2012)

Part 104 Chapter 13: Income That Counts Under IRS Rules – FCC Programs

Rule 13.1 – Income That Counts

A. The following is not an exhaustive list of the types of income that counts but is meant to cover the types most commonly encountered If not addressed herein, IRS tax rules provide the governing policy.

1. Employee Compensation includes all things received in payment for personal services, such as wages, salaries, commissions, fees, bonuses, tips, severance pay, sick pay paid by an employer while out on sick leave and back pay awards. Employment income that counts is the gross income prior to any payroll deductions.

2. Volunteer Income. The treatment of income received as a volunteer is as follows:

a) Peace Corp – living allowances paid to the volunteer for housing, utilities, supplies, food and clothing are not counted as income. Countable wages includes allowances paid to a spouse and minor children while the volunteer is a volunteer leader training in the U.S.; living allowances designated as basic compensation; leave allowances and readjustment allowances.

b) VISTA (Volunteers in Service to America) – meal and lodging allowances paid to the volunteer are counted as wages.

c) AmeriCorps education awards and living allowances are countable income.

d) National Senior Service Corps programs, includes the RSVP or Retired Senior Volunteer Program, Foster Grandparent Program, and Senior Companion Program. Income received for supportive services or reimbursements for out-of-pocket expenses are not counted as income.

3. Military Pay – payments received as a member of a military service are wages. Military retirement benefits are treated as pensions. Allowances, such as a basic allowance for housing or subsistence, are generally not taxable income and do not count as income.

4. Self-Employment – for IRS purposes, an individual is considered to be self-employed if the individual has a trade or business as a sole proprietor, an independent contractor, is a member of a partnership that carries on a trade or business or is otherwise in business for himself/herself, including a part-time business. Self-employment is business income less allowable business expenses that results in a net profit or loss. Net profit counts as income. Annualize the income to arrive at a monthly countable amount provided the business has been in existence for a twelve (12) month period. Annualize even if the income is received over a short period of time during the year unless the business is designed to be seasonal, such as a summer business that operates only three (3) months out of the year. Such business income would be averaged over the period of time the business covers. If a business has been in existence less than a full taxable year, average over the period of time the business has been in existence.

   a) Partnership income – each partner's distributive share of profit counts as self-employment income which is annualized.

5. Rental Income – countable income includes the net proceeds after allowing all IRS allowed deductions for rental income.

6. Farm Income – farm income that counts is the net earnings or profit that remains after allowing all IRS allowed business expenses involved in raising livestock, poultry or fish or from the growing of fruits or vegetables. Farm income is annualized or averaged over the time the farming business operates, as appropriate.

7. Royalties from copyrights, patents and oil, gas and mineral properties are taxable income and therefore countable.

8. Unemployment Compensation – all unemployment compensation benefits are countable as income.

9. Retirement, Survivors and Disability Insurance (RSDI) or benefits paid by the Social Security Administration are only partially taxable as income under certain conditions but are fully countable as income for insurance affordability programs.

10. Alimony payments received are countable as income to the divorced or separated spouse receiving the payment.

11. Annuities – payments from annuities are countable as income.

12. Pensions and Retirement benefits are countable as income, including pensions paid by any private, municipal, county, state or federal plan.

13. Estate and trust income is countable income when distributed or when it should have been distributed, regardless of whether it was actually distributed.

14. Gambling, Lotteries and Raffle Winnings – cash winnings are countable income in the month received.

15. Jury duty pay is countable as income.

16. Alternative trade adjustment assistance (ATAA) payments received from a state agency under the Demonstration Project for Alternative Trade Adjustment Assistance for Older Workers is countable as income.

17. Interest income, including tax-exempt interest, is countable under MAGI rules.

18. Disability benefits received through an accident or health insurance plan – the IRS rules for counting such benefits are as follows:

    a) If both the individual and the employer paid the premiums for the plan, only the amount received for disability that is due to the employer's payments is countable as income,

    b) If the individual paid the entire cost of the plan, the payments are not countable as income,

    c) If the premiums of a plan were paid through a cafeteria plan and the amount of the premium was not taxable income to the individual, the premiums are considered paid by the employer and the disability payments are countable as income.

Source: 42 CFR § 435.603 (Rev. 2012)

Part 104 Chapter 14: Verification of Income – FCC Programs

Rule 14.1 – Verification Requirements

A. The ACA mandates that states rely heavily on electronic data sources to verify income. Data sources include IRS tax return data for households that file taxes, the Social Security Administration (SSA) for benefits paid through SSA and state data sources such as the MS Department of Employment Security for wage and unemployment compensation verification. Other available state and federal data sources may be used as appropriate.

B. Self-attested income reported on the application form must be compared to income verified through electronic data sources to determine if the various sources are reasonably compatible and allow a decision regarding eligibility or ineligibility for Medicaid, CHIP or other insurance affordability programs.

Rule 14.2 – Reasonable Compatibility Rules

A. Income verified from electronic data sources that is reasonably compatible with self-attested income allows a Medicaid or CHIP decision regarding eligibility without requesting paper verification from the applicant.

B. The first test of reasonable compatibility for income is the comparison of income reported from the federal data services hub against income declared or self-attested on the application form. If both sources are at or below the appropriate Medicaid income limit for the household size, Medicaid approval is allowed for individuals in the household who otherwise qualify for Medicaid. If both sources are above the Medicaid limit, Medicaid is denied but CHIP eligibility for children in the household will be assessed and adults in the household will referred to the Federal Market Place as appropriate.

C. Discrepancies in income that result from comparing income from the federal hub to self-attested income will result in a hierarchy of attempts to resolve the discrepancy prior to requesting that the applicant provide paper verification. Attempts include the comparison of income to a state-established threshold that would allow a decision and/or pending the decision awaiting secondary data sources to arrive for comparison purposes. A written request for paper verification will be requested only when:

    1. The applicant fails to provide a reasonable explanation for the discrepancy when contacted.

    2. Efforts to contact the individual to discuss reasons for any discrepancy fail.

    3. Reported income is not available for verification through an electronic data source.

Source: 42 CFR § 435.945 (rev. 2012)

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 105
Budgeting

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Title 23: Division of Medicaid

Part 105: Budgeting

Part 105 Chapter 1: Introduction to Budgeting – FCC Programs

Rule 1.1: Budgeting Rules for FCC Programs

A. The Affordable Care Act (ACA) requires the use of MAGI-based budgeting rules for determining household size, household composition, household income and need standards which are all defined below. MAGI-based budgeting processes include rules for households that file federal income taxes and rules for households that do not file federal income taxes, referred to as non-filer households.

B. Household or family size is the number of persons counted as members of an individual's household. If one of the household members is pregnant, the pregnant woman is counted as herself plus the number of children she is expected to deliver. Individuals cannot choose who is to be included or excluded from their household for budgeting purposes, even though all household members may not be applying. All household members and their relationship to each other, tax filing status and marital status are considered for budgeting purposes. Married couples living together must always be included in the same household, regardless of the tax filing status of the couple.

C. Household income, as defined in Part 104, Chapter 11, includes every individual included in the household. The only allowable disregard is a five (5) percentage point disregard of the FPL based on household size. The income of children and tax dependents other than a spouse or child who are not required or expected to file a tax return is not included in household income whether or not the individual actually files a tax return, unless a specified exception exists.

D. Need standards that were in effect for FCC covered categories of eligibility prior to the implementation of the ACA must be converted to MAGI-equivalent levels to account for any income disregards in use prior to the ACA. The limits, based on either a state-established threshold or federal poverty levels, are adjusted to account for an average of income disregards in use prior to the ACA and cannot be less than the income levels in use prior to the ACA. Income limits in use for FCC programs effective with the implementation of the ACA are referred to as MAGI-equivalent income standards. The appropriate need standard to use in determining the eligibility of an individual is based on the age of the individual applying, the individual's household size and total household income as determined using MAGI income rules.

E. MAGI need standards are applicable to MAGI-based categories of eligibility for applications approved on and after implementation of the ACA. Ongoing cases will be transitioned to the new MAGI need standards at the time the case is reviewed after implementation of the ACA, unless otherwise mandated by the ACA.

F. Children who lose Medicaid eligibility during the conversion to MAGI whose sole reason for ineligibility is the loss of income disregards allowed prior to the implementation of the ACA will be granted a twelve (12) month protected period of CHIP eligibility. CHIP children

losing eligibility due to the loss of income disregards will be referred to the HIX as the ACA affords no equivalent protection for children losing CHIP eligibility.

G. Household composition and determining whose income counts for MAGI based categories of eligibility are determined by using tax filer rules, exceptions to tax filer rules or non-tax filer rules, as appropriate. It is necessary to evaluate each household member individually in order to apply the appropriate household composition rule.

Source: 42 CFR§ 435.603 (Rev. 2012)

Rule 1.2: Tax Filer Rules

A. A tax filer's household includes the tax filer, spouse and all dependents that the tax filer claims or plans to claim in the tax year for which eligibility is requested.

1. Spouses whose tax filing status is married filing jointly are considered one household whether living together or separately.
2. Spouses whose tax filing status is married filing separately are considered one household if living together. If living apart, they are treated as two (2) separate households.
3. A tax filer household in any other tax filing status includes the tax filer and all dependents that the tax filer claims.

B. A tax dependent's household is the same as the tax filer's household, with certain exceptions. The exceptions to counting tax dependents according to tax filer rules are described in Rule 1.3.

C. If a tax dependent is married and living with his/her spouse but claimed by a parent as a tax dependent, the tax dependent's household includes the parent tax filer's household plus the tax dependent's spouse. The spouse's household would be limited to the two (2) spouses unless both spouses were claimed by their separate parent(s).

D. A tax filer's household income includes all countable MAGI income received by household members except the income of a tax dependent does not count unless the dependent is required to file a federal tax return.

E. A tax dependent who is also a parent of child(ren) living in the household must have his/her income counted toward his/her child(ren), regardless of whether the tax dependent parent is required to file a tax return. The tax dependent's income would not count in the tax filer's household but would count in the child(ren)'s household using non-filer rules.

Source: 42 CFR§ 435.603 (Rev. 2012)

Rule 1.3: Exceptions to Tax Filer Rules

A. A tax dependent who is not the tax filer's spouse or child is treated as a non-filer, described in Rule 1.4.

B. A tax dependent under age 19 who lives with two parents who do not expect to file a joint tax return is treated as a non-filer, described in Rule 1.4.

C. A tax dependent claimed as a tax dependent by a non-custodial parent is treated as a non-filer, described in Rule 1.4. The child is not a member of the custodial parent's household even though the child physically resides in the home. The child's income does not count in the custodial parent's household income.

Source: 42 CFR§ 435.603 (Rev. 2012)

Rule 1.4: Non-Filer Rules

A. A non-filer is someone who neither files a federal tax return nor is claimed as a tax dependent. For individuals who are non-filers or exceptions to tax filer rules, budgeting rules depend on whether the individual is an adult or child under age 19 living in the same household.

B. A non-filer adult's household includes the non-filer, the non-filer's spouse and his/her children living together. Income includes all countable MAGI income received by the household members except the income of a child not required to file a federal tax return does not count as income to the household. The exception to the rule of counting a child's income based on his/her tax filing requirement is this: if a child is also a parent of child(ren) living in the household, the child's income must be counted toward his/her child(ren) regardless of the requirement to file a federal tax return.

C. A non-filer child's household includes the non-filer child and the child's parent(s) and siblings living together.

Source: 42 CFR§ 435.603 (Rev. 2012)

Part 105 Chapter 2: Extended Medicaid for Parent(s) and Caretaker Relatives

Rule 2.1: Budgeting Rules for Extended Medicaid Due to Increased Earnings

A. Parent(s) or Caretaker Relatives that lose Medicaid due to increased hours or income from employment are eligible for extended Medicaid for up to twelve (12) consecutive months from the month of ineligibility provided the adult(s) received Medicaid as a parent or caretaker relative for at least three (3) of the six (6) months immediately preceding the month in which the individual becomes ineligible. Extended Medicaid due to increased earnings is also referred to as Transitional Medicaid Assistance or TMA.

B. If the change in income is not reported timely, eligibility for extended Medicaid is determined using a look-back process where actual income information is gathered after the fact and the determination of the appropriate twelve (12) month period is calculated to begin the month after the month the family became ineligible for Medicaid.

C. The child(ren) associated with the parent(s) or caretaker relative case are also eligible for the same twelve (12) month period of extended Medicaid eligibility. Since children are

guaranteed twelve (12) continuous months of eligibility once eligibility is established and at each review establishing continuing eligibility, the period of extended Medicaid under this provision cannot shorten a child's twelve (12) month period of continuous eligibility. When there is an overlap, the protected periods of eligibility run concurrently.

Source: § 1902 (e)(1)(B) and §1925 of the Social Security Act

Rule 2.2: Budgeting Rules for Extended Medicaid – Increased Spousal Support

A. Parent(s), meaning a single parent or parent and step-parent family, that lose Medicaid in the parent/caretaker relative category of coverage due to new or increased spousal support under title IV-D of the Social Security Act must continue to receive Medicaid for four (4) consecutive months following the month of ineligibility. The parent(s) must have received Medicaid for at least three (3) of the six (6) months immediately preceding the month in which the individual becomes ineligible.

B. If the change in income is not reported timely, eligibility for extended Medicaid is determined using a look-back process where actual income information is gathered after the fact and the determination of the appropriate four (4) month period is calculated to begin the month after the month the family became ineligible for Medicaid.

C. The child(ren) associated with the parent(s) losing Medicaid are also eligible for the same four (4) month period of extended Medicaid eligibility. The provision to grant four (4) months of extended coverage cannot shorten a child's twelve (12) month period of continuous eligibility. When there is an overlap, the protected periods of eligibility run concurrently.

Source: 42 CFR § 435.115 (Rev. 1994)

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 200
General Provider Information

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Title 23: Division of Medicaid

Part 200: General Provider Information

Part 200 Chapter 1: General Administrative Rules for Providers

Rule 1.1: Disclosure of Confidential Information

A. Records and information acquired in the administration of any part of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in rules and regulations of the Department of Health and Human Services (DHHS) or when authorized by the Secretary of Health and Human Services.

B. A provider may disclose records or information acquired under the Medicaid program only when:

   1. The record or information is to be used in connection with a claim, or

   2. To verify the utilization of Medicaid benefits; and

   3. The disclosure is necessary for the proper performance of the duties of any employee of:

      a) The Division of Medicaid,

      b) Any public or private agency or organization under an agreement with Division of Medicaid in regard to meeting requirements of the Medicaid program,

      c) The Attorney General Medicaid Fraud Control Unit,

      d) A duly authorized legal hearing, or

      e) Representative of the Secretary of Health and Human Services office.

C. If a beneficiary or beneficiary's attorney requests medical records, billing information, etc., these records should be released in accordance with the Third Party Procedures described in Part 300, Chapter 7.

D. Providers that are utilizing collection and/or billing agencies should know that the Division of Medicaid and its fiscal agent cannot release information to these companies without a signed release from the Medicaid beneficiary. Information can only be furnished to:

   1. The provider that provided the service to the Medicaid beneficiary, or

   2. To a provider's business agent, billing service, or accounting firm that regularly handles claims filing for the provider,

a) If, and only if the company has a written agreement with the provider, and

b) Has a confidentiality agreement with the Division of Medicaid that is on file with the fiscal agent.

E. State law requires that any medical information concerning a Medicaid beneficiary that is released by a provider must contain the following information:

1. The person is a Medicaid beneficiary,

2. His/her Medicaid identification number, and

3. The bill has been paid by Medicaid or will be submitted to Medicaid.

Source: Miss. Code Ann. § 43-13-121; Social Security Act Section 1902(a)(7); Title XIX Social Security Act

Rule 1.2: Access to Public Information

A. Public access to records maintained by the Division of Medicaid is described in Section 25-61-1 et seq. of the Mississippi Code of 1972, as amended. An exception to this public access for Medicaid purposes is beneficiary specific information which must be kept confidential in accordance with 42 CFR 431.300 through 431.307 as discussed in Chapter 200, Rule 1.1, and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 CFR 160 and 164.

B. Provider manuals/bulletins and other Division of Medicaid information including the complete Medicaid Eligibility Manual, the Title XIX State Plan for the Mississippi Division of Medicaid and certain fee schedules are available for viewing and/or printing.

C. Records furnished to the Division of Medicaid by third parties that may contain trade secrets or confidential commercial or financial information will not be released until notice to the third party has been given. Such records will be released within a reasonable period of time, unless the third party has obtained a court order protecting the records as confidential. If the third party notifies the Division of Medicaid that it will seek a court order to protect the records as confidential, the Division of Medicaid will notify the requestor.

D. Any person seeking a public record pursuant to the Mississippi Public Records Act, Section 25-61-1, et seq., should make the request in writing. The written request should include the following information:

1. Name of requestor,

2. Address of requestor,

3. Other contact information, including telephone number and any e-mail address,

4. Identification of the public records adequate for the public records officer or designee to locate, and

5. The date and time of day of the request.

Source: Miss. Code Ann. § 43-13-121; Miss. Code Ann. § 25-61-1; 42 CFR 431.300 – 431.307; HIPAA 45 CFR 160 and 164

Rule 1.3: Maintenance of Records

A. All professional, institutional, and contractual providers participating in the Medicaid program are required to maintain all records that will disclose services rendered and/or billed under the program and, upon request, make such records available to representatives of Centers for Medicare and Medicaid Services (CMS), the Division of Medicaid, the Attorney General Medicaid Fraud Control Unit, or DHHS in substantiation of any and all claims.

B. General Requirements for All Records

1. Records must also be legible, appropriate, and correct. All entries within a medical record should be written legibly to ensure beneficiary safety and appropriate billing and/or reviewing. All information contained within a medical record should be written or otherwise compiled on appropriate provider documentation forms. All entries within the medical record should be made without a space between entries. Corrections and late entries, when absolutely necessary, should be documented appropriately, as evidenced below. Every effort should be taken to make correct and timely entries initially in the medical record. All entries must be made in a permanent form, such as by use of indelible ink. Entries made in pencil are not acceptable. At no time should corrective tape, corrective liquid, erasers or other obliteration supplies be used to remove or change information on or in the medical record. A medical record is a legal document, and it is illegal to tamper with or falsify such documents.

   a) Entry Correction:

      1) Draw a single line through the error making certain that the error entry, though crossed out, is still legible.

      2) Place date, time, and initials as to when the entry was marked out.

      3) Enter the correct information in a new entry on the next available line or in the next available space. The current date/time should be used when beginning this entry. The time the event/incident occurred can be placed within the entry text itself.

      4) Never use corrective tape, corrective liquid or other obliteration supplies to change or erase any part of the medical record.

b) Late Entries:

1) Identify the new entry as a “Late Entry” in the medical record.

2) Enter the current date and time when the entry is actually being written in the medical record. Please note that this should not be the date and time the incident/event actually occurred.

3) Identify the incident and refer to the date and time that the incident occurred within the late entry.

4) Document information as soon as possible.

5) Never use corrective tape, corrective liquid or other obliteration supplies to change or erase any part of the medical record.

2. In order for the Division of Medicaid to fulfill its obligation to verify services rendered to Medicaid beneficiaries and paid for by Medicaid, the provider must maintain auditable records that will substantiate the claim submitted to Medicaid. Refer to specific Parts of this Administrative Code for detailed documentation requirements.

a) The Division of Medicaid staff shall have immediate access to the provider’s physical services location, facilities, records, documents, books, prescriptions, invoices, radiographs, and any other records relating to licensure, medical care, and services rendered to beneficiaries, and billings/claims during regular business hours (8 a.m. to 5 p.m., Monday – Friday) and all other hours when employees of the provider are normally available and conducting the business of the provider.

b) The Division of Medicaid staff shall have immediate access to any administrative, maintenance, and storage locations within, or separate from, the service location.

C. Absence of Adequate Records to Verify Services - If a provider’s records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to the Division of Medicaid any money received from the Medicaid program for such nonsubstantiated services. If a refund is not received within thirty (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 provider.

D. Record Retention Requirements - Providers must maintain compliance with the MS Code as follows:

1. Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program shall keep and maintain books, documents and other records as

prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report."

2. "It shall be the duty of each provider participating in the medical assistance program to keep and maintain books, documents, and other records as prescribed by the Division of Medicaid in substantiation of its claim for services rendered Medicaid recipients, and such books, documents, and other records shall be kept and maintained for a period of five (5) years or for whatever longer period as may be required or prescribed under federal or state statutes and shall be subject to audit by the Division. The Division shall be entitled to full recoupment of the amount it has paid any provider of medical service who has failed to keep or maintain records as required herein."

3. All providers must maintain records that substantiate claims for services rendered and/or billed under the program for a minimum of five (5) years. The minimum three (3) year retention requirement for records that substantiate cost reports applies only to cost reports and only to the aforementioned providers. The cost reports and related records for all other providers should be kept and maintained for a period of at least five (5) years following the date all audit findings are resolved.

4. A 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.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 1.4: Fundraising

A. Fundraising may only be used to obtain funds needed to pay for medical/treatment costs not normally covered by the Mississippi Medicaid program. Such costs include, but are not limited to the following:

   1. Transportation for family members,

   2. Food and lodging for the beneficiary and family,

   3. Child care,

   5. Non-covered medical equipment, or

   6. Non-covered medical services.

B. Fundraising Criteria:

1. Prior to accepting donations, arrangements must be made to place donations in a trust fund/ special account.

2. The trust fund/special account must be established/administered in compliance with all applicable federal and state rules/regulations.

3. The trust fund/special account must be managed/administered by someone other than the beneficiary or the beneficiary's family member/legal guardian (i.e., the beneficiary or the beneficiary's family member/legal guardian may not have direct access to the fund/account).

4. The trust fund/special account must be maintained separate from personal monies belonging to the beneficiary or the beneficiary's family member/legal guardian (i.e., mixed funds could be counted as income or an asset which could result in a loss or reduction of Medicaid benefits).

5. Legible documentation on income and expenditures must be maintained and must be made available to the Division of Medicaid, the fiscal agent, and/or the UM/QIO upon request.

C. All sources of income must be reported to the source of eligibility. Donated funds for the purpose of payment of medical services are considered a third party source. Refer to Part 306.

D. Provider/facilities must adhere to conditions of participation as a Medicaid provider and cannot participate in fundraising for beneficiaries to raise additional funds to pay for Medicaid covered procedures and/or related services. Refer to Part 200, Chapter 4.

Source: Miss. Code Ann. § 43-13-121

Rule 1.5: Limited English Proficiency Plan (LEP)

For Division of Medicaid purposes, this plan is established to define the mandated compliance requirements pertinent to the provision of services to individuals with limited English proficiency (LEP), established procedures for requisitioning forms in Spanish and Vietnamese, and for accessing and/or hiring and utilizing qualified interpreters. This rule provides provisions to ensure awareness of the program by beneficiaries/applicants with limited English proficiency, employee training and requirements for reporting, records retention for the LEP program and monitoring oversight of the language assistance program to ensure LEP persons meaningful access to the program.

Source: Miss. Code Ann. § 43-13-121; Title VI Civil Rights Act 1964 USC Section 2000(d)

Part 200 Chapter 2: Benefits

Rule 2.1: Medicaid Services

A. Federally Mandated Services - The following services are mandated for Mississippi Medicaid:

   1. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (Mississippi Cool Kids Program,

   2. Expanded EPSDT,

   3. Family Planning,

   4. Federally Qualified Health Center (FQHC),

   5. Home Health,

   6. Hospital Inpatient,

   7. Hospital Outpatient,

   8. Laboratory,

   9. Nurse Practitioner,

   10. Nursing Facility,

   11. Physician,

   12. Radiology,

   13. Rural Health Clinic, and

   14. Transportation (including emergent/non-emergent ambulance, air ambulance & NET).

B. Optional services covered by State:

   1. Ambulatory Surgical Center,

   2. Chiropractic,

   3. Community Mental Health,

   4. Dental,

   5. Dialysis,

6. Durable Medical Equipment,
7. Eyeglasses and Vision,
8. Freestanding Psychiatric Hospital,
9. Hearing Services and Hearing Aids,
10. Hospice,
11. Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Services,
12. Medical Supplies,
13. Occupational Therapy,
14. Physical Therapy,
15. Podiatry,
16. Prescription Drugs,
17. Psychiatric Residential Treatment Facilities,
18. Speech Therapy,
19. Hospital Swing Bed, and
20. MS State Department of Health Clinic.

C. Waivered services which are optional:

1. HCBS – Assisted Living Waiver,
2. HCBS – Elderly and Disabled Waiver,
3. HCBS – Independent Living Waiver,
4. HCBS – Intellectual Disabilities/Developmental Disabilities Waiver,
5. HCBS - Traumatic Brain Injury/Spinal Cord Injury Waiver,
6. Mississippi Youth Programs Around the Clock (MYPAC),
7. Family Planning Waiver, and

8. Healthier Mississippi 1115 Waiver.

Source: Miss. Code Ann. § 43-13-121; Social Security Act Section 1902(a); 42 CFR 440.1; 42 USC § 1396d; 440.210; 440.220

Rule 2.2: Non-Covered Services

A. The Division of Medicaid does not cover certain items and services including, but not limited to, the following:

1. Items or services which are furnished gratuitously without regard to the beneficiary's ability to pay and without expectation of payment from any source, including, but not limited to:

   a) Free diagnostic services provided by a health department, and

   b) Services provided as part of a health fair.

2. Services provided by the following except as specified by the State Plan or a 1915(c) waiver:

   a) Anyone legally responsible for a beneficiary/participant,

   b) An individual, corporation, partnership or other organization which has assumed the responsibility for the care of a beneficiary, but does not include the Division of Medicaid, a licensed hospital, or a licensed nursing home within the state,

   c) The following family members:

      1) Spouse,

      2) Parent, step-parent or foster parent,

      3) Child, step-child, grandchild or step-grandchild,

      4) Grandparent or step-grandparent,

      5) Sibling or step-sibling, or

   d) Anyone who resides in the home with the beneficiary regardless of relationship.

3. Services provided by a registered nurse (RN) or licensed practical nurse (LPN) to their family members, as defined in Miss. Admin. Code Part 200, Rule 2.2 A.2.c).

4. Services denied by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity.

5. Services, procedures, supplies or drugs still in clinical trials deemed as investigational or experimental in nature.

6. Procedures, products and services for conditions and indications not approved by the Federal Drug Administration (FDA) and/or that do not follow medically accepted indications and dosing limits supported by one (1) or more of the official compendia as designated by the Centers for Medicare and Medicaid Services (CMS) including, but not limited to:

   a) Physician administered drugs and implantable drug system devices,

   b) Skin and tissue substitutes, and/or

   c) Implantable medical devices.

7. Any operative procedure, or any portion of a procedure, performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

8. Reconstructive breast procedures performed to produce a symmetrical appearance.

9. Infertility studies, procedures to enhance fertility including reversal of sterilization, artificial or intrauterine insemination, or in-vitro fertilization.

10. Gastric surgery techniques or procedures for the treatment of obesity or weight control, regardless of medical necessity.

11. Routine foot care in the absence of systemic conditions.

12. Prosthetic or orthotic devices and orthopedic shoes except crossover claims allowed by Medicare.

13. Services provided to Specified Low Income Medicare Beneficiaries (SLMB), Qualified Medicare Beneficiaries (QMB), and Qualifying Individuals (QI) except as described in Miss. Admin. Code Part 200, Rule 3.4.

B. The Division of Medicaid does not cover items or services not directly related to the treatment of an illness or injury, including, but not limited to:

1. Television except as described in Miss. Admin. Code Part 207,

2. Massage,

3. Haircuts except as described in Miss. Admin. Code Part 207,

4. Interest on late pay claims,

5. Telephone contacts/consultations,

6. Missed or cancelled appointments, or

7. Wigs.

C. The Division of Medicaid does not reimburse for items and services ordered, prescribed, administered, supplied or provided by providers, entities, or financial institutions who:

1. Have been excluded by the Department of Health and Human Services (DHHS),

2. Have been excluded by Medicare,

3. Are no longer licensed by their governing board(s),

4. Are respiratory therapists requesting direct payment for services,

5. Are freestanding substance abuse rehabilitation centers,

6. Are free-standing psychiatric facilities,

7. Are located outside of the United States,

8. Are not currently enrolled as a Mississippi Medicaid provider, or

9. Have not conducted criminal history records checks on each employee of the entity hired since 1989 who provides, and/or would provide direct patient care or services to adults or vulnerable persons in accordance with the Mississippi Vulnerable Persons Act.

D. The Division of Medicaid does not cover the following three (3) Never Events in the inpatient hospital, outpatient hospital and other types of healthcare settings:

1. Wrong surgery or other invasive procedure performed on a beneficiary,

2. Surgical or other invasive procedure performed on the wrong body part, or

3. Surgical or other invasive procedure performed on the wrong beneficiary.

E. The Division of Medicaid does not cover inpatient hospital Health Care-Acquired Conditions (HCACs) as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric beneficiaries.

F. The Division of Medicaid does not cover nursing facility services or duplicative hospice services for persons enrolled in a Home and Community-Based Services (HCBS) waiver

program or enrollment in more than one (1) HCBS waiver program including, but not limited to:

1. Elderly and Disabled (E&D) Waiver,

2. Independent Living (IL) Waiver,

3. Assisted Living (AL) Waiver,

4. Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver, or

5. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver.

G. Services not specifically listed or defined by the Division of Medicaid are not covered, unless part of the expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

H. The Division of Medicaid does not reimburse for any exclusion listed elsewhere in the Miss. Admin. Code Title 23, Mississippi Medicaid Bulletins, or other Mississippi Medicaid publications.

Source: 29 USC § 1185b; 42 USC § 1396n; Miss. Code Ann. §§ 43-13-121, 43-47-7; SPA 2011-006, 2012-001; 30 Miss. Admin. Code Part 2820, Rule 1.2 S.2).

History: Revised Miss. Admin. Code Part 200, Rule 2.2.F. eff. 06/01/2016; Added a New Miss. Admin. Code Part 200, Rule 2.2 A.2.a)-d) and C.9., reformatted and revised Miss. Admin. Code Part 200, Rule 2.2 including removing duplicative language, effective 12/01/2015; Added Miss. Admin. Code Part 200, Rule 2.2 A. 36. and Rule 2.2 D. eff. 10/01/2014; Rule 2.2 B. and 2.2 C. added to correspond with approved SPA 2011-004 and 2011-006 effective 10/01/11 and SPA 2012-001 effective 06/01/2012.

Rule 2.3: Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles

A. A state is not required to cover any Medicare cost sharing expenses related to payment for deductibles, coinsurance, or co-payments for dual eligibles which exceed what the state's Medicaid program would have paid for such service for a beneficiary who is not a dual eligible. When a state's payment for Medicare cost-sharing for a dual eligible is reduced or eliminated the Medicare payment plus the state's Medicaid payment is considered payment in full. The dually eligible beneficiary cannot be billed the difference between the provider's charge and the Medicare and Medicaid payment.

B. Medicare Part A crossover nursing facility, hospice and home health agency claims for dually eligible beneficiaries are reimbursed as listed below:

1. The Medicaid reimbursement combined with the Medicare reimbursement will not exceed what the Mississippi Medicaid program would have paid for such service for a

beneficiary who is not dually eligible.

2. All service limits will be applied to beneficiaries who are dually eligible when reimbursement is made toward covered services with service limits. Once the service limits are reached each state fiscal year, no additional payments will be made for these services.

3. All providers must accept the Medicare and Medicaid payment as payment in full. The provider is prohibited from billing the beneficiary the balance between the provider's charge and Medicare and Medicaid payments.

C. For Medicare Part A crossover claims from hospitals (inpatient) and all Part B crossover claims, Medicaid reimburses the full deductible and coinsurance amount for dual eligibles.

Source: Miss. Code Ann. § 43-13-121; Balanced Budget Act of 1997

Part 200 Chapter 3: Beneficiary Information

Rule 3.1: Coverage of Eligibility Groups

A. The Division of Medicaid covers full Medicaid benefits for the following eligibility groups:

1. Individuals receiving Supplemental Security Income (SSI),

2. Certain former SSI recipients specified in federal and/or state law,

3. Parents and caretaker relatives of minor children living at home whose income is at or below the applicable limit,

4. Pregnant beneficiaries,

5. Infants born to Medicaid eligible mothers,

6. Children up to age nineteen (19) whose household income is at or below the applicable limit,

7. Children receiving adoption assistance or foster care maintenance payments,

8. Former foster care children under twenty-six (26) years old who received Medicaid at age eighteen (18) prior to being released from foster care by the Department of Human Services (DHS),

9. Institutionalized beneficiaries,

10. Disabled children living at home,

11. Working disabled, and

12. Certain women with breast and/or cervical cancer screened by the Mississippi State Department of Health (MSDH).

B. The Division of Medicaid covers:

1. Medicare Part A premiums for certain qualified working disabled persons,

2. Medicare Part B premiums for Specified Low Income Beneficiaries (SLMB) and Qualified Individuals (QI),

3. Medicare Part A and B cost sharing, including premiums, deductibles, coinsurance and any copays, for Qualified Medicare Beneficiaries (QMB) regardless of whether or not the service provided is covered by the Division of Medicaid, and

4. Medicare Part C coinsurance and deductible for beneficiaries in applicable Categories of Eligibility (COE).

C. The Division of Medicaid covers full Medicaid benefits for beneficiaries receiving Home and Community-Based Services (HCBS) and additional services as specified in Miss. Admin. Code Part 208 through the following 1915(c) waivers:

1. Assisted Living (AL) Waiver,

2. Elderly and Disabled (E&D) Waiver,

3. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver,

4. Traumatic Bain/Spinal Cord Injury (TBI/SCI) Waiver, and

5. Independent Living (IL) Waiver.

D. The Division of Medicaid covers those services specified in Miss. Admin. Code Part 221 for beneficiaries enrolled in the 1115(a) Family Planning Waiver (FPW).

E. The Division of Medicaid covers full Medicaid benefits for beneficiaries enrolled in the 1115(a) Healthier Mississippi Waiver (HMW) excluding the following:

1. Long-term care services, including, but not limited to:

a) Nursing facility,

b) Swing bed,

c) Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or

d) Services provided by an HCBS waiver.

2. Maternity and newborn care services.

F. The Division of Medicaid covers emergency services, excluding transplant services, for aliens who meet the requirements of Miss. Admin. Code Part 100, Rule 8.10.

Source: 42 USC § 1396a(a)(10)(E)(i); 42 USC § 1396a(a)(17); 42 USC § 1396d(p)(3); 42 CFR § 435.116; Miss. Code Ann. §§ 43-13-115, 43-13-121; SPA 13-0019.

History: Revised to correspond with SPA 13-0019 (eff. 01/01/14) and Healthier Mississippi Waiver (eff. 01/01/2015) and eff. 04/01/2016; Removed 3.c.2.d.v) to reflect CMS waiver (eff. 04/01/2004) eff. 12/01/2013.

Rule 3.2: Newborn Child Eligibility

A. Newborn to a Medicaid-eligible Mother

1. Newborn children may become Medicaid beneficiaries effective on his/her date of birth.

2. Infants born to Medicaid–eligible mothers are eligible for the first (1st) year of the infant's life provided the mother was eligible during her pregnancy and the child lives with her.

3. Newborns adopted at birth or released for adoption at birth are eligible for the first (1st) year of the newborn's life. Termination of parental rights requires a notice of approval be issued by the Division of Medicaid to the child's place of residence.

4. Newborn Who Is Not Medicaid-eligible at the Time of Birth Application must be made to the appropriate Medicaid regional office. If eligibility criteria are met and there are unpaid bills, eligibility may be established for as much as three (3) months prior to the date of application.

Source: Miss. Code Ann. § 43-13-121; 42 USC 1396A(e)(4)-(12)

Rule 3.3: Beneficiary Retroactive Eligibility

A. Retroactive eligibility is available to individuals during all or part of a three (3) month period before application for Medicaid. Applicants must meet financial and need requirements.

B. Medicaid covered services paid for by a beneficiary during the three (3) month period may be refunded at the option of the provider of services and billed to Medicaid when eligibility is validated in accordance with timely filing requirements.

C. Services requiring prior authorization provided during the period of retroactive eligibility cannot be denied due to failure to secure prior authorization. Prior authorization for such services must be obtained before reimbursement is made.

Source: Miss. Code Ann. § 43-13-121

Rule 3.4: Eligibility for Medicare and Medicaid

Medicare is the primary payor for a beneficiary who is both Medicare and Medicaid eligible and has four (4) parts:

A. Medicare Part A

1. The Division of Medicaid pays for the Medicare Part A premium through a "buy-in" process for individuals who have income that does not exceed 100% of the poverty level and are classified as Qualified Medicare Beneficiaries (QMB) and QMB-dual recipients, meaning the recipient is dually eligible as both a QMB and has full Medicaid through other coverage.

2. The Centers for Medicare and Medicaid Services (CMS) and the Division of Medicaid work jointly to ensure that all eligible individuals are included in the "buy-in" process for Medicare coverage. Persons who may be Medicaid-eligible should apply at the appropriate certifying agency.

B. Medicare Part B

1. The Division of Medicaid pays the Medicare Part B premium through a "buy-in" agreement with the Social Security Administration (SSA) for all Medicaid eligible individuals who also qualify for Medicare Part B. CMS and the Division of Medicaid work jointly to ensure that all eligible individuals are included in the "buy-in" process.

2. The Division of Medicaid also pays Part B premiums for specified low-income Medicare beneficiaries (SLMBs) and certain qualifying individuals (QIs). SLMBs and QIs do not receive a Medicaid ID card or any other benefits.

C. Medicare Part C (Medicare Advantage Plans)

1. The Division of Medicaid pays for the Medicare Part C coinsurance and deductible for beneficiaries in applicable Categories of Eligibility (COE).

2. For purposes of reimbursement, co-payments charged by a Medicare Part C plan are considered to be coinsurance.

D. Medicare Part D (Medicare Prescription Drug Plan)

1. When Medicaid beneficiaries have both Medicare and Medicaid coverage, pharmacy providers are required to bill Medicare for drugs covered by that program.

2. The Division of Medicaid considers the Medicare payment as payment in full for Medicare Part D pharmacy claims.

Source: 42 U.S.C. § 1396a; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/2015.

Rule 3.5: Verification of Eligibility

A. It is the responsibility of the Medicaid provider to verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service. Evidence of eligibility is demonstrated by the Medicaid identification card issued to each Medicaid eligible member in a family. A beneficiary is expected to present his/her Medicaid identification card when services are rendered.

B. A picture ID such as a driver's license or school ID card is required to confirm the identity of the person presenting for service. If no picture ID is available, verification must be made by verifying the social security number and/or date of birth.

C. If it is found that the person presenting for services was not the Medicaid beneficiary to whom the card was issued, the provider is responsible for refunding any monies paid by Medicaid to the provider for those services provided.

D. A plastic identification card is not a guarantee of Medicaid eligibility.

E. Medicaid providers may verify beneficiary eligibility status by one (1) of the following methods:

    1. Calling the Automated Voice Response System (AVRS),

    2. Using the point of service eligibility verification system, or

    3. Calling the fiscal agent.

Source: Miss. Code Ann. § 43-13-121

Rule 3.6: Freedom of Choice of Providers

A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Any individual eligible for medical assistance, including drugs, may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required.

B. Providers of Medicaid services agree to comply with this section of the Act in the Provider Agreement. This means that providers may not take any action to deny freedom of choice to individuals eligible for Medicaid by using systems, methods, or devices which would require persons eligible for Medicaid to obtain a service from a particular provider.

C. This also means that providers may not require any individuals eligible for Medicaid to sign a statement of waiver, if such statement would, in any manner, deny or restrict that individual's free choice of a provider of any services for which the individual may be eligible. Providers cannot use any method of inducement, including free transportation, refreshments, cash or gifts, to influence a beneficiary to select a certain provider.

D. Exception: Under a federal waiver or approved State Plan amendment, freedom of choice may be restricted for individuals enrolled in a managed care program. These individuals are required to receive primary care from a primary care provider (PCP) and have specialty care prior authorized by the PCP.

Source: Miss. Code Ann. § 43-13-121; Social Security 1902(a)(23)

Rule 3.7: Beneficiary Cost Sharing

A. The Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services, such as enrollment fee payments, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges.

B. The Division of Medicaid applies co-payments to the following beneficiary group or services.

1. Beneficiary Group/Service and Co-Payment Amounts are as follows:

a) Ambulance is $3.00 per trip,

b) Ambulatory Surgical Center is $3.00 per visit,

c) Dental is $3.00 per visit,

d) Durable Medical Equipment (DME), Orthotics, Prosthetics (excludes medical supplies) is up to $3.00 per item (varies per State payment for each item). Items priced as listed:

1) $10.00 or less: co-payment is $0.50,

2) $10.01 - $25.00: co-payment is $1.00,

3) $25.01 - $50.00: co-payment is $2.00,

4) $50.01 or more: co-payment is $3.00.

e) Federally Qualified Health Center (FQHC) is $3.00 per visit,

f) Home Health is $3.00 per visit,

g) MS State Department of Health is $3.00 per visit,

h) Hospital Inpatient is $10.00 per day,

i) Hospital Outpatient is $3.00 per visit,

j) Physician (office, home, emergency room, ophthalmological) is $3.00 per visit,

k) Prescriptions are $3.00 per prescription, including refills,

l) Vision is $3.00 per pair of eyeglasses, and

m) Rural Health Clinic (RHC) is $3.00 per visit.

2. In the absence of knowledge or indication to the contrary, the provider may accept the beneficiary's assertion that he/she cannot afford to pay the cost sharing co-payment amount. The provider may not deny services to any eligible Medicaid individual due to the individual's inability to pay the cost of the co-payment. However, the individual's inability to pay the co-payment amount does not alter the Medicaid reimbursement amount for the claim, unless the beneficiary or service is excluded from the co-payment rule.

3. Collecting the co-payment amount from the beneficiary is the responsibility of the provider. In cases of claim adjustments, the responsibility of refunding or collecting additional cost sharing co-payments from the beneficiary remains the responsibility of the provider.

C. The following beneficiary groups or services are exempt from payment of the co-payments. When the beneficiary or service is exempt from the co-payment, the applicable co-payment exception code must be indicated on the claim. If the exception code is not present, a co-payment will be deducted.

1. Infant

2. Children Under Eighteen (18)

3. Pregnant Women

a) Prenatal Care

b) Labor and Delivery

c) Routine Postpartum Care: The immediate postpartum period which begins on the last day of the pregnancy and extends through the end of the month in which the sixty (60) day period following termination of the pregnancy.

d) Complications of pregnancy likely to affect the pregnancy, such as hypertension, diabetes, urinary tract infection, and services furnished during the postpartum period for conditions or complications related to the pregnancy.

4. Nursing Facility

   a) Services furnished to any individual who is a resident in a nursing facility, ICF/MR or PRTF.

   b) This exception code is applicable to the facility charges, professional fees, and pharmaceuticals.

5. Family Planning - applicable to family planning services and supplies.

6. Emergency Services

   a) Services performed in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

      1) Placing the patient's health in serious jeopardy,

      2) Serious impairment to bodily functions, or

      3) Serious dysfunction of any bodily organ or part.

   b) The documentation in the medical records must justify the service as a true emergency.

7. Chemotherapy Drug Therapy for Cancer

   a) Applicable only to facility charges for chemotherapy services performed in the outpatient department of the hospital. Treatment of cancer with drugs that can destroy cancer cells.

   b) This exception code does not apply to the physician charges.

8. Radiation Therapy

   a) Applicable only to facility charges for radiation therapy performed in the outpatient department of the hospital.

      1) Therapeutic radiology services.

      2) Non-diagnostic in nature

3) Includes therapy by injection or ingestion of radioactive substances.

b) This exception code does not apply to physician charges.

9. Laboratory/Laboratory Pathology

a) Applicable only to facility charges when beneficiary is only receiving laboratory services in the outpatient department of the hospital.

1) Diagnostic and routine clinical laboratory tests.

2) Diagnostic and routine laboratory tests on tissues and cultures.

b) This exception code does not apply to physician charges.

10. Dialysis Facility - No Exception Code Required

a) Hospital based or freestanding dialysis facility charges are exempt from co-payment. However, the provider is not required to indicate an exception code when billing the claim.

b) This exception does not apply to physician charges.

D. For beneficiaries covered under a Home and Community Based Services Waiver, the co-payment is exempt if the service is being paid through the waiver. If services are being paid through regular Mississippi Medicaid State Plan benefits, the co-payment is applicable unless exempt by one (1) of the beneficiary groups or services listed above.

Source: Social Security Act § 1902(a)(14); 42 CFR § 447.50 – 447.59; Miss. Code Ann. §§ 43-13-117(49), 121.

History: Revised Miss. Admin. Code Part 200, Rule 1.2.B.h) to correspond with SPA 2012-008 (eff. 10/01/2012) eff. 05/01/2014.

Rule 3.8: Charges Not Beneficiary's Responsibility

A. Providers who have agreed to be Medicaid providers are expected to bill Medicaid for Medicaid covered services and accept Medicaid payment as payment in full.

B. Some charges are not the beneficiary's responsibility and must not be billed to the beneficiary. Those included, but not limited to:

1. The beneficiary may not be billed for Medicaid covered services except in the following situations:

a) If the person is ineligible; or

b) If person has chosen to receive and agreed to pay for care not covered by the Medicaid program.

2. The beneficiary may not be held liable for a claim or portion of a claim when a determination that the services were not medically necessary is made based on the professional opinion of appropriate and qualified persons performing peer review of Medicaid cases.

3. The beneficiary may not be held liable for billed charges above the Medicaid maximum allowable.

4. The beneficiary may not be billed for claims denied because of provider errors. It is the responsibility of the provider to file claims in a timely manner, to correct errors, and to provide essential information necessary to process the Medicaid claim.

5. The beneficiary may not be billed for claims denied because of errors made by DOM, the fiscal agent, or due to changes in federal or state mandates.

6. The beneficiary may not be billed for services denied because a provider failed to request required authorization for a service or failed to meet procedural requirements.

7. For dual eligibles, the beneficiary may not be billed for the portion of a claim remaining after Medicare and Medicaid have paid.

8. The beneficiary may not be billed for the completion and submission of a Medicaid claim form. If the provider agrees to accept the patient as a Medicaid beneficiary and agrees to bill Medicaid for the services rendered, the beneficiary may not be charged for this billing procedure.

9. The beneficiary may not be billed for telephone calls or missed/cancelled appointments.

10. The beneficiary may not be charged for the cost of copying medical records.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 447.15

Rule 3.9: Charges Beneficiary's Responsibility

A. Medicaid beneficiaries may be charged for the following:

1. The beneficiary is responsible for all expenses for non-covered services, such as services that are not covered under the scope of the Medicaid program, or services received in excess of program benefit limitations. The beneficiary is responsible for services received during a period of ineligibility.

2. Any applicable cost-sharing amount applied by the Medicaid program is the responsibility of the beneficiary.

3. Beneficiaries enrolled in managed care programs that insist upon receiving services that are not authorized by the primary care provider (PCP) may be required to pay for such services. For example, if the beneficiary seeks care in a hospital emergency room (ER) for services that can be provided in the PCP's office and are not authorized by the PCP for treatment in the ER; the beneficiary may be responsible for payment of the ER services beyond the medical assessment. The beneficiary sees a specialist for services that are not excluded from managed care and are not considered emergent/urgent, and the PCP has not made the referral or denies authorization; the beneficiary may be responsible for payment of such services.

4. The beneficiary, or responsible adult, is held accountable and responsible for knowingly allowing or continuing to allow an unauthorized person to use a Medicaid card or beneficiary's identity to obtain benefits otherwise not allowed. Any charges to or payments by the Division of Medicaid for services requested and/or received in an attempt to defraud the provider of services and/or Medicaid are billable to the cardholder or his/her responsible party, or the imposter.

B. This list is not all-inclusive.

Source: Miss. Code Ann. § 43-13-121

Part 200 Chapter 4: Provider Enrollment

Rule 4.1: Definitions

A. Providers: All health care entities including individual practitioners, institutional providers, and providers of medical equipment or goods related to care that are currently enrolled in the Medicaid program.

B. National Provider Identifier (NPI): A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers as noted in 45 CFR 162. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA.

C. Sole Proprietor: A Sole Proprietor is a form of business in which one (1) person owns all of the assets of the business and is solely liable for all debts on an individual basis. As a result of the National Provider Identifier (NPI) requirements, a Sole Proprietor must apply for their NPI as individuals. Medicaid will no longer issue a group number to an individual effective with the adoption of this rule revision. The subpart concept does not apply to a sole proprietorship, even one (1) with multiple locations, because the sole proprietorship is not an organization as defined in the final NPI Rule. An individual Medicaid provider number and the appropriate NPI issued by the Centers for Medicare & Medicaid Services (CMS) are

entered into the Medicaid system with the individual's social security number (SSN); and if applicable, the Federal Employer Identification Number (FEIN) assigned to it. If this number is used as a Medicaid provider billing number, income or earnings information are reported to the IRS for this SSN or FEIN, as applicable. Deferred compensation is only available via a sole proprietor's SSN.

D. Group/Organization: A Group/Organization provider is not an individual/sole proprietor. This includes hospitals, long-term care facilities, laboratories, home health agencies, ambulance companies, and group practices; suppliers of durable medical equipment or pharmacies. Any subpart of the group/organization must apply for a different Medicaid provider number as determined by the provider type per Medicaid rule. A group provider requesting individual providers/servicing providers to be affiliated to their billing provider number must be approved Medicaid providers. For monies to be reported to the IRS on its Tax Identification, the group provider should be the biller, unless otherwise restricted by the Division of Medicaid. Group providers that have various servicing locations should apply to Medicaid to become a provider according to their enumeration application with CMS. The provider should also apply to Medicaid to become a provider according to the conduct of their own standard transactions and as required by the Division of Medicaid's program rules.

E. Effective Date: The earliest date a provider may begin billing for services.

F. Retro Eligibility: Retro eligibility is defined as a request of a date of eligibility from a Medicaid provider applicant or a currently enrolled Medicaid provider for consideration of approval of a Medicaid provider number for past dates of service. The Division of Medicaid has the sole discretion to determine the final retro eligibility effective date.

G. Officer: Any person whose position is listed as being that of an officer in the provider's "articles of incorporation" or "corporate bylaws" or anyone who is appointed by the board of directors as an officer in accordance with the provider's corporate bylaws.

H. Director: A member of the provider's "board of directors." It does not necessarily include a person who may have the word "director" in his/her job title. Moreover, where a provider has a governing body that does not use the term "board of directors," the members of that governing body will still be considered "director". Thus, if the provider has a governing body title "board of trustees," as opposed to "board of directors," the individual trustees are considered "directors" for Medicaid enrollment purposes.

I. Managing/Directing Employee: A managing/directing employee may be a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the entity, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the entity.

J. Authorized Official: An appointed official to whom the organization has granted the legal authority to enroll it in the Medicaid program, to make changes or updates to the organization's status in the Medicaid program, and to commit the organization to fully abide

by the statutes, regulations, and program instructions of the Medicaid program. Example include: chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner.

K. Delegated Official: An individual who is delegated by an authorized official of the authority to report changes and updates to the entity's enrollment record. A delegated official must be an individual with an "ownership or control interest," or be a W-2 managing employee of the entity. Documentation in the application or as an attachment must be included with the application. A change of a delegated official will only be made to the file with the appropriate documentation signed by a documented authorized official.

L. Majority Interest: Ownership interest greater than fifty percent (50%) of the voting interest in a business enterprise.

Source: Miss. Code Ann. § 43-13-121; 45 CFR 162; 45 CFR 160.103; 69 FR 3434; 42 CFR § 455.440

Rule 4.2: Conditions of Participation

A. Providers must comply with the following conditions to participate in the Mississippi Medicaid program:

1. All providers must complete provider agreements and/or provider enrollment application packages per the requirements of the Division of Medicaid.

2. The provider must be licensed and/or certified by the appropriate federal and/or state authority, as applicable.

3. Agree to furnish required documentation of the provider's business transactions per 42 CFR §455.105(b) to the Division of Medicaid or to the Department of Health & Human Services (HHS) within thirty-five (35) days of the date on the request.

4. Agree to abide by the requirements of 42 CFR, PARTS 405, 424, 438, 447, 455, 457, 498, and 1007 of the Affordable Care Act (ACA) concerning the following:

   a) Provider Screening Procedures (42 CFR §424.518) which based on the category of the provider type can include license verifications; database checks of eligible professionals, owners, managing employees etc; fingerprinting and criminal background checks; unscheduled or unannounced site visits based on required screening rules.

   b) Provider Application Fees (42 CFR §424.514).

   c) Temporary Moratorium (42 CFR §424.570).

   d) Provider Termination (42 CFR §455.416).

e) Payment Suspensions (42 CFR §455.23).

5. The provider agrees to review, complete and submit a completed re-validation document as required by the policies of Division of Medicaid. All providers must undergo a revalidation screening process at least once every five years in accordance with 42 CFR §455.414.

6. All professional and institutional providers participating in the Medicaid program are required to keep records that fully disclose the extent of services rendered and billed under the program. These records must be retained for a minimum of five (5) years in order to comply with all federal and state regulations and laws. When there is a change of ownership or retirement, a provider must continue to maintain all Medicaid beneficiary records, unless an alternative method for maintaining the records has been established and approved by the Division of Medicaid. Upon request, providers are required to make such records available to representatives of the Division of Medicaid and others as provided by law in validation of any claims. The Division of Medicaid staff shall have immediate access to the provider's physical location, facilities, records, documents, and any other records relating to medical care and services rendered to beneficiaries during regular business hours. Providers must maintain records as indicated in Part 200 Chapter 1, Rule 1.3, Maintenance of Records.

7. The provider must comply with the requirements of the Social Security Act and federal regulations concerning: (a) disclosure by providers of ownership and control information; and (b) disclosure of information by a provider's owners of any persons with convictions of criminal offenses against Medicare, Medicaid, or the Title XX services program. If the Division of Medicaid ascertains that a provider has been convicted of a felony under federal or state law for an offense that the Division of Medicaid determines is detrimental to the best interests of the program or of Medicaid beneficiaries, the Division of Medicaid may refuse to enter into an agreement with such provider, or may terminate or refuse to renew an existing agreement.

8. The provider must agree to accept payment for Medicaid covered services in accordance with the rules and regulations for reimbursement, as declared by the Secretary of Health and Human Services and by the state of Mississippi, and established under the Mississippi Medicaid program.

9. The provider must agree to accept, as payment in full, the amount paid by the Medicaid program for all services covered under the Medicaid program within the beneficiary's service limits with the exception of authorized deductibles, co-insurance, and co-payments. All services covered under the Medicaid program will be made available to the beneficiary. Beneficiaries will not be required to make deposits or payments on charges for services covered by Medicaid. A provider cannot pick and choose procedures for which the provider will accept Medicaid. At no time shall the provider be authorized to split services and require the beneficiary to pay for one type of service and Medicaid to pay for another. All services provided to Medicaid beneficiaries will be billed to

Medicaid only where Medicaid covers said services, unless some other resources, other than the beneficiary or the beneficiary's family will pay for the service.

10. For most medical services rendered, the provider must agree to take all reasonable measures to determine the legal liabilities of third parties including Medicare and private health insurance to pay for Medicaid covered services, and if third party liability is established, to bill the third party before filing a Medicaid claim. Exceptions to this rule are outlined in Part 306, Third Party Recovery. For the purpose of this provision, the term "third party" includes an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the medical costs of injury, disease or disability of a Medicaid beneficiary and to report any such payments as third parties on claims filed for Medicaid payment.

11. Participating providers of services under the Medicaid program, i.e., physicians, dentists, hospitals, nursing facilities, pharmacies, etc., must comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age of Discrimination Act of 1975. Under the terms of these Acts, a participating provider or vendor of services under any program using federal funds is prohibited from making a distinction in the provision of services to beneficiaries on the grounds of race, color, national origin or handicap. This includes, but is not limited to, distinctions made on the basis of race, color, national origin, or handicap with respect to: (a) waiting rooms, (b) hours of appointment, (c) order of seeing patients, or (d) assignment of patients to beds, rooms or sections of a facility. The Division of Medicaid is responsible for routine and complaint investigations dealing with these two (2) Acts.

12. Participating providers are prohibited from making a distinction in the provision of services to Medicaid beneficiaries on the grounds of being Medicaid beneficiaries. This includes, but is not limited to, making distinctions with regard to waiting rooms, hours of appointment, or order of seeing patients, third party sources (pursuant to federal regulations), and quality of services provided, including those provided in a facility.

13. The provider must agree that claims submitted will accurately reflect both the nature of the service and who performed the service.

14. The provider must maintain a copy of the Administrative Code for Mississippi Medicaid and all revisions.

15. Participating providers must be eligible to participate in the Medicaid program as determined by DHHS-Office of Inspector General (DHHS-OIG). Certain individuals and entities are ineligible to participate in the Medicaid program on the basis of their exclusion as sanctioned by DHHS-OIG by authority contained in Sections 1128 and 1156 of the Social Security Act. The effect of exclusion is that no program payment will be made for any items or services, including administrative and management services, furnished, ordered or prescribed by an excluded individual or entity under the Medicare, Medicaid, and State Children's Health Insurance Programs during the period of the exclusion. Program payments will not be made to an entity in which an excluded person

is serving as an employee, administrator, operator, or in any other capacity, for any services including administrative and management services furnished, ordered, or prescribed on or after the effective date of the exclusion. In addition, no payment may be made to any business or facility that submits bills for payment of items or services provided by an excluded party. The exclusion remains in effect until the subject is reinstated by action of the DHHS-OIG. It is the responsibility of each Medicaid provider to assure that no excluded person or entity is employed in a capacity which would allow the excluded party to order, provide, prescribe, or supply services or medical care for beneficiaries, or allow the excluded party to hold an administrative, billing, or management position involving services or billing for beneficiaries.

B. Out of State Providers - Out of state providers must comply with all applicable program policies required by the Division of Medicaid and all applicable provider enrollment criteria in this Part. Home state requirements may not be substituted for Mississippi requirements. Retro-eligibility for emergency services must meet all provider enrollment criteria and the program rules.

Source: Miss. Code Ann. § 43-13-121; 43-13-118; 42 CFR § 455.412; 42 CFR § 455.105(b); 42 CFR § 405, 424, 438, 447, 455, 457, 498, 1007; 42 CFR § 424.518; 42 CFR § 424.514; 42 CFR § 424.570; 42 CFR § 455.416; 42 CFR § 455.23; 42 CFR § 455.414; 42 CFR § 455.106

Rule 4.3: Change of Ownership

A. A change of ownership of a provider/facility as defined by the Division of Medicaid includes, but is not limited to: intervivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions or other comparable arrangements whenever the person or entity acquires or controls a majority interest of the facility or service. The new owner, upon consummation of the transaction effecting the change of ownership, shall, as a condition of participation, assume liability, jointly and severally, with the prior owner for any and all amounts that may be due to the Medicaid program.

B. The new ownership agreement shall be subject to any restrictions, conditions, penalties, sanctions or other remedial actions taken by the Division of Medicaid, the state agency or the federal agency against the prior owner of the facility.

C. The agreement will also remain subject to all applicable statutes and regulations, including, but not limited to:

1. Any statement of deficiencies cited by the State Agency that are not in substantial compliance, including any existing plan of correction,

2. Any expiration date,

3. Compliance with applicable health and safety standards,

4. Compliance with ownership and financial disclosure requirements, and

5. Compliance with civil rights and the rights of individuals with developmental disability requirements.

D. A provider/ facility that undergoes a change of ownership must:

1. Notify the Division of Medicaid in writing of the effective date of the change.

2. Submit a Provider Enrollment Change of Ownership application and provider agreement to the fiscal agent. Upon approval of the application by the Division of Medicaid, the provider file is updated with the new owner's information. The provider number is not changed; however, a new taxpayer identification segment is established for the new owner.

E. When there is a change of ownership or retirement/closure, a provider must continue to maintain all Medicaid beneficiary records, unless an alternative method for maintaining the records has been established in writing, and approved by the Division of Medicaid as required by HIPPA.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 489.18; 42 CFR § 455.104

Rule 4.4: Termination of Provider Agreement

A. Pursuant to 42 CFR 489.55, payment is available for up to thirty (30) days after the effective date of termination for inpatient hospital services, nursing facility services, psychiatric residential treatment facility services, ICF/MR facility services, home health services, and hospice services furnished under a plan established before the effective date of termination.

B. When the Division of Medicaid terminates a provider agreement, federal regulations allow payments to continue for up to thirty (30) days to permit time for an orderly transfer of Medicaid beneficiaries. The facility must notify all Medicaid beneficiaries who are residents, families, and/or sponsors in writing within forty-eight (48) hours of notice of termination of Medicaid participation. The facility must also submit to the Division of Medicaid a current list of Medicaid beneficiaries who are residents along with the name, address and telephone number, when available of the family and/or the sponsor and the beneficiary's attending physician. Medicaid staff also notifies the beneficiaries, families and/or sponsors and can assist the families and the facility in making other facility arrangements for the beneficiaries.

C. Reinstatement may be granted after a provider has been terminated by the licensing or certification board, Office of Inspector General, CMS, or Division of Medicaid when conditions of reinstatement have been satisfied by the sanctioning entity. Notification of re-instatement from the appropriate entity must be provided with an application for re-instatement to participate in the Medicaid program. The Division of Medicaid has the sole discretion to determine the final retro-eligibility effective date.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 489.55; 42 CFR § 489.57;

Rule 4.5: Licensure Expiration

A. Each provider who chooses to participate in the Mississippi Medicaid program must maintain current information as required by the Division of Medicaid such as licensure, permits, and/or certification from their governing board at all times while enrolled as a Medicaid provider. Current licensure information must be on file with the Division of Medicaid or the fiscal agent. At any time that the license, permit, or certification of the provider, or the license, permit, or certification of an employee of the provider upon which provider eligibility results from, is suspended, revoked, surrendered, or expired, or the person ceases to be an agent/employee of the provider, the provider is ineligible to provide services to Medicaid beneficiaries and file claims for services.

B. If a provider's license has expired and his/her Medicaid provider number has been closed for less than one year, the provider must submit a copy of his/her current license and update other information that may have changed in order for his/her Medicaid provider number to be re-opened. If the provider's Medicaid provider number has been closed for more than one year, the provider must re-enroll as a Medicaid provider.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 455.412; 42 CFR § 455.450

Rule 4.6: Advertising by Provider

A. No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet, or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems, the word "Medicaid" or "Division of Medicaid", or "Medicaid program", or "Mississippi Medicaid", or "Mississippi Division of Medicaid" in a manner which such person knows or should know would convey, or in a manner which reasonably could be interpreted or construed as conveying, the false impression that such item is approved, endorsed, or authorized by the Mississippi Division of Medicaid.

B. Providers may list Medicaid as a pay source they will accept, e.g., most third-party insurance, Medicare, and Medicaid accepted.

Source: Miss. Code Ann. § 43-13-121

Rule 4.7: Change of Tax ID

A. Providers who change tax identification numbers under circumstances other than those described in Rule 4.3, Change of Ownership and Rule 4.8, Requirements for All Providers must:

    1. Request the change and the effective date of change in writing,

    2. Submit a signed original W-9 form,

3. Submit verification of the tax identification number on a preprinted document from the Internal Revenue Service (IRS), and

4. Submit verification of the National Provider Identifier (NPPES confirmation).

B. The provider does not need to submit a Provider Enrollment Change of Ownership application. The provider number is not changed; however, a new taxpayer identification segment will be established.

Source: Miss. Code Ann. § 43-13-121

Rule 4.8: Requirements for All Providers

A. All providers are required to submit the following documentation:

1. Mississippi Medicaid Provider Enrollment Application

   a) Individuals and Sole Proprietor applications must be signed by the individual provider.

   b) Business/Entity applications must be signed by the Authorized Official.

2. Medical Assistance Participation Agreement (Provider Agreement) - Two (2) original agreements required.

3. Direct Deposit Authorization/Agreement Form

   a) Include a copy of a voided check, deposit slip, or letter from the bank noting the account number and transit routing number.

   b) Starter checks and counter deposit slips are not acceptable.

4. W-9

   a) Name on the W-9 should match the written confirmation from the IRS confirming your Tax Identification Number with the legal business name/legal name as noted in Section 1 of the Mississippi Medicaid Provider Enrollment Application. Note: This information is needed if enrolling as a professional corporation or limited liability company, or enrolling as a sole proprietor using the Employer Identification Number.

   b) Name on the W-9 should match the documentation to confirm the social security number verification for any provider enrolling as an individual sole proprietor.

5. EDI Provider Agreement and Enrollment Form is required if the intent is to submit electronically.

6. Civil Rights Compliance Information Request Packet including the following:

   a) A copy of the provider's Nondiscrimination Policy.

   b) A copy of the provider's Limited English Proficiency Policy.

   c) A copy of the provider's Sensory and Speech Impairment Policy.

   d) A copy of the provider's Notice of Program Accessibility Policy.

   e) Statement of compliance, signature required. A copy of the DHHS Office of Civil Rights letter of compliance may be submitted in lieu of completing the Division of Medicaid's compliance packet.

   f) A copy of the provider's published newspaper article stating the provider's non-discrimination policy, required only for healthcare facilities.

Source: Miss. Code Ann. § 43-13-121

Rule 4.9: Group Providers

A. Business/ Entity enrolling as a group of providers so that all monies received shall report to the tax identification number of the business. The following criteria must apply:

   1. The enrolling provider has a tax identification number.

   2. The enrolling provider is not a sole proprietor.

   3. The enrolling provider employs and notes an active individual servicing provider within their application.

B. Providers enrolling as a group must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 for all providers, the requirements for their individual provider type requirements outlined in the assigned chapters of this code and the requirements listed below for group providers:

   1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

   2. Written confirmation from the IRS confirming your tax identification number and legal business name.

   3. CLIA certificate and CLIA Certification form, if applicable.

   4. At least one active individual provider is linked to the enrolling group.

C. This rule is applicable to the following provider types:

1. CRNA,
2. Nurse Practitioner,
3. Dentist,
4. Physician Assistant,
5. Dietician/ Nutritionist,
6. Occupational therapist,
7. Physical therapist,
8. Speech Therapist,
9. Optometrist,
10. Audiologist,
11. Nurse Midwife,
12. Pharmacist Disease Management,
13. Physician,
14. Osteopath (DO),
15. Chiropractor,
16. Podiatrist,
17. Psychologist, and
18. Licensed Certified Social Worker.

Source: Miss. Code Ann. § 43-13-121

Rule 4.10: 340B Providers

A. The Division of Medicaid defines a 340B provider as a nonprofit healthcare organization that meets the requirements of, and is considered to be, a covered entity under Section 340B of the Public Health Service Act which has elected to enroll in the 340B program.

B. [Reserved]

C. Covered 340B drugs, as found in section 1927 (k)(2) of the Social Security Act, include the following outpatient drugs:

1. FDA-approved prescription drugs,

2. Over-the-counter (OTC) drugs written on a prescription,

3. Biological products that can be dispensed only by a prescription (other than vaccines), and

4. FDA-approved insulin.

D. Covered entities eligible to participate in the 340B program include, but are not limited to:

1. Health Centers, such as:

a) Federally Qualified Health Centers,

b) Federally Qualified Health Center Look-Alikes, and

c) Tribal/Urban Indian Health Centers.

2. Hospitals, such as:

a) Children's Hospitals,

b) Critical Access Hospitals,

c) Disproportionate Share Hospitals,

d) Free Standing Cancer Hospitals,

e) Rural Referral Centers, and

f) Sole Community Hospitals.

3. Specialized Clinics, such as:

a) Black Lung Clinics,

b) Comprehensive Hemophilia Diagnostic Treatment Centers,

c) Title X Family Planning Clinics,

d) Sexually Transmitted Disease Clinics, and

e) Tuberculosis Clinics.

E. [Reserved]

F. [Reserved]

G. Covered entities participating in the 340B program are prohibited from:

1. Reselling or otherwise transferring discounted outpatient drugs to anyone other than a beneficiary of the covered entity, and

2. Receiving duplicate discounts or rebates.

H. A contract pharmacy, defined by the Division of Medicaid as an agent of a 340B covered entity and ineligible to be a freestanding 340B covered entity, cannot dispense and bill the Division of Medicaid for 340B outpatient drugs for Medicaid beneficiaries.

I. A covered entity found in violation of Miss. Admin. Code Part 200, Rule 4.10.G is liable to the manufacturer of the covered outpatient drug that is the subject of the violation in an amount equal to the reduction in the price of the drug provided under the agreement between the entity and the manufacturer.

J. [Reserved]

K. A covered entity who knowingly or willfully makes, or causes to be made, a false statement, attestation or representation of a material fact in any application and/or form for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws pursuant to Miss. Admin. Code Part 200, Rule 1.3.

Source: Sec. 340B of the Public Health Service Act (Pub. L. 102-585), as amended by the Patient Protection and Affordable Care Act (Pub. L. 111-148), Health Care and Education Reconciliation Act (Pub. L. 111-152) and Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309); 42 U.S.C.A. § 256b(a)(5)(A); Miss. Code Ann. §§ 43-13-117, 121.

History: Removed Miss. Admin. Code Part 200, Chapter 4, Rule 4.10, B, E, F, and J to correspond with the withdrawal of SPA 14-015 eff. 11/01/2014; New Rule eff. 07/01/2014 to correspond with SPA 14-015 (eff. 07/01/2014).

Part 200 Chapter 5: General

Rule 5.1: Medically Necessary

A. The Division of Medicaid will provide coverage for services when it is determined that the medically necessary criteria and guidelines listed below are met.

B. "Medically necessary" or "medical necessity" is defined as health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

   1. Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the patient's medical condition,

   2. Compatible with the standards of acceptable medical practice in the United States,

   3. Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms,

   4. Not provided solely for the convenience of the beneficiary or family, or the convenience of any health care provider,

   5. Not primarily custodial care

   6. There is no other effective and more conservative or substantially less costly treatment service and setting available, and

   7. The service is not experimental, investigational or cosmetic in nature.

C. All Mississippi Medicaid program policies, exclusions, limitations, and service limits, etc., apply. The fact that a service is medically necessary does not, of itself, qualify the service for reimbursement.

Source: Miss. Code Ann. § 43-13-121

Rule 5.2: Consent for Minors

A. Whenever a health care practitioner treats a Medicaid beneficiary, it is the responsibility of the practitioner to have a clear understanding of the legal framework within which care is to be provided to minors.

B. All Mississippi Medicaid providers are responsible for following and documenting compliance with their state law, federal laws, rules, policies, and/or guidance in the delivery of healthcare services to minors.

Source: Miss. Code Ann. § 43-13-121; § 41-41-3; 41-41-7; 41-41-13, 41-41-14; 41-41-13; §7129-81(h)(Supp. 1971)

Rule 5.3: Wellness Program

A. Wellness Services for Adults

1. Annual Health Screening/Physical Examinations for Beneficiaries for Adults (Age 21 and over)

   a) The Division of Medicaid covers annual physical examinations for adults.

   b) The co-payment amount of $3.00 for a physician visit will not be applicable to beneficiaries age eighteen (18) and over.

   c) The annual physical examination will not be counted toward the physician visit limit of twelve (12) per fiscal year.

   d) Appropriate age-related screenings such as those listed below will be reimbursed separately when performed as part of the annual physical exam.

      1) Cardiovascular Screening - The Division of Medicaid will pay for an annual screening of cholesterol, lipids, and triglyceride levels.

      2) Diabetes Screening - An annual screening for diabetes is covered. The screening may include appropriate laboratory and urine studies.

      3) Cervical and Vaginal Cancer Screening - A Pap test and a pelvic exam are covered yearly for women.

      4) Screening Mammography - The Division of Medicaid covers annual mammography for women beginning at age forty (40).

      5) Colorectal Cancer Screening - A yearly screening for occult blood is covered for individuals beginning at age fifty (50), or individuals who are <50 and identified as high risk. A flexible sigmoidoscopy or barium enema is covered every five (5) years, or a colonoscopy is covered every ten (10) years. High risk individuals have one (1) or more of the following colorectal cancer risk factors:

         i) A personal history of colorectal cancer or adenomatous polyps,

         ii) A personal history of chronic inflammatory bowel disease, either Crohn's disease or ulcerative colitis,

         iii) A strong family history of colorectal cancer or polyps including cancer polyps in a 1st degree relative [parent, sibling, or child] younger than sixty (60) or in

two (2) or more 1st degree relatives of any age, or

iv) A known family history of hereditary colorectal cancer syndromes such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colon cancer (HNPCC).

6) Prostate Cancer Screening - A prostate-specific antigen (PSA) blood test and digital rectal examination (DRE) are covered annually for men beginning at age fifty (50). Both screenings are covered annually beginning at age forty-five (45) for men of African-American descent.

7) Bone Density Studies are allowed every twenty-four (24) months for women age sixty-five (65) and older.

8) Vision and Glaucoma Screening eye exams are covered as specified in Part 217 Vision Services.

9) Influenza and Pneumonia Vaccines are covered services for both children and adults under Mississippi Medicaid as outlined in Part 224 Immunizations.

B. Wellness Services for Children (Under Age 21)

1. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, a mandatory service under Medicaid, provides preventive and comprehensive health services for Medicaid eligible children and youths up to age twenty-one (21). Children will access the mandatory periodic screening services through EPSDT providers. EPSDT providers will follow the Division of Medicaid's rules for the EPSDT Program.

2. No co-payment is applicable for services to children under age eighteen (18). The provider must report the co-payment Exception Code "C" on claims for beneficiaries under age eighteen (18). The codes for the periodic screening examinations do not apply toward the physician visit limit per fiscal year.

C. Wellness Services for Dual Eligibles

1. Beneficiaries whose Medicare Part B coverage begins on or after January 1, 2005 will have Medicare coverage for a one time only "Welcome to Medicare" Physical Examination within the first six (6) months of the Medicare coverage.

2. If the beneficiary has both Medicare and Mississippi Medicaid, the routine annual physical examination is not covered under Medicaid if the beneficiary is eligible for or has already received the "Welcome to Medicare" physical examination. The Division of Medicaid will not duplicate benefits for routine annual physical examinations covered by Medicare and will not provide an annual physical examination until twelve (12) months has elapsed from the original effective date of the Medicare Part B coverage. For these instances, it is the sole responsibility of the provider to determine whether Medicare or

Mississippi Medicaid is the appropriate billing source.

3. Dual eligibles whose Medicare Part B effective date is prior to January 1, 2005 will be eligible for the physical examination as outlined above for adults or children.

D. Diagnostic and/or Screening Procedures are radiology and laboratory procedures which are a standard part of a routine adult annual age/gender physical examination or well child periodic screening may be billed by the provider performing the procedure, and coverage will be determined based on current Mississippi Medicaid policies for the individual procedures.

E. Exclusions – Non-Covered

1. Physicals for school, sports, or employment, will not be covered and must not be billed to Medicaid.

2. Physical examinations are not covered for beneficiaries in an institutional setting including those that are in a nursing home or intermediate care facility for the mentally retarded (ICF/MR) or those covered in Family Planning Category of Eligibility or Pregnant Women Category of Eligibility.

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

Rule 5.4: Tobacco Cessation

A. Tobacco Cessation Medications - The following types of tobacco cessation medications are covered in the Mississippi Medicaid program:

1. Over-the-counter nicotine products,

2. Legend or prescription nicotine replacement products,

3. Bupropion Hydrochloride, and

4. Varenicline Tartrate.

B. A physician's prescription will be required for all legend and over-the-counter tobacco cessation medications. Each prescription will count toward the monthly limit.

C. The Division of Medicaid will monitor the beneficiary's utilization of tobacco cessation products for over utilization or misuse; and in instances where there are patterns suggesting over utilization or misuse, the prescribing physician(s) will be contacted for justification of medical necessity.

Source: Miss. Code Ann. § 43-13-121

Rule 5.5: Mobile Medical Units Other Than Independent Diagnostic Treatment Facilities

A. For Division of Medicaid purposes, a mobile medical unit is defined as a self-contained facility or unit that can be moved, towed, or transported from one location to another and provides prevention, screening, diagnostic, and treatment services. This rule and definition excludes services provided in an Independent Diagnostic Treatment Facility (IDTF). See Part 219, Rule 1.3.

B. Mobile medical units must satisfy the following criteria:

1. Must be owned and operated by a current Medicaid provider that has a permanent fixed office location where healthcare services are provided during normal business hours on a daily basis and the fixed office location is available for contact twenty-four (24) hours a day, seven (7) days a week.

2. Must maintain fixed schedule for locations.

3. Must have a separate Medicaid provider number from the permanent fixed office location

4. Must have a physician, physician assistant, dentist, certified audiologist, chiropractor, pharmacist, optometrist, ophthalmologist, or nurse practitioner available to furnish direct patient care services at all times during business hours.

5. Must have a written procedure that includes emergency follow-up care for beneficiaries treated in the mobile medical unit and arrangements for treatment in a facility which is permanently established in the area.

6. Must have communication capabilities which will enable the staff to contact necessary emergency personnel in the event of an emergency.

7. Must ensure the driver of the mobile unit possesses a valid Mississippi driver's license of the appropriate class, the vehicle has a current Mississippi motor vehicle tag, and the vehicle has had a current Mississippi motor vehicle inspection.

8. Must comply with all applicable federal, state, and local laws, regulations and ordinances governing biohazard waste, waste water (black and grey), construction, safety, sanitation, insurance, and zoning.

9. Must be accessible in accordance with the Americans with Disabilities Act.

10. Must have properly functioning sterilization system for sterilizing reusable medical equipment.

11. Must have access to an adequate supply of potable (suitable for drinking) and portable water, including hot water.

12. Must have access to toilets and sanitary hand washing facilities.

C. All service limits apply, and services are subject to all rules and regulations applied by the Mississippi Division of Medicaid for each program area.

D. Documentation

1. Beneficiary records must be maintained at the permanent fixed physical office location and a copy of the beneficiary's record must be maintained in the mobile unit.

2. At a minimum, the records must contain the following on each beneficiary:

a) Date of service,

b) History taken on initial visit,

c) Chief complaint on each visit,

d) Tests, radiographs and results. Radiographs must be legible, contain the beneficiary's name and the date, and must be maintained on file with the beneficiary's records,

e) Diagnosis,

f) Treatment, including prescriptions,

g) Signature or initials of provider after each visit, and

h) Copies of hospital and/or emergency room records that are available.

3. Providers must maintain proper and complete documentation to verify the services. The provider has full responsibility for maintaining documentation to justify the services provided. Maintenance of all records should be in compliance with Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; Americans with Disabilities Act

Rule 5.6: Diabetes Self-Management Training (DSMT)

A. The Division of Medicaid defines Diabetes Self-Management Training (DSMT) as an interactive and collaborative process through which beneficiaries with diabetes gain the knowledge and skills needed to modify their behavior and self-manage the disease and its related conditions.

B. The Division of Medicaid does not enroll a provider for the sole purpose of performing DSMT because DSMT is not a separately recognized provider type. The provider seeking reimbursement for DSMT must meet all of the required criteria set forth in Miss. Admin. Code Part 200, Rule 4.8 in addition to being:

1. A current Mississippi Medicaid provider,

2. Located in the State of Mississippi, and

3. Accredited by the American Diabetes Association (ADA) or the American Association of Diabetes Educators (AADE).

C. The Division of Medicaid covers DSMT when medically necessary, ordered by a physician, physician assistant, or nurse practitioner who is actively managing the beneficiary's diabetes, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or a designated entity and when all the following criteria are met:

1. The beneficiary has been diagnosed with diabetes by a physician,

2. The services are provided under the direct supervision of a physician, physician assistant, nurse practitioner, pharmacist or a registered nurse certified as a diabetes educator, and

3. The program meets the current ADA training standards.

D. The DSMT Plan of Care must include, but is not limited to:

1. An assessment of the beneficiary's specific needs for training,

2. Identification of the beneficiary's specific diabetes self-management goals,

3. Behavioral interventions directed toward helping the beneficiary achieve identified self-management goals, and

4. Evaluation of the beneficiary's progress towards identified self-management goals.

E. DSMT includes:

1. One (1) initial training per lifetime which:

a) Must be provided within a continuous six (6) month period which begins with the initial individual assessment visit.

b) Cannot exceed a total of seven (7) hours, provided in increments no less than thirty (30) minutes, which:

1) May include up to one (1) hour of individual training for assessment of the beneficiary's training needs.

2) Includes up to six (6) hours of training in a group setting consisting of two (2) or more individuals except when the ordering physician determines:

(a) A beneficiary would benefit from individual sessions instead of group sessions which the physician's order must include a statement specifying DSMT training in individual sessions along with an explanation, or

(b) A medical condition prevents the beneficiary from completing the seven (7) hours of initial training within six (6) months. Prior authorization for an extension to the six (6) month time-frame must be obtained from the UM/QIO.

2. Follow-up training which:

a) Must be ordered by the physician actively managing the beneficiary's diabetes, including documentation in the medical record of the specific medical condition that the follow-up training must address,

b) Is furnished any time in a year following the year in which the beneficiary completes the initial training,

c) Includes a maximum of two (2) hours each year,

d) Is furnished in increments of no less than thirty (30) minutes, and

e) Is provided in group sessions consisting of two (2) or more individuals unless the ordering physician determines a beneficiary would benefit from individual sessions instead of group sessions. The physician's order must include a statement specifying DSMT training in individual sessions along with an explanation.

F. Beneficiaries under the age of eighteen (18) must be accompanied by a parent/guardian/legal representative.

G. The Division of Medicaid pays for all medically necessary services for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: 42 CFR § 410.141; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Moved from Miss. Admin. Code Part 202, Rule 2.11 and revised Miss. Admin. Code Part 200, Rule 5.6.C. eff. 12/01/2015; New Rule eff. 04/01/2015.

Part 200 Chapter 6: Indian Health Services

Rule 6.1: Provision of Indian Health Services

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.

Source: Miss. Code Ann. § 43-13-121; Public Law 93-638; Public Law 94-437

Rule 6.2: Beneficiary Enrollment

Applicants of American Indian/Alaskan Native descent are subject to the same eligibility criteria as any other applicant. Refer to Part 200, Chapter 3, Rule 3.1.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 136.12

Rule 6.3: Provider Enrollment/Participation Requirements

A. Indian Health Service (IHS) Facilities/Tribal 638 Health Facilities - In accordance with Sec. 1911.[42 U.S.C. 1396j] (a) (b) 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. Refer to Part 200 Chapter 4, Rule 4.2 for Conditions of Participation.

B. All Other Providers - All other providers must complete the enrollment requirements for their respective provider type. Refer to Part 200 Chapter 4, Rule 4.2.

Source: Miss. Code Ann. § 43-13-121; 42 USC 1396j(a)(b)

Rule 6.4: Covered Services

American Indians/Alaskan Natives who meet the Division of Medicaid eligibility criteria receive the same benefits as any other beneficiary in the same category of eligibility. All limitations, exclusions, and prior authorization requirements apply.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 136.11

Rule 6.5: Reimbursement

A. Indian Health Service (IHS) Facilities/Tribal 638 Health Facilities/Providers

1. In accordance with Social Security Act, the Division of Medicaid will reimburse Indian Health Service Facilities/Tribal 638 Health Facilities/Providers as follows:

   a) Inpatient Hospital - per diem rate

   b) Outpatient Hospital, includes physician and clinic services – encounter rate

   c) Dental Services – encounter rate

   d) Other approved providers will be reimbursed according to the current payment methodology, e.g., fee for service, per diem, encounter etc., for the respective provider type.

2. The Social Security Act provides that one hundred (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 also defined in section 4 of the Indian Health Care Improvement Act.

B. Non-Indian Health/Tribal 638 Providers who are not Indian Health Service Facilities/Tribal 638 Facilities will be reimbursed according to the current payment methodology, e.g., fee for service, per diem, encounter, etc. for the respective provider type.

Source: Miss. Code Ann. § 43-13-121; Sec. 1911. [42 U.S.C. 1396j] (a)(b)(c)(d); Section 1905(b)

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 201
Transportation Services

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Title 23: Division of Medicaid

Part 201: Transportation Services

Part 201 Chapter 1: Ambulance

Subchapter 1: General

Rule 1.1.1: Ambulance Provider Enrollment Requirements

A. All ambulance providers whose origin, or site of pickup, is within the state of Mississippi, must be licensed in accordance with the requirements of the Mississippi State Department of Health, Office of Emergency Medical Services (OEMS) unless otherwise exempt. The exempt status is determined by the Office of Emergency Medical services. Any ambulance service provider who obtains a license and permit issued by the OEMS may qualify as a provider of ambulance service under the Medicaid program when the provider has met the requirements in Part 200, Chapter 4, Rule 4.8 in addition to the following:

   1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

   2. Copy of current provider license or permit.

   3. Written confirmation from the IRS confirming your tax identification number and legal business name.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.1.2: Definitions

A. Basic Life Support (BLS): Basic life support (BLS) ambulance services are supportive and non-definitive in nature. A basic ambulance is one that provides transportation plus the equipment and staff needed for such basic services as assessment and support of airway, breathing, oxygenation, and circulation; prevention of disability; and first aid including control of bleeding, splinting fractures, treatment for shock, delivery of babies, etc. BLS assessment includes brief and limited patient assessment and management procedures including evaluation of vital signs, mental and neurologic states, and hemodynamic stability.

B. Advanced Life Support (ALS): Advanced life support ambulance services include definitive medical treatment and complex specialized life sustaining procedures. Patient assessment is usually-complex and extensive, requiring frequent assessment of the vital signs, oxygenation, cardiac activity and hemodynamic status. Examples of advanced life support services are manual defibrillation/cardioversion, endotracheal intubation, cardiac pacing, chest decompression, insertion of central venous lines, administering life-sustaining drugs that are essential to, or that yields information that is essential to, the restoration or continuation of a bodily function important to the continuation of human life, and cardiopulmonary

resuscitation. Documentation must support the need for ALS services.

C. Appropriate Facilities: The facility/institution is generally equipped to provide the needed treatment for the patient's condition and is willing to accept the patient.

D. Bed Confined / Bedridden: Bed confined is defined as the inability to get up from bed without assistance, and inability to ambulate, and inability to sit in a chair, including a wheelchair. All three (3) of the above conditions must be met and will be applied to all transports. This term is used synonymously with the terms “bedridden” or “stretcher bound”. However, it is not synonymous with “bedrest” or “non-ambulatory”.

E. Medically Necessary Emergency Ground or Air Ambulance Service: To be considered as a medically necessary emergency for ground or air ambulance services, all three (3) of the following criteria must be met:

1. Ambulance (BLS or ALS) transport to the nearest hospital where treatment for an accidental injury or medical emergency is available,

2. The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the patient's health, and

3. The injury or medical emergency is sudden, of such severity that the absence of immediate medical care could reasonably result in permanently placing the patient's health in jeopardy, and/or serious impairment of bodily functions, and/or serious and permanent dysfunction of any body organ or part, or other serious medical consequence.

F. Medically Necessary Non-Emergency Ground: To be considered as medically necessary non-emergency for ground or air ambulance service, all three (3) of the following criteria must be met:

1. Ambulance transport to or from the nearest appropriate facility for the beneficiary to receive non-emergency medical care that cannot be provided in their place of residence or medical facility where the patient is an inpatient, and

2. The use of other means of transportation is medically contraindicated because it would endanger or be detrimental to the patient's health, and

3. The patient suffers from an injury or debilitated physical condition(s) that results in the patient being totally bedridden or bed confined.

G. Patient Loaded Mileage: The patient is on board the ambulance. Mileage to the point of pick-up, no patient on board, does not qualify as "patient loaded."

H. Medical Necessity: Medical necessity is established from the patient's condition at the time of transport, not the diagnosis. The patient's condition must be of such severity that the use of any other method of transportation is contraindicated or not possible. In cases where other

means of transportation could be utilized, the fact that there is no other means of transportation available does not justify medical necessity. In addition, if the patient is able to be transported by other means of transportation, but requires assistance from others in getting in or out of the other type of vehicle, the fact that such assistance is not available does not justify medical necessity.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.1.3: Reimbursement

Ambulance services will be reimbursed from a statewide uniform fixed fee schedule based on seventy percent (70%) of the rate established under Medicare (Title XVIII of the Social Security Act), as amended.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.1.4: Documentation Requirements

A. Providers of ambulance services must satisfy all documentation and maintenance of records in accordance with Part 200, Chapter 1, Rule 1.3 and maintain auditable records that will substantiate the claim submitted to Medicaid. At a minimum, the records must contain the following on each patient:

1. Time and by whom the call was originated,

2. Diagnosis, if known, or nature of illness or injury,

3. Medical necessity clearly described,

4. For non-emergency ambulance services, the original Certificate of Medical Necessity, signed by the physician, nurse practitioner, or physician assistant must be kept on file at all times,

5. Patient's condition in detail which includes, but is not limited to, vital signs, level of consciousness, ability to sit/stand/walk, etc.,

6. Site of pick-up with address if known, time of pick-up, and recording of odometer reading, if air transport, site should be identified so that it can be located on a map,

7. Point of destination, time of arrival, and recording of odometer reading,

8. Detailed record of all services and treatment administered to the patient,

9. Documentation that the patient was taken to the closest appropriate facility or the reason that facility was unable to accept the patient that caused him/her to be taken to another facility,

10. Trip ticket must be included, and

11. Copies of prior approvals, when applicable.

B. Providers must maintain proper and complete documentation to verify the services provided.

Source: Miss. Code Ann. §§ 41-59-41; 43-13-121.

Rule 1.1.5: Mileage

A. The initial patient loaded twenty-five (25) miles are always included in the base rate and must not be billed separately to Medicaid. Odometer readings must be documented on the ambulance transport record. Odometer readings are defined as actual odometer reading rather than a number of miles.

B. Reimbursement for mileage will be allowed beginning with the twenty-sixth (26th) patient loaded mile.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.1.6: Injectable Drugs

A. Ambulance providers must bill for injectable drugs, excluding solutions, using the appropriate procedure codes. Only the units actually administered are to be billed. The medical record must include documentation that substantiates the medical necessity of the drug.

B. Unused Injectable Drugs - If a portion of the drug in a single use or multiple dose use vial must be discarded, DOM will not reimburse for the discarded amount of the drug. Providers may not bill Mississippi Medicaid beneficiaries for the discarded drug.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.1.7: Ambulance Transport of Nursing Facility Residents by Ambulance

A. Medically necessary emergency and non-emergency ambulance transports to and from a nursing facility are covered. All medically necessary ambulance transports to and from a nursing facility must be billed by the ambulance provider.

1. The Ambulance Program policies apply to both emergency and non-emergency ambulance transports. This includes ambulance transport of Medicaid beneficiaries to and from dialysis treatments.

2. The nursing facility is responsible for arranging both emergency and non-emergency ambulance transports, including working with the ambulance providers to ensure that the

Certificate of Medical Necessity forms are completed in advance of the date that the ambulance transportation is required so that appointments do not have to be canceled due to no access to transportation. Beneficiaries must not be denied access to medical care because the nursing facilities have not arranged transportation in advance. The nursing home may not bill the beneficiary or family for covered ambulance transports.

B. Nursing Home Transports: If a beneficiary does not meet the coverage criteria for ambulance transportation through the Ambulance Program or non-emergency transportation through the NET Program, the nursing facility must arrange transportation through the family, if available, the nursing facility, or outside resources.

1. The cost for ambulance transports not covered through the Ambulance Program or the NET Program must be reported in the nursing facility cost report.

2. A nursing facility may ask the family to transport the beneficiary in a personal vehicle if the condition of the beneficiary allows that mode of transportation. However, if the family is not available or chooses not to transport the beneficiary, the nursing facility is responsible for arranging/providing transportation by use of nursing facility vehicles or through outside resources. The nursing facility may not require the family to transport the beneficiary, and the nursing facility may not bill the family for transportation by other means.

Source: 42 CFR § 431.53; Miss. Code Ann. § 43-13-121.

Rule 1.1.8: Transport of Dual Eligibles

A. For beneficiaries covered under Medicare and Medicaid, dual eligibles, ambulance providers may file a claim with Medicaid for non-emergency ambulance services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity, like transport to a physician's office.

B. For ambulance transport to and from dialysis treatments, Mississippi Medicaid will only pay the deductible and coinsurance based on Medicare's allowed charges on cases approved by Medicare if the patient is covered by both Medicare and Mississippi Medicaid. If Medicare benefits are denied because (1) the patient is being taken to a non-approved dialysis facility or (2) the medical necessity criteria for ambulance transport is not satisfied, Medicaid will not approve benefits for the ambulance transport.

C. The six (6) month timely filing limitation for filing crossover claims is applicable with no exceptions.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.1.9: Non-Covered Services

Non-covered ambulance services include, but are not limited to, the following:

A. Transfer from a hospital that has appropriate facilities for treatment to another hospital.

B. Transportation of a deceased patient to a funeral home.

C. The beneficiary was pronounced dead prior to the time the ambulance was called. Pronouncement of death must be made by an individual who is licensed or otherwise authorized under State law to pronounce death in the State where such pronouncement is made.

D. Waiting time charges – the charge by an ambulance company for time spent while waiting for the patient.

E. The patient refused to be transported after the ambulance arrives in response to a call.

F. Separate charges for assessing the patient's condition or taking vital signs.

G. First-aid or other medical type treatment provided by ambulance staff to a patient who is not subsequently transported to the closest appropriate facility.

H. Non-injectable drugs and separate charges for intravenous solutions.

I. Separate charges for supplies and equipment.

J. Transportation of Medicare eligible patients to and from dialysis, except on crossover claims.

K. Non-emergency air transportation that has not been prior approved by the Division of Medicaid.

L. Mileage beyond the closest appropriate facility.

M. Charges for extra attendants such as EMT's, nurses, physicians, respiratory therapists, etc.

N. Transports for the convenience of the patient and/or family.

O. ALS or BLS emergency ambulance services and non-emergency ambulance services for which the medical necessity criteria have not been satisfied.

P. Transport of beneficiaries receiving Hospice benefits through Mississippi Medicaid.

Q. Services not specifically listed as covered services.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.1.10: Subscription Programs

Ambulance providers who offer subscription programs must be aware that the services offered in these programs are usually covered by Mississippi Medicaid, either through the Ambulance or through the Non-Emergency Transportation (NET) program. Selling a subscription to a Medicaid beneficiary could be interpreted as charging for the ambulance service. Providers must accept Medicaid payment as payment in full; therefore, there are no out of pocket expenses other than the ambulance co-payment per trip which is the responsibility of the beneficiary. Selling a subscription to cover co-payments could be interpreted as charging for a service not yet provided the Medicaid beneficiary.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.1.11: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

Subchapter 2: Emergency (Ground/Air)

Rule 1.2.1: Emergency Ground Ambulance

A. To qualify as an Advanced Life Support (ALS) or Basic Life Support (BLS) emergency ambulance service, the trip must be:

   1. For patient loaded trips only,

   2. For medically necessary emergency services to the closest appropriate hospital for treatment, and

   3. In an appropriate ALS or BLS vehicle that has been licensed by the state.

B. Emergency ambulance providers are required to file all Medicaid claims on a CMS-1500 claim form. The provider must bill the appropriate ALS or BLS code applicable to the service rendered and the appropriate modifier to indicate origin and destination of the trip.

Source: Miss. Code Ann. § 41-59-9.

Rule 1.2.2: Multiple Patients/Arrivals

A. Multiple Patients - More than one (1) patient may be transported in one vehicle. When multiple patients are transferred in the same vehicle, the submitted charge must reflect the usual charge for one (1) patient divided by the number of patients on board. This is applicable to both the base and mileage charges.

B. Multiple Arrivals - When multiple units respond to a call for services, Mississippi Medicaid will only reimburse the unit that actually transports the patient.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.2.3: Air Ambulance

A. All air ambulance providers must be licensed in the state of Mississippi in order to transport a patient from one location to another within the state or from Mississippi to another state. Licensing is the responsibility of the Mississippi State Department of Health, Office of Emergency Medical Services.

B. Emergency Air Ambulance, or Helicopter - To qualify as an emergency air ambulance, or helicopter service, the trip must be:

   1. For patient loaded trips only,

   2. For medically necessary emergency services to the closest appropriate hospital for treatment, and

   3. In an appropriate air ambulance, or helicopter.

C. Urgent Air Ambulance, Fixed Wing - To qualify as urgent air ambulance transport, the trip must be:

   1. Prior approved by the Division of Medicaid,

   2. For patient loaded miles only,

   3. For medically necessary urgent services to the appropriate facility for treatment, and

   4. In an appropriate fixed wing air ambulance.

D. If a request for urgent ambulance transport is received on Saturday or Sunday or on a holiday and the ambulance provider chooses to transport without prior approval, the provider may submit information to the Division of Medicaid on the next working day. In such cases, the Division of Medicaid will review the information on a retrospective basis and provide approval if all coverage criteria is satisfied.

E. Coverage is not available for patient or family preference or convenience. (Transport is not billable/reimbursable to a service not covered by Medicaid.)

Source: Miss. Code Ann. §§ 41-59-9, 43-13-121.

Subchapter 3: Non-Emergency

Rule 1.3.1: Non-Emergency Ground Ambulance

A. To qualify as non-emergency ambulance transport or for transport to a dialysis facility, the trip must be:

   1. For patient loaded miles only,

   2. For medically necessary non-emergency services to the appropriate facility for treatment, and

   3. In an appropriate ALS or BLS certified vehicle.

B. The fact that a patient is receiving intravenous fluids does not justify the medical necessity for ambulance transport. The patient's condition must be of such severity that ambulance transportation is justified.

C. The ambulance provider must obtain a Certificate of Medical Necessity (CMN) completed and signed by the attending physician, nurse practitioner, or physician assistant. The CMN form must be completed in detail, must describe all three (3) conditions that satisfy the criteria for non-emergency medical transportation, and must document the reason transportation by any other means is contraindicated. If the ambulance provider is unable to obtain the signed certification statement from the attending physician (MD), nurse practitioner (NP), or physician assistant (PA), a clinical nurse specialist (CNS), registered nurse (RN), or discharge planner (DC), who is employed by the hospital or facility where the beneficiary is being treated and who has knowledge of the beneficiary's condition at the time the transport was ordered, may complete and sign the Certification of Medical Necessity.

D. The original Certificate of Medical Necessity must be completed, dated, and signed prior to or within five (5) calendar days of the transport and must be kept on file by the provider and be available to the Division of Medicaid and/or its representatives for review at all times. If the ambulance provider's records do not contain the original Certificate of Medical Necessity, the provider may be asked to refund to the Mississippi Medicaid program any money received from the program for the service(s) provided. The Certificate of Medical Necessity is required to justify the medical necessity for the service(s) provided.

E. The original Certificate of Medical Necessity form will only be valid for sixty (60) days. For instances in which repetitive trips are required the Certificate of Medical Necessity form must be completed, dated, and signed every sixty (60) days upon reassessment of the patient's condition. These additional forms must also be retained in the ambulance provider's records.

Source: 42 CFR § 431.53; Miss. Code Ann. §§ 41-59-9, 43-13-121.

Part 201 Chapter 2: Non-Emergency Transportation (NET) (Non-Ambulance)

Rule 2.1: NET Broker Program

A. The Division of Medicaid contracts with a NET Broker to provide non-emergency transportation (NET) to Medicaid beneficiaries in appropriate vehicles, including wheelchair vans, taxis, minivans, and sedans depending on the beneficiary's mobility status and personal capabilities on the date of service.

   1. Other non-Medicaid funded sources for non-emergency transportation services must be utilized first with the Medicaid NET program being the last resort.

   2. Beneficiaries are not allowed to request a particular NET Provider for transportation.

B. The NET Broker is responsible for administering and operating the NET Program in accordance with Medicaid policy, including but not limited to, the authorization, coordination, scheduling, management, and reimbursement of NET services and must:

   1. Operate statewide.

   2. Authorize and schedule NET services within set timeframes:

      a) Ninety-eight percent (98%) of routine NET services within three (3) business days after receipt of the request, and

      b) One hundred percent (100%) of routine NET services within ten (10) business days after receipt of the request.

   3. Notify the Division of Medicaid prior to denying a request for transport to a provider not geographically closest to the beneficiary's residence if the NET Broker is unable to obtain a medical certification from the medical provider certifying that the beneficiary is unable to be treated at a closer facility. A medical certification is not required if the transport is to the University of Mississippi Medical Center in Jackson, MS.

   4. Allow long distance transportation for up to ninety (90) days, if necessary, if a beneficiary has recently moved to a new area to maintain continuity of care until the transition of the beneficiary's care to a closer appropriate provider is completed. The NET Broker must monitor the frequency of these NET authorizations involving excessive distances per beneficiary.

   5. Ensure NET Providers arrive at the drop-off and pick-up destinations within Medicaid's minimum requirements.

   6. Perform post-transportation authorizations in instances when prior authorization was not obtainable.

   7. Request additional information, if necessary, within twenty-four (24) hours of the initial receipt of a request and place the request on hold. The request must specify the date the additional information must be submitted. The request for transport can be denied if the information is not received by the date specified with the exception of NET service appointments for chemotherapy, dialysis, and high-risk risk pregnancy.

8. Provide education to beneficiaries and NET Providers on NET services and procedures.

9. Maintain a current Medicaid approved NET Provider Manual/Operations Procedure Manual.

10. Perform criminal background checks on all NET Drivers to ensure excluded persons or entities are not paid any state or federal funds in compliance with Mississippi law [Refer to Part 201, Rule 2.6.D.], and ensure NET drivers meet Medicaid minimum requirements.

    a) The NET Broker must conduct criminal background checks upon initial hire, including but not limited to:

        1) A one-time criminal background check requiring fingerprinting,

        2) National and state criminal background checks utilizing personal identification data, including, but not limited to:

            (a) Name and date-of-birth,

            (b) Social security number, or

            (c) Driver's license number.

        3) A Mississippi Sex Offender Registry check, and

        4) A Motor Vehicle Record check.

    b) The NET Broker must conduct criminal background checks annually, including but not limited to:

        1) National and state criminal background checks utilizing personal identification data, including, but not limited to:

            (a) Name and date-of-birth,

            (b) Social security number, or

            (c) Driver's license number.

        2) A Mississippi Sex Offender Registry check, and

        3) A Motor Vehicle Record check.

    c) Effective April 01, 2015 the NET Broker must ensure the NET Providers comply

with the one-time fingerprinting check requirement as listed below:

1) The NET Broker must have all NET Drivers' fingerprinting checks on file. The NET Broker is prohibited from reimbursing the NET Provider for transportation services by a NET Driver whose fingerprinting check is not on file.

2) New NET Providers must submit to the NET Broker all NET Driver fingerprinting checks within ninety (90) days from the contracted start date.

3) NET Providers must submit to the NET Broker all fingerprinting checks for newly hired NET Drivers within ninety (90) days from the date of employment if hired after the contracted start date.

4) The NET Broker may utilize the fingerprinting record obtained by a previous Medicaid NET Provider to meet the one-time fingerprinting check requirement if the NET Driver changes employment.

d) The NET Broker must not reimburse the NET Provider for transportation services rendered if the NET Provider fails to comply with any of the fingerprinting check requirements listed in Miss. Admin. Code Part 201, Rule 2.1.B.10.

e) The NET Broker must recoup any funds paid to the NET Provider for services rendered by a NET Driver who fails the fingerprinting check.

11. Ensure vehicles meet Medicaid minimum requirements. Perform and document required vehicle inspections with submission of inspection reports to the Division of Medicaid no later than the fifteenth (15th) day of the month following the inspection.

12. Maintain an adequate number of NET Providers and trained staff to provide scheduled transports in a given geographical area.

13. Maintain a file of current executed NET Provider contracts and:

    a) Require provider enrollment forms to include disclosure of complete ownership, control, and relationship information from all providers,

    b) Include contract language requiring the NET Broker to notify the Division of Medicaid of such disclosures on a timely basis, and

    c) Provide to the Division of Medicaid upon request.

14. Make timely payments to NET Providers.

15. Meet quality assurance and monitoring requirements including, but not limited to:

    a) On-street observations,

b) Accident and incident reporting,

c) Statistical reporting of transports,

d) Statistical reporting of transport call center operations,

e) Analysis of complaints,

f) Driver licensure, driving records, experience, training and annual random drug testing of all NET Drivers,

g) Participant assistance,

h) Completion of driver transport logs,

i) Driver communication with dispatcher, and

j) Routine scheduled vehicle inspections and maintenance.

16. Maintain all required up-to-date electronic and data systems.

17. Meet all Medicaid call center requirements.

18. Conduct the following random validation checks of monthly requests to verify NET Provider claims for reimbursement match authorized transports and to verify the transports actually occurred. The NET Broker must document the reason the NET Provider failed to properly authorize or render the service.

    a) Three percent (3%) of pre-transportation requests verifying that a beneficiary's appointment with the medical service provider is for a covered medical service, and

    b) Two percent (2%) of post-transportation services verifying a beneficiary's appointment is for a covered medical service.

19. Submit reports, data or other materials by the date due as determined by the Division of Medicaid.

20. Must obtain a medical certification statement from the beneficiary's physician if an adult attendant is required to accompany the beneficiary.

C. The Division of Medicaid, at its sole discretion, may assess damages if the NET Broker fails to perform the responsibilities in Rule 2.1.B. resulting in additional administrative costs to the Division of Medicaid.

1. The Division of Medicaid must give written notice to the NET Broker of any unmet responsibility that could result in an assessment of damages and the proposed amount of the damages.

2. The NET Broker has thirty (30) days from the date of the notice to dispute the determination.

D. Reporting

1. The NET Broker must report within three (3) business days all allegations of sexual harassment or physical abuse by a driver, beneficiary or other passenger to the Division of Medicaid and per state law to the Mississippi Department of Human Services (MDHS).

   a) NET Providers must report all allegations of sexual harassment or physical abuse to the NET Broker.

   b) Medicaid beneficiaries should report any incident of abuse or sexual harassment directly to the NET Broker.

2. The NET Broker must refer suspected Medicaid fraud, abuse or misuse by beneficiaries, NET Providers or NET Broker staff to the Division of Medicaid's Office of Program Integrity within three (3) business days after discovery of the suspected Medicaid fraud, abuse or misuse.

3. The NET Broker must document all accidents/incidents occurring on a scheduled transport when a beneficiary is present in the vehicle and submit the accident/incident report to the Division of Medicaid within seventy-two (72) hours of the accident/incident.

E. Meals and Lodging

1. Meals for day transports are not covered under the NET Program.

2. Overnight stays may be warranted if the medical service is only available in another county, city, or state requiring extensive travel time and distance.

   a) Related travel expenses are covered including overnight lodging and meals for eligible beneficiaries and one (1) adult attendant while in transit to and from the provider rendering the medical service.

   b) If the medical treatment facility does not provide room and board, overnight lodging and meals are covered for the beneficiary and one (1) adult attendant.

F. Adult Attendants

1. One (1) adult attendant may accompany a beneficiary during transport if all the following

conditions are met:

a) The beneficiary's need and type of assistance required is certified as medically necessary by the beneficiary's attending medical provider prior to the transport,

b) The adult attendant is qualified to provide the type of assistance required, and

c) Travel with the adult attendant is prior authorized by the NET Broker.

2. The NET Broker must pay the following limited costs for one (1) adult attendant to accompany a beneficiary during transport:

a) Expense when a separate ticket must be purchased for the adult attendant to provide the required assistance to the beneficiary. No other costs associated with the adult attendant's travel will be paid by the NET Broker.

b) All costs associated with attendant care must be documented with receipts and submitted to the Division of Medicaid. Meals are not covered for a day transport when an overnight stay is not required.

Source: 42 CFR §§ 431.53, 440.170(a)(1), (3) – (4); Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 201, Rule 2.1.B.10. eff. 04/01/2015. Revised eff. 04/01/2013.

Rule 2.2: Eligibility

A. NET services are non-covered for beneficiaries enrolled in the following categories of eligibility:

1. Family Planning Waiver,

2. Qualified Medicare Beneficiary (QMB),

3. Specified Low-Income Medicare Beneficiary (SLMB), and

4. Qualified Individual (QI-1).

B. NET services are covered for beneficiaries who:

1. Require the services covered by the Division of Medicaid from a Medicaid approved provider,

2. Have no other means of getting to and/or from the provider for a Medicaid covered service,

3. Have not exceeded any service limits associated with the covered service, and

4. Are not able to receive transportation services to medical services from any other source.

Source: 42 CFR § 431.53; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2013.

Rule 2.3: NET Services

A. NET services are covered if all the following criteria are met:

1. The medical service for which NET service is requested is a covered Medicaid medical service.

2. The beneficiary:

   a) Is eligible for NET services,

   b) Has a medical need which requires NET services, and

   c) Does not have access to available transportation.

3. The transport must be:

   a) In a vehicle which meets the medical needs of the beneficiary given their mobility status and personal capabilities on the date of service,

   b) The most economical mode of transportation. The NET Broker must document the reason in detail if the NET Broker authorizes a mode of transportation that is not the most economical,

   c) Provided by a NET Provider closest to the beneficiary. The NET Broker must document the reason in detail if a transport is authorized for a NET Provider which is not the closest to the beneficiary's residence or medical service provider,

   d) For a single covered medical service appointment, and

   e) Requested at least three (3) business days before the NET service is needed.

4. If an adult attendant is necessary the NET Broker must obtain a medical certification statement from the beneficiary's physician prior to the transport.

B. NET services are non-covered if:

1. The beneficiary is not eligible for NET services on the requested date of service,

2. The beneficiary does not have a medical need requiring NET services,

3. The medical service is not covered for NET services requested,

4. The beneficiary has access to available transportation,

5. Transportation to the medical service is covered under another program,

6. The request for post-transportation authorization is not received in a timely manner and/or did not meet established criteria,

7. The medical appointment is not scheduled or was not kept,

8. NET Broker cannot confirm the medical appointment,

9. The transport is not requested in a timely manner and is unable to be scheduled for the requested date and time,

10. Additional documentation was requested by the NET Broker and not received timely,

11. The beneficiary refuses the appropriate mode of transportation, or

12. The beneficiary refuses the NET Provider assigned to the transport and another appropriate NET Provider is not available.

C. The NET Broker must deny non-covered NET services and document the reason for the denial on the same business day and mail the denial letter to the beneficiary no later than the next business day following the date of the denial decision.

1. The denial letter must contain the beneficiary's right to appeal.

2. The Division of Medicaid, in its sole discretion, may add, modify or delete denial reasons without additional payment to the NET Broker or a contract amendment.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2013.

Rule 2.4: Transport of Nursing Facility Residents by NET

Non-emergency transportation for nursing facility residents is covered under the NET Program. [Refer to Part 207, Rule 2.11.]

Source: 42 CFR § 431.53; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2013.

Rule 2.5: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.6: NET Driver Requirements

A. The NET Broker must ensure that all NET Drivers complete a criminal background check verifying the NET Driver is not excluded per Miss. Code Ann. § 43-13-121. [Refer to Miss. Admin. Code Part 201, Rule 2.1.B.10.]

B. The NET Broker must ensure NET Drivers:

1. Abide by federal, state, and local laws.

2. Be at least eighteen (18) years of age and have a current valid driver's license to operate the assigned vehicle.

3. Be courteous, patient and helpful to all passengers and be neat and clean in appearance.

4. Wear a visible, easily read name tag which identifies the employee and the employer.

5. Provide an appropriate level of assistance to a beneficiary when requested or when necessitated by the beneficiary's mobility status or personal condition, including curb-to-curb, door-to-door, and hand-to-hand assistance, as required.

   a) The NET driver must confirm the beneficiary is safely inside the residence or facility before departing the drop-off point.

   b) The NET driver is responsible for properly securing any mobility devices used by the beneficiary.

6. Assist beneficiaries in the process of being seated, confirm all seat belts are fastened properly and all passengers are safely and properly secured.

7. Park the vehicle:

   a) In a safe location out of traffic if a beneficiary or other passenger's behavior or any other condition impedes the safe operation of the vehicle, notify the dispatcher and request assistance.

b) To prevent the beneficiary from crossing streets to reach the entrance of their destination.

8. Must provide verbal directions to passengers as appropriate.

9. Notify the NET Provider immediately to report an emergency such as an accident/ incident or vehicle breakdown to arrange for alternative transportation for the beneficiaries on board. The NET Provider must report all accidents/incidents and breakdowns to the NET Broker.

10. Report all no-shows immediately to the NET Provider and the NET Provider must notify the NET Broker so the authorization can be cancelled.

C. The NET Brokers must ensure NET Drivers do not:

1. Leave a beneficiary unattended at any time.

2. Use alcohol, narcotics, illegal drugs, or prescription medications that impair their ability to perform.

3. Smoke in the vehicle, while assisting a beneficiary or in the presence of the beneficiary. Beneficiaries or their adult attendant cannot smoke in the vehicle.

4. Wear any type of headphones while on duty, with the exception of hands-free headsets for mobile telephones which can only be used for communication with the NET Provider or to call 911 in an emergency.

5. Touch any passenger except as appropriate and necessary to assist the passenger into or out of the vehicle, into a seat and to secure the seatbelt or as necessary to render first aid or assistance which the NET Driver has been trained.

6. Provide NET services to Medicaid beneficiaries without completing a national and state background check.

D. The NET Broker must ensure a NET Driver is removed from NET service if he/she:

1. Fails an annual random drug test.

2. Is convicted of:

a) Two (2) moving violations or accidents related to transportation provided under the NET Broker Program, or

b) Any federal or state crime listed in Miss. Code Ann. § 43-13-121.

3. Has a suspended or revoked driver’s license for moving traffic violations in the previous

five (5) years.

Source: Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 201, Rule 2.6.A, C.6., and D.2.b). eff. 04/01/2015. Revised Miss. Admin. Code Part 201, Rule 2.6 to include 04/01/2012 compilation omission eff. 04/01/2013.

Rule 2.7: Vehicle Requirements

A. All vehicles used for transport must:

1. Adhere to all federal, state, county or local laws and ordinances.

2. Not exceed the vehicle manufacturer's approved seating capacity for number of persons in the vehicle, including the driver.

3. Have a functioning heating and air-conditioning system which maintains a temperature comfortable to the beneficiary at all times.

4. Have functioning seat belts and restraints as required by federal, state, county or local statute or ordinance and:

   a) Have an easily visible interior sign in capital letters that reads" All passengers must wear seat belts",

   b) Store seat belts off the floor when not in use,

   c) Have at least two (2) seat belt extensions available, and

   d) Be equipped with at least one (1) seat belt cutter within easy reach of the driver for use in emergency situations.

5. Have an accurate, operating speedometer and odometer.

6. Be operated within the manufacturer's safe operating standards at all times.

7. Have two (2) exterior rear view mirrors, one (1) on each side of the vehicle.

8. Be equipped with an interior mirror for monitoring the passenger compartment.

9. Have a clean exterior free of broken mirrors or windows, excessive grime, major dents or paint damage that detracts from the overall appearance of the vehicles.

10. Have a clean interior free of torn upholstery, including floor and ceiling coverings, damaged or broken seats, protruding sharp edges, dirt, oil, grease or litter, hazardous

debris, or unsecured items.

11. Display the NET Provider's business name and telephone number in a minimum of three (3) inch high lettering in a color that contrasts with the surrounding background on at least both sides of the exterior of the vehicle and have:

    a) No words displayed on the interior or exterior of the vehicle indicating Medicaid beneficiaries are being transported, or

    b) A NET Provider's business name which does not imply Medicaid beneficiaries are being transported.

12. Have the license number and NET Broker's toll-free and local phone numbers prominently displayed in the interior of each vehicle with complaint procedures clearly visible and available in written format upon request.

13. Be non-smoking at all times with a visible interior sign in all capital letters that reads: "No smoking".

14. Have a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms.

15. Be equipped with a first aid kit stocked with antiseptic cleansing wipes, antibiotic ointment, assorted sizes of adhesive and gauze bandages, tape, scissors, latex-free or other impermeable gloves and sterile eyewash.

16. Contain a current map of the applicable geographic area with sufficient detail to locate beneficiary and provider addresses.

17. Be equipped with an appropriate working fire extinguisher stored in a safe, secure location.

18. Have insurance coverage for all vehicles at all times in compliance with state law and any county or city ordinance.

19. Be equipped with a "spill kit" that includes liquid spill absorbent, latex-free or other impermeable gloves, hazardous waste disposal bags, scrub brush, disinfectant and deodorizer.

20. Be in compliance with applicable Americans with Disabilities Act (ADA) Accessibility Specifications for Transportation.

B. The NET Broker must:

1. Ensure all NET Providers maintain all vehicles which meet or exceed local, state and federal requirements and the manufacturer's safety mechanical operating, and

maintenance standards.

2. Supply all NET Providers with a copy of the ADA vehicle requirements and inspect the vehicles for compliance during the scheduled bi-annual vehicle inspections.

3. Have in its network NET Providers with the capability to perform bariatric transports of beneficiaries up to eight hundred (800) pounds.

4. Maintain documentation on the lifting capacity of each vehicle in its network to timely schedule transports for beneficiaries requiring a lift.

5. Require every vehicle in a NET Provider's fleet has a real-time link via a phone or two-way radio. Pagers are not acceptable as a substitute.

6. Test all communication equipment during regularly scheduled vehicle inspections.

7. Inspect all NET Provider vehicles prior to the Operations Start Date and at least every six (6) months thereafter.

8. Place the Medicaid approved inspection sticker on the outside of the passenger side rear window upon completion of a successful inspection.

9. Maintain records of inspections and make them available to the Division of Medicaid upon request.

C. Authorized employees of the Division of Medicaid or the NET Broker must immediately remove from service any vehicle or NET Driver found to be out of compliance with Miss. Admin. Code Part 201, Rule 2.1 or with any federal or state regulations.

1. The vehicle or NET Driver may be returned to service only after the NET Broker verifies the deficiencies have been corrected.

2. Any deficiencies and actions taken to remedy deficiencies shall be documented and become a part of the vehicle's and the NET Driver's permanent records.

Source: Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 201, Rule 2.7 to include 04/01/2012 compilation omission eff. 04/01/2013.

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 202
Hospital Services

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Title 23: Division of Medicaid

Part 202: Hospital Services

Part 202 Chapter 1: Inpatient Services

Rule 1.1: Definitions

A. Medicaid considers a patient an inpatient if formally admitted as an inpatient with the expectation that he/she will remain at least overnight and occupy a bed even though it later develops that he/she can be discharged or is transferred to another hospital and does not actually use a hospital bed overnight.

B. Inpatient services are services that are ordinarily furnished by the hospital for the care and treatments of the beneficiary, solely during his/her stay in the hospital.

C. 3-Day Payment Window

1. The 3-day Payment Window Rule applies to inpatient stays in hospitals, or an entity wholly owned or operated by an acute facility, paid under the APR-DRG methodology and the inpatient claims must include the following:

    a) Diagnostic services provided to a beneficiary within three (3) days prior to and including the date of an inpatient admission and;

    b) Therapeutic (non-diagnostic) services related to an inpatient admission and provided to a beneficiary within three (3) days prior to and including the date of the inpatient admission:

        1) Therapeutic services clinically distinct or independent from the reason for the beneficiary's inpatient admission may be separately billed on an outpatient claims with the appropriate code.

        2) Such separately billed services are subject to review. Medical record documentation must support that the services are unrelated to the inpatient admission.

2. Maintenance renal dialysis provided on an outpatient basis within the three (3) days prior to and including the date of an inpatient admission may be separately billed and separately paid.

3. Although the Division of Medicaid's policy is based on Medicare policy, Medicaid's policy applies if there is a difference.

Source: 42 CFR § 440.2, 440.10; Miss. Code Ann. § 43-13-121.

History: Revised - 10/01/2012

Rule 1.2: Provider Enrollment

Hospital providers, including psychiatric hospitals and swing bed providers applying for enrollment into the Medicaid program must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

B. Written confirmation from the IRS confirming your tax identification number and legal business name.

C. CLIA certificate and completed certification form.

D. Licensed freestanding psychiatric hospitals must submit Joint Commission on Accreditation of Health Care Organization (JCAHO).

E. Copy of current Medicare certification or Tie-In Notice. EOMB is not acceptable.

F. Out of state facility: Copy of outstanding claims, if applicable.

G. Copy of hospital license

1. Out-of-state facility: Copy of license/certification in effect during the claims period for which they are billing.

2. In-state facility: A copy of letter from the Mississippi State Department of Health is acceptable.

3. Hospital undergoing a Change of Ownership (CHOW): License in effect for the new owner.

Source: 42 CFR § 482.11; Miss. Code Ann. § 43-13-121.

Rule 1.3: Prior Authorization of Inpatient Hospital Services

A. Requirement

1. Prior authorization is required from the appropriate Utilization Management/Quality Improvement Organization (UM/QIO) for all inpatient hospital admissions except for obstetrical deliveries and well newborns with a length of stay under six (6) days.

   a) Emergent admissions and urgent admissions must be authorized on the next working day after admission.

b) Failure to obtain the prior authorization will result in denial of payment to all providers billing for services including, but not limited to, the hospital and the attending physician.

2. Prior authorization must be obtained from the appropriate UM/QIO when a Medicaid beneficiary:

   a) Has third party insurance, and/or

   b) Is also covered by Medicare Part A only or Medicare Part B only.

3. Prior authorizations are not required for Medicaid beneficiaries who are also covered by both Medicare Part A and Part B unless inpatient Medicare benefits are exhausted.

4. Inpatient hospital stays that exceed the Diagnostic Related Group (DRG) Long Stay Threshold require a Treatment Authorization Number (TAN) for inpatient days that exceed the threshold.

B. Non-Approved Services

1. Medicaid beneficiaries in hospitals shall be billed for inpatient care occurring after they have received written notification of Medicaid non-approval of hospital services. Notification prior to the beneficiary's admission shall be cause to bill the beneficiary for full payment if he/she enters the hospital. Notification at or after admission shall be cause to bill the beneficiary for all services provided after receipt of the notice.

2. The hospital cannot bill the Medicaid beneficiary for an inpatient stay when it is determined upon retrospective review by the appropriate UM/QIO that the admission did not meet inpatient care criteria.

C. Maternity-Related Services

1. Hospitals must report all admissions for deliveries to the Division of Medicaid and the appropriate UM/QIO. The hospitals must report the admissions in accordance with the requirements provided by the Division of Medicaid and the appropriate UM/QIO. A TAN is issued to cover up to nineteen (19) days, the DRG Long Stay Threshold, for a delivery.

2. For admissions exceeding nineteen (19) days for a delivery, providers must submit a request for a continued stay in accordance with the policies and procedures provided by the appropriate UM/QIO.

D. Newborns

1. Well newborn services provided in the hospital must be billed separately from the mother's hospital claim.

   a) The hospital must notify the Division of Medicaid within five (5) calendar days of a

newborn's birth via the Newborn Enrollment Form located on the Division of Medicaid's website.

b) The Division of Medicaid will notify the provider within five (5) business days of the newborn's permanent Medicaid identification (ID) number.

2. The hospital must obtain a TAN for sick newborns requiring hospitalization whose length of stay is six (6) days or more. The baby's date of birth is the sick newborn's beginning date for certification. A sick newborn whose length of stay exceeds nineteen (19) days requires a concurrent review by the appropriate UM/QIO.

3. The hospital must obtain authorization for newborns delivered outside the hospital and newborns admitted to accommodations other than well baby.

Source: 42 USC § 1395f; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2015; Revised eff. 10/01/2012.

Rule 1.4: Covered Services

A. Covered inpatient services include:

1. Ancillary services.

2. Drugs, excluding take home drugs.

3. Supplies.

4. Oxygen.

5. Durable Medical Equipment.

6. The cost of implantable programmable baclofen drug pumps used to treat spasticity which are implanted in an inpatient hospital setting are reimbursed through the Mississippi Medicaid APR-DRG payment.

7. Newborn Hearing Screens - refer to Part 218.

8. Therapy Services

a) Therapeutic services ordinarily furnished to inpatients by the hospital, or by others under arrangements made by the hospital, are covered.

b) Inpatient services rendered by a psychologist or a therapist who is employed by the hospital, and whose services are normally included in the billing of the hospital, are covered in the same manner as the services of other non-physician hospital employees.

9. Inpatient Psychiatric Services are covered in the following settings as outlined:

   a) Acute Freestanding Psychiatric Facility

      1) Services available for children up to age twenty-one (21).

      2) Certification by the UM/QIO is required for the admission and for a continued stay after nineteen (19) days.

   b) Psychiatric Unit at a Medical Surgical Facility

      1) Services available to children or adults.

      2) Certification by the UM/QIO is required for the admission and for a continued stay after nineteen (19) days.

10. Inpatient or outpatient hospital services rendered to a beneficiary who leaves the hospital against medical advice.

11. Canceled or incomplete procedures related to the beneficiary's medical condition. Services performed before the surgical or other procedure is canceled or terminated before completion due to a change in the beneficiary's condition.

B. The division of Medicaid covers medically necessary inpatient procedures. Refer to Part 202, Chapter 5.

   1. Moved to Rule 5.3.

   2. Moved to Rule 5.6.

   3. Moved to Rule 5.4.

   4. Moved to Rule 5.1.

   5. Moved to Rule 5.2.

   6. Moved to Rule 5.5.

C. Hospitals with Multiple Accommodations:

   The Division of Medicaid does not specifically reimburse hospitals for the cost of accommodations. Billed charges do factor into the calculation of the APR-DRG outlier payments.

1. Private Room: When private room accommodations are furnished, the following rules will govern:

   a) Private Room/Critical Care Units – Medically Necessary – The reasonable cost/charges of a private room or other accommodations more expensive than semi-private are covered services when such accommodations are medically necessary. Private rooms will be considered medically necessary when the physician documents that the patient's condition requires him/her to be isolated for his/her own health or for the health of others. This includes the use of critical care units.

   b) Private Room – Not Medically Necessary – Based on Availability – When accommodations more expensive than semi-private are furnished, the assigned accommodations are considered medically necessary and cost/charges are covered by The Division of Medicaid if at the time of admission less expensive accommodations are not available (this includes hospitals with private rooms only.) The subsequent availability of semi-private or ward accommodations would offer to the hospital the right to transfer that patient to such accommodations or, at the express request of the patient, to allow him/her to continue occupancy of the private room as a private-room patient enjoying a personal comfort item and subject to be billed the room differential charge.

   c) Private Room – Requested by Beneficiary – When a private room is not medically necessary but is furnished at the beneficiary's request, the hospital may charge the patient no more than the difference between the customary charge for the accommodations furnished and the customary charge for the semi-private accommodations at the rate in effect at the time services are rendered. No such charge may be made to the patient unless he/she requested the more expensive accommodations with the knowledge that he/she would be charged the differential. The patient's account file, over the signature of an authorized hospital employee, should reflect the patient's knowledge that the differential charge will be expected.

   d) Deluxe Accommodations – The Division of Medicaid does not cover deluxe accommodations and/or deluxe services. These would include a suite/birthing suite, or a room substantially more spacious than is required for treatment, or specifically equipped or decorated, or serviced for the comfort and convenience of persons willing to pay a differential for such amenities. A room differential cannot be charged to the beneficiary when the differential is based on such factors as differences between older and newer wings, proximity to lounge, elevators or nursing stations, or a desirable view. Such rooms are standard on-bed units and not deluxe rooms for purposes of this instruction.

2. Semi-private Room – Two (2) beds per room – The Division of Medicaid will cover the reasonable cost/charges of semi-private accommodations.

3. Ward Accommodations – Three (3) or more beds per room – If less than semi-private accommodations are furnished, The Division of Medicaid will cover the cost/charges or

the accommodation furnished only if the patient requests such or when semi-private accommodations are not available. If less than semi-private accommodations are furnished because all semi-private rooms are filled, the patient should be transferred to semi-private accommodations as soon as one becomes available.

Source: SPA 2012-008; Miss. Code Ann. §§ 43-13-117 (A)(1)(d)(e), 43-13-121.

History: Revised Rule 1.4.B(1-6) eff. 10/01/2013: Rules 1.4A.8(a)(b), 1.4.A.9(a)(b), 1.4C. eff. 10/01/2012 to correspond with SPA 2012-008.

Chapter 5: Hospital Procedures

Rule 1.5: Non-Covered Services

A. Services provided in a geriatric psychiatric unit of a hospital.

B. Services rendered to a Medicaid beneficiary and billed by a physician employed by or contracted with the hospital.

C. Elective cancellation of procedures not related to the beneficiary's medical condition.

1. Surgical or other procedures canceled due to scheduling conflicts of the operating suite or physicians, beneficiary request, or other reasons not related to medical necessity.

2. Additional room and board days required due to rescheduling.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.6 - Refer to Chapter 5, Rule 5.1

Rule 1.7 - Refer to Chapter 5, Rule 5.2

Rule 1.8 - Refer to Chapter 5, Rule 5.3 and Rule 5.6

Rule 1.9 - Refer to Chapter 5, Rule 5.4

Rule 1.10 - Refer to Chapter 5, Rule 5.5

Rule 1.11: Documentation Requirements

The hospital must maintain legible and auditable records that will substantiate the claim submitted to Medicaid. At a minimum, the records must contain the following on each patient:

A. Date of service.

B. A comprehensive history and physical assessment/report, including the patient's presenting

complaint.

C. Diagnosis(es) to substantiate the hospitalization and all treatments/procedures rendered during the hospitalization.

D. The specific name/type of all diagnostic studies, including lab, x-ray, and the like, and the medical indication and results/finding of the studies.

E. Documentation and consult reports to substantiate treatment/procedures rendered, the patient's response to the treatment/procedure; and the signature or initials of the appropriate health care worker providing the treatment/procedure, including but not limited to the physician, nurse, therapist, dietitian.

F. The name, strength, dosage, route, either IM, IV, PO, topical, enteral, intracatheter, date and time, indication for, and the administration of all medications administered to the patient.

G. Discharge planning and instructions, including the signature or initials of the health care worker performing the instruction; the name of the person being instructed; date and time of instruction; whether the instructions are given in writing, verbally, by telephone or other means; and how much instruction was comprehended by the beneficiary, including level of proficiency on return demonstration when a procedure is being taught.

H. Discharge orders for medications, treatments and procedures that indicate whether the orders/prescriptions are issued in writing, verbally, or by telephone, and to whom the orders are issued.

I. Signed physician orders for all medications, treatments, and procedures rendered to the patient.

J. All x-ray images, including films and digital images, films, and digital images must be of such quality that they can be clearly interpreted.

Source: 42 CFR § 424.13; Miss. Code Ann. § 43-13-121.

Rule 1.12: Disproportionate Share Hospital

The Disproportionate Share Hospital (DSH) program and the qualifications for participation in the DSH program are defined in Attachment 4.19-A of the Medicaid State Plan.

Source: 42 CFR § 447.298; Miss. Code Ann. § 43-13-121.

Rule 1.13: Out-of-State Facilities

A. Out-of-state hospitals are reimbursed under the APR-DRG payment methodology. The inpatient cost-to-charge ratios (CCRs) used to pay cost outlier payments for each out-of-state hospital are set annually using the Federal Register that applies to the federal fiscal year

beginning October 1 of each year, issued prior to the reimbursement period. The inpatient CCR is calculated using the sum of the statewide average operating urban CCR plus the statewide average capital CCR for each state.

B. For transplants not available in Mississippi, payment for transplant services performed outside of Mississippi is made under the MS APR-DRG payment methodology including a policy adjustor. If access to quality services is unavailable under the MS APR-DRG payment methodology, a case rate may be set as described in Part 202, Chapter 4, Rule 4.7.
C. For specialized services not available in Mississippi, the Division of Medicaid will make payment using the MS APR-DRG payment methodology. If MS APR-DRG payment limits access to care, the Division will reimburse what the domicile state pays for the service or a comparable payment other states reimburse under APR-DRG.

Source: 42 CFR § 431.52; 42 USC § 1395f, also known as, Social Security Act § 1814; Miss. Code Ann. §§ 43-13-121, 43-13-117(A)(1)(d).

History: Revised - 01/01/2013, 10/01/2012

Rule 1.14: Inpatient Hospital Payments

A. For admissions dated October 1, 2012 and after, the Division of Medicaid reimburses all hospitals a per stay rate based on All Patient Refined Diagnosis Related Groups (APR-DRGs). APR-DRGs classify each case based on information contained on the inpatient Medicaid claim including diagnosis, procedures performed, patient age, patient sex, and discharge status. The APR-DRG payment is determined by multiplying the APR-DRG relative weight by the APR-DRG base rate. Medicaid uses a prospective method of reimbursement and will not make retroactive adjustments except as specified in the Title XIX Inpatient Hospital Reimbursement Plan.

B. Medicaid may adjust APR-DRG rates pursuant to changes in federal and/or state laws or regulations or to obtain budget goals. All Plan changes must be approved by the federal grantor agency.

C. Extraordinarily costly cases in relation to other cases within the same DRG because of the severity of the illness or complicating conditions may qualify for a cost outlier payment. This is an add-on payment for expenses that are not predictable by the diagnoses, procedures performed, and other statistical data captured by the DRG grouper.

1. The additional payment for a cost outlier is determined by calculating the hospital's estimated loss. The estimated loss is determined by multiplying the covered charges by the hospital's inpatient cost-to-charge ratio minus the DRG base payment. If the estimated loss is greater than the DRG cost outlier threshold established by the Division of Medicaid, then the cost outlier payment equals the estimated loss minus the DRG cost outlier threshold multiplied by the DRG Marginal Cost Percentage. For purposes of this calculation, the DRG base payment is net of any applicable transfer adjustment.

2. Stays assigned to mental health DRGs are not eligible for cost outlier payments, but may qualify for a day outlier payment if the mental health stay exceeds the DRG Long Stay Threshold.

D. Cost-to-Charge Ratio (CCR) Used to Calculate Cost Outlier Payments

1. The Cost-to-Charge Ratios (CCRs) use to calculate cost outlier payments are calculated annually for each provider by performing a desk review program developed by the Division of Medicaid, using the most recent filed cost report. The Division accepts amended original cost reports if the cost report is submitted prior to the end of the reimbursement period in which the cost report is used for payment purposes. If the provider's inpatient cost-to-charge ratio used to pay cost outlier payments is changed as a result of the amended cost report, no retroactive adjustments are made to cost outlier payments using the amended cost-to-charge ratio. After the amended desk review is completed and the thirty (30) day appeal option has been exhausted the new inpatient cost-to-charge ratio is entered into the Mississippi Medicaid Management Information System and is in effect from the date of entry through the end of the current reimbursement period.

2. Out-of-state hospitals are reimbursed under the APR-DRG payment methodology. The inpatient cost-to-charge ratios (CCRs) used to pay cost outlier payments for each out-of-state hospital are set annually using the Federal Register that applies to the federal fiscal year beginning October 1 of each year, issued prior to the reimbursement period. The inpatient CCR is calculated using the sum of the statewide average operating urban CCR plus the statewide average capital CCR for each state.

3. A Mississippi facility which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the sale. The seller must file a final cost report with the Division of Medicaid from the date of the last cost report to the effective date of the sale. The filing of a final cost report may be waived by the Division, if the cost report is not needed for reimbursement purposes. The new owner must file a cost report from the date of change of ownership through the end of the Medicare cost report year end. The new owner must submit provider enrollment information required under the Division of Medicaid policy.

4. The inpatient cost-to-charge ratio of the old owner is used to pay cost outlier payments for the new owner. The new owner's inpatient cost-to-charge ratio used to pay cost outlier payments is calculated for the first rate year beginning October 1, for which the new owner's cost report is available. There are no retroactive adjustments to a new owner's inpatient cost-to-charge ratio used to pay cost outlier payments.

5. New Mississippi hospitals beginning operations during a reporting year must file an initial cost report from the date of certification to the end of the cost report year end. Each rate year the inpatient cost-to-charge ratio used to pay outlier payments for each Mississippi hospital is grouped by bed class of facilities and an average inpatient cost-to-charge ratio is determined for each class. The initial inpatient cost-to-charge ratio used to pay cost

outlier payments to a new hospital will be the average inpatient cost-to-charge ratio used for the bed class of Mississippi hospitals as of the effective date of the Medicaid provider agreement until the inpatient cost-to-charge ratio is recalculated based on the new hospital's initial cost report. There are no retroactive adjustments to a new hospital's inpatient cost-to-charge ratio used to pay cost outlier payments.

Source: Social Security Act § 1814 142 USC 1395f; 42 U.S.C. § 139 SWW. Also known as Social Security Act § 1886; 42 CFR § 447.325; Miss. Code Ann. §§ 43-13-121, 43-13-117 (A)(1)(d).

History: Revised - 10/01/2012

Rule 1.15: Cost Reports

A. Facilities must submit a Uniform Cost Report to Medicaid following the close of their Medicare Title XVIII approved year end. Any deviations to the reporting year, such as a Medicare approved change in fiscal year end should be submitted to Division of Medicaid in writing. In cases where there is a change in the fiscal year end, the most recent cost report is used to perform the desk review. All other filing requirements shall be the same as those for Title XVIII, unless specifically outlined in the Hospital State Plan.

B. Cost reports must be submitted on or before the last day of the fifth (5th) month following the close of the reporting period. Should the due date fall on a weekend, a State of Mississippi holiday, or a federal holiday, the due date shall be the first (1st) business day following such weekend or holiday. Medicaid does not grant routine extensions for cost reports. Extensions of time to file may be granted due to unusual situations or to match a Medicare filing. Extraordinary circumstances are considered on a case-by-case basis. Extensions may only be granted by the Executive Director of the Division of Medicaid.

C. Cost reports that are either postmarked or hand delivered after the due date will be assessed a penalty in the amount of fifty dollars ($50.00) per day the cost report is delinquent.

D. Hospitals that do not file a cost report within six (6) calendar months after the close of its reporting period are subject to cancellation of its Provider Agreement at the discretion of Medicaid.

E. All cost reports are required to detail their entire reporting year making appropriate adjustments as required by the Hospital State Plan for determination of allowable costs. The cost report must be prepared in accordance with the methods of reimbursement and cost findings in accordance with Title XVIII (Medicare) Principles of Reimbursement except where further interpreted by the Provider Reimbursement Manual, Section 2414 or as modified by the State Plan.

F. All cost reports must be filed with DOM. When it is determined that a cost report has been submitted that is not complete enough to perform a desk review, the provider is notified. The provider must submit a complete cost report. When it is determined that certain information

is missing, providers are allowed a specified amount of time to submit the requested information. For cost reports which are submitted by the due date, ten (10) working days from the date of the provider's receipt of the request for additional information are allowed for the provider to submit the additional information. If requested additional information has not been submitted by the specified date, an additional request for the information is made. The provider is given five (5) working days from the date of the provider's receipt of the second request for information. Information that is requested that is not submitted following either the first or the second request may not be submitted for reimbursement purposes. Providers are not be allowed to submit the information at a later date, the cost report may not be amended in order to submit the additional information, and an appeal of the disallowance of the costs associated with the requested information may not be made. Adjustments may be made to the cost report by the Division of Medicaid to disallow expenses for which required documentation, including cost findings, is omitted.

G. For cost reports submitted after the due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If there is no response to the request, an additional five (5) working days will be allowed for submission of the requested information. Hospitals that do not respond will not be allowed to submit the information at a later date, the cost report may not be amended in order to submit the additional information, and an appeal of the disallowance of the costs associated with the requested information may not be made. Adjustments may be made to the cost report by the Division of Medicaid to disallow expenses for which required documentation, including cost findings, is omitted.

H. Cost reports that are incomplete will be subject to the penalty provisions for delinquent cost reports until the required additional information is submitted.

Source: Social Security Act § 1886(f)(1)(A), § 1886(b), § 1815(a), § 1833(e); 42 CFR §§ 412.52; 413.20, 413.24, 413.40; Miss. Code Ann. § 43-13-121.

History: Revised - 10/01/2012

Rule 1.16: Split Billing

A. Under DRG-based payment, hospitals cannot split bill Medicaid claims when a stay crosses a state fiscal year end, cost report year end, or under any other circumstance.

B. For Mississippi Medicaid, the twenty-three (23) hour observation stay is not considered a split bill.

Source: Miss. Code Ann. §§ 43-13-117 (A)(1)(d), 43-13-121.

History: Revised - 10/01/2012

Rule 1.17: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.18: Review for Medical Necessity and/or Independent Verification and Validation (IV&V)

A. The Division of Medicaid defines Review for Medical Necessity and/or Independent Verification and Validation (IV&V) as the Utilization Management/Quality Improvement Organization (UM/QIO) or Division of Medicaid, or designee, review of services of Medicaid beneficiaries in the inpatient setting for including, but not limited to, the following:

    1. Meeting clinical guidelines for medical necessity. [Refer to Part 200, Rule 5.1 for definition of medical necessity],

    2. Appropriateness of setting and quality of care,

    3. Appropriate lengths of stay and services, and

    4. Correct All Patient Refined Diagnosis Related Groups (APR-DRG) assignment.

B. The inpatient hospital provider must submit the requested documentation to the UM/QIO or the Division of Medicaid, or designee, within the specified time frame in the Notice.

C. Inpatient hospital providers may request an Administrative Appeal when the provider is dissatisfied with final administrative decisions of the Division of Medicaid relating to disallowances as a result of a review for medical necessity or an IV&V decision described in Miss. Admin. Code Part 202, Rule 1.18.A.

D. Providers must comply with the appeal provisions in Miss. Admin. Code Part 300, Rule 1.1.

Source: 42 CFR Part 456, § 307.15(b)(10); Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New eff. 09/01/2014.

Part 202 Chapter 2: Outpatient Services

Rule 2.1: General

Medicaid provides financial assistance for outpatient hospital services. An outpatient is a person who is being provided services by a hospital other than on an inpatient basis or for whom laboratory or radiology services are performed for a referring physician. All rules set forth in Part 202, Chapter 1, are applicable to outpatient services in addition to those specifically outlined in this chapter.

Source: 42 CFR § 440.20(a); Miss. Code Ann. § 43-13-121.

Rule 2.2: Outpatient Hospital Services

A. Medicaid defines outpatient hospital services as preventative, diagnostic, therapeutic, rehabilitative, or palliative services provided by a licensed hospital to an outpatient by or under the direction of a physician or dentist.

1. Medically necessary outpatient hospital services are covered when all of the following criteria apply:

   a) Outpatient services are provided in a clinic or other facility that is not located inside the hospital.

   b) The clinic or other facility has been designated as an outpatient facility by the hospital.

   c) The clinic or other facility was in operation or under construction on July 1, 2009. and

   d) The costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report.

2. For hospital clinics not located inside the hospital and constructed after July 1, 2009 the Medicare thirty five (35) mile rule will apply.

3. Outpatient services must be provided by hospital salaried or contracted employees. For purposes of this rule, contracted services are defined as hospital services provided according to a written agreement between a hospital and the health care professional providing the hospital services.

4. Hospitals may bill only for services provided in the hospital's outpatient department as defined above.

B. Off Site Services are services provided off site and outside of the outpatient hospital departments by contracted or employed hospital employees are not covered as outpatient hospital services.

C. Partial hospitalization programs or day treatment programs are not covered in an outpatient hospital setting. The Division of Medicaid defines partial hospitalization or day treatment programs as:

1. Those clearly billed as partial hospitalization/day treatment,

2. Those represented to the community as partial hospitalization programs or day treatment programs, or

3. Those billed to the Division of Medicaid using revenue and procedure codes reflecting multiple units or daily services.

D. Professional Fees are physician services performed in hospital owned physician clinics. Hospitals are covered and must be submitted under a physician group provider number.

Source: 42 CFR § 440.20(a); Miss. Code Ann. § 43-13-121.

Rule 2.3: Emergency Department Outpatient Visits

A. Emergency department services, also referred to as emergency room services, are allowed for all beneficiaries without limitations. Emergency department services provided by hospitals, except for Indian Health Services, are reimbursed using the outpatient prospective payment methodology.

B. Services provided during an emergency department visit resulting in an inpatient hospital admission must be included on the inpatient hospital claim.

1. The "Statement Covers Period From Date" on the inpatient hospital claim is the first date the beneficiary enters the emergency department.

2. The "Treatment Authorization Code" on the inpatient hospital claim is the Treatment Authorization Number (TAN) received from the Utilization Management and Quality Improvement Organization (UM/QIO) which corresponds with the date the physician documents the inpatient hospital admission in the physician's orders.

   a) A TAN is not required for an emergency department visit directly preceding an inpatient admission.

   b) A TAN issued by the UM/QIO is only required for an inpatient admission/continued stay.

Source: 42 CFR §§ 440.230, 447.204; SPA 2012-008; SPA 2012-009; Miss. Code Ann. § 43-13-121.

History: Removed Rule 2.3.B language to correspond with SPA 2012-009 (eff. 09/01/2012) and added language for clarification with SPA 2012-008 (eff. 10/01/2012) eff. 11/01/2013, Revised eff. 01/01/2013, Revised eff. 11/01/2012, Revised eff. 09/01/2012.

Rule 2.4: Outpatient (23-Hour) Observation Services

Medicaid defines outpatient twenty-three (23) hour observation services as those services furnished on a hospital's premises, whether in an emergency department or a designated non-critical care area, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate a beneficiary's condition or determine the need for possible admission as an inpatient.

1. The terms “outpatient observation”, “twenty-three (23) hour observation”, and/or “day patient” are interchangeable.

2. The availability of outpatient observation services does not mean that services for which an overnight stay is anticipated may be performed and billed to the Division of Medicaid on an outpatient basis.

B. Outpatient observation services must be documented in the physician’s orders by a physician or other individual authorized by hospital staff bylaws to admit patients to the hospital or to order outpatient diagnostic tests or treatments. The decision for ordering outpatient hospital observation services or an inpatient hospital admission is solely the responsibility of the physician. Factors that must be taken into consideration by the physician or authorized individual when ordering outpatient observation are:

1. Severity of the beneficiary’s signs and symptoms,

2. Degree of medical uncertainty the beneficiary may experience an adverse occurrence,

3. Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the beneficiary to remain at the hospital for more than twenty-three (23) hours to assist in assessing whether the beneficiary should be admitted, and

4. Availability of diagnostic procedures at the time and location where the beneficiary seeks services.

Non-Covered Services

1. Medicaid does not cover more than twenty-three (23) consecutive hours in an observation period and only covers service that are appropriate to the specific medical needs of the beneficiary.

2. Medicaid considers the following as non-covered outpatient observation services:

a) Substitution of outpatient services provided in outpatient observation for physician-ordered inpatient hospital services.

b) Services not reasonable, necessary or cost effective for the diagnosis or treatment of a beneficiary.

c) Services provided solely for the convenience of the beneficiary, facility, family or the physician.

d) Excessive time and/or amount of services medically required by the condition of the beneficiary.

e) Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for outpatient observation services.

f) Discharging beneficiaries receiving inpatient hospital services to outpatient observation services.

g) Services for routine preparation and recovery of a beneficiary following diagnostic testing or therapeutic services provided in the facility.

h) Services provided when an overnight stay is planned prior to, or following, the performance of procedures such as surgery, chemotherapy, or blood transfusions.

i) Services provided in an intensive care unit.

j) Services provided without a physician's order and without documentation of the time, date, and medical reason for outpatient observation services.

k) Services provided without clear documentation as to the unusual or uncommon circumstances that would necessitate outpatient observation services.

l) Complex cases requiring inpatient hospital services.

m) Routine post-operative monitoring during the standard recovery period.

n) Routine preparation services furnished prior to diagnostic testing in the hospital outpatient department and the recovery afterwards.

o) Outpatient observation services billed concurrently with therapeutic services such as chemotherapy or physical therapy.

Medical Records Documentation

1. The medical record must substantiate the medical necessity for observation including appropriateness of the setting. When the outpatient observation setting is non-covered, all services provided in the outpatient observation setting are also non-covered.

2. Documentation in the medical record must include:

   a) Orders for outpatient observation services and the reason for outpatient observation services must be documented in the physician's orders and not the emergency department record and must specify "admit to observation." Only an original or electronic signature is acceptable.

   b) Changes from "outpatient observation to "inpatient hospital" must be ordered by a physician or authorized individual.

c) Changes from outpatient observation services to inpatient hospital services must be supported by documentation of medical necessity.

d) A physician's order for inpatient hospital admission and discharge from outpatient observation.

e) Documentation a physician had face-to-face contact with the beneficiary at least once during outpatient observation.

f) The actual time of outpatient observation and the services provided.

E. Billing

1. Medicaid considers the twenty-three (23) hour outpatient observation stay as an outpatient service when the stay does not result in an inpatient hospital admission.

2. Services provided during outpatient observation resulting in an inpatient hospital admission must be included on the inpatient hospital claim.

   a) The "Statement Covers Period From Date" on the inpatient hospital claim is the first date the beneficiary received outpatient observation services.

   b) The "Treatment Authorization Code" on the inpatient hospital claim is the Treatment Authorization Number (TAN) received from the Utilization Management and Quality Improvement Organization (UM/QIO) which corresponds with the date the physician documents the inpatient hospital admission in the physician's orders.

      1) A TAN is not required for outpatient observation services directly preceding an inpatient admission.

      2) A TAN issued by the UM/QIO is only required for an inpatient admission/continued stay.

Source: 42 CFR §§ 440.2(a), 482.24(c); SPA 2012-008; Miss. Code Ann. § 43-13-121.

History: Revised E.2. to correspond with SPA 2012-008 (eff. 10/01/2012) and added language for clarification to E.2. eff. 11/01/13.

Rule 2.5: Outpatient Dialysis

Services provided in hospital-based renal dialysis units (RDU) are covered and are not subject to any visit limitations.

Source: Miss. Code Ann. § 43-13-117(2), 43-13-121.

Rule 2.6: Mental Health Services

A. Mental Health services are covered when:

1. Provided in an outpatient department of a general hospital, and outpatient mental health services are not covered in acute freestanding psychiatric facilities.

2. Prior authorized through the Utilization Management and Quality Improvement Organization (UM/QIO). Failure to obtain prior authorization will result in denial of payment.

B. Outpatient hospital mental health services will be reimbursed using the same methodology as other outpatient hospital services.

Source: 42 CFR § 410.155; Miss. Code Ann. § 43-13-121.

Rule 2.7: Out-of-State Facilities

Out-of-state hospitals will be reimbursed using the same methodology as Mississippi hospitals.

Source: 42 CFR § 431.52; Miss. Code Ann. §§ 43-13-121, 43-13-117 (A)(2)(c).

History: 9/1/2012

Rule 2.8: Outpatient Rates

A. Except as otherwise specified all outpatient hospital services for all hospitals except Indian Health Services will be reimbursed under a prospective payment methodology.

B. Hospital-based clinics may not bill facility fees unless they are a teaching hospital with a resident-to-bed ratio of 0.25 or greater.

Source: 42 CFR § 447.321; Miss. Code Ann. §§ 43-13-121, 43-13-117 (A)(2)(c).

History: 9/1/2012

Rule 2.9: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.10: Phase II Cardiac Rehabilitation Services

A. The Division of Medicaid defines Phase II Cardiac Rehabilitation services as a physician supervised program designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to their optimal functional status including their physiological, psychological, social, vocational and emotional status including, but not limited to:

   1. Formal exercise sessions with continuous electrocardiographic (ECG) monitoring,

   2. Risk factor education, and

   3. Behavior modification counseling.

B. Providers must comply with all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to:

   1. Being a current Mississippi Division of Medicaid provider,

   2. Being located in the state of Mississippi, and

   3. Holding a current certification from the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR).

C. The Division of Medicaid covers Phase II Cardiac Rehabilitation services for beneficiaries eighteen (18) and older for one (1) of the qualifying episodes:

   1. Acute myocardial infarction within the preceding twelve (12) months,

   2. Coronary artery bypass graft within six (6) months,

   3. Percutaneous transluminal coronary angioplasty or percutaneous coronary intervention within six (6) months,

   4. Heart valve repair/replacement within six (6) months,

   5. Heart transplant within one (1) year, or

   6. Stable angina positive stress test within six (6) months.

D. The Division of Medicaid covers up to thirty-six (36) Phase II Cardiac Rehabilitation sessions per twelve (12) months regardless of the number of qualifying episodes.

   1. The twelve (12) month period begins with the initiation of Phase II Cardiac Rehabilitation.

2. Phase II Cardiac Rehabilitation is covered for only one (1) qualifying episode during the twelve (12) month period.

3. The thirty-six (36) Phase II Cardiac Rehabilitation sessions must occur within twelve (12) weeks from initiation of services unless a medical condition prevents the beneficiary from completing the thirty-six (36) sessions. Prior authorization for the extension must be obtained from the Utilization Management and Quality Improvement Organization (UM/QIO) up to an additional twelve (12) weeks.

E. Phase II Cardiac Rehabilitation Services must be:

1. Furnished in the outpatient hospital setting with physician supervision as required in compliance with AACVPR guidelines, and

2. Prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO).

F. The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: 42 CFR § 410.49; Miss. Code Ann. § 43-13-121.

History: New Rule eff. 02/01/2014.

Rule 2.11: Refer to Part 200, Chapter 5, Rule 5.6

Part 202 Chapter 3: Swing Beds

Rule 3.1: Definition

Swing bed services are extended care services provided in a hospital bed that has been designated as such. Services consist of one or more of the following:

A. Skilled nursing care and related services for patients requiring medical or nursing care,

B. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and

C. On a regular basis, health related care and services to individuals who, because of their medical status, require care and services above the level of room and board which can be made available to them only through institutional facilities.

Source: Miss. Code Ann. § 43-13-121.

Rule 3.2: Certification of Providers/ Provider Enrollment

A. The Division of Medicaid requires any hospital certified for participation in the Medicare

swing bed program who wants to participate in the Medicaid program to become a provider. A separate provider number from the hospital is required for the swing bed.

B. Hospital providers, including swing bed providers applying for enrollment into the Medicaid program must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to submitting the following provider type specific requirements:

1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

2. Written confirmation from the IRS confirming the provider's tax identification number and legal business name.

3. CLIA certificate and submit the completed certification form.

4. Joint Commission on Accreditation of Health Care Organization (JCAHO) for licensed hospitals.

5. Copy of current Medicare certification or Tie-In Notice. Explanation of Medicare Benefits (EOMB) is not acceptable.

6. Copy of outstanding claims, if applicable, for out-of state facility.

7. Copy of Hospital license:

   a. Copy of license/certification, in effect during the claims period for which they are billing for out-of state facility.

   b. In-state facility: A copy of letter from the Mississippi State Department of Health is acceptable for in-state facility.

   c. License in effect for the new owner for Hospital undergoing a Change of Ownership (CHOW).

Source: Miss. Code Ann. § 43-13-121.

Rule 3.3: Coverage Criteria

A. Swing bed services are covered when all these criteria are met:

1. Services to be furnished are ordered by a physician, are consistent with the nature and severity of the beneficiary's illness or injury, medical needs, and accepted standards of medical practice, and are reasonable in duration and quantity,

2. The beneficiary requires daily and continuous (not intermittent) skilled nursing and/or rehabilitation services to prevent or minimize deterioration or to sustain health status,

3. The beneficiary does not require daily supervision of a physician but does require a physician visit and evaluation at least every thirty (30) days while the beneficiary is in the swing bed setting,

4. A nursing facility bed is not available and the required services cannot be safely and effectively provided in the beneficiary's residence,

5. In addition to the need for skilled nursing and/or rehabilitation services, the beneficiary must require, at a minimum, assistance with at least three (3) activities of daily living (eating, toileting, personal hygiene, bathing, ambulation, dressing) which cannot be safely and cost-effectively provided in the beneficiary's residence and which must be performed by, or under the supervision of, registered nurses, licensed practical nurses, physical therapists, or occupational therapists.

6. Swing bed services may be covered as long as the beneficiary meets the coverage criteria and there is no available bed in a nursing facility. It is expected that the beneficiary will be discharged or transferred to a nursing facility when the beneficiary's condition allows or a nursing home bed becomes available.

B. Swing bed services are not covered when the beneficiary does not meet the coverage criteria in this Part. Examples include, but are not limited to, the following:

1. The primary service is oral medications.

2. The beneficiary is capable of independent ambulation, dressing, feeding, toileting, and hygiene.

3. Insulin injections are the only service a beneficiary is receiving, and prior to hospitalization, the beneficiary was on self-injections at the beneficiary's residence.

4. The beneficiary and/or primary caregiver are capable of being taught to safely perform the necessary treatment at the beneficiary's residence.

5. When services can be safely and more cost-effectively provided in the beneficiary's residence.

6. If the beneficiary needs intermittent rather than daily and continuous care.

7. If a beneficiary's condition requires an acute inpatient hospital level of care.

Source: Miss. Code Ann. § 43-13-121.

Rule 3.4: Reimbursement

A. Individuals who are placed in swing beds in a hospital may have Medicare only, Medicare

and Medicaid, or Medicaid only.

1. In all instances where a Medicaid beneficiary is covered by Medicare, Medicare is the primary payer for a swing bed stay.

2. Medicaid covers swing bed care for Medicare and Medicaid dual eligibles when:

   a) The Medicaid beneficiary's medical condition does not qualify for Medicare, or

   b) Medicare benefits are exhausted.

B. The methods and standards used to determine payment rates to hospital providers of nursing facility (NF) services furnished by a swing bed hospital provides for payment for the routine NF services at the average rate per patient day paid to NFs for routine services furnished during the previous calendar year.

C. Beneficiaries who have Part A Medicare are the responsibility of the Medicare program when in a swing bed. Medicaid will cover the Medicare coinsurance after the 20th consecutive day in a swing bed for Medicare/Medicaid beneficiaries through day one hundred (100) or the last day covered by Medicare, whichever comes first.

D. The swing bed facility must provide and pay for all services and supplies required by the plan of care and ordered by a physician. During the course of a covered Medicaid stay, the facility may not charge a resident for the following items and services:

1. Nursing services,

2. Specialized rehabilitative services,

3. Dietary services,

4. Activity programs,

5. Room/bed maintenance services,

6. Routine personal hygiene items and services,

7. Personal laundry, or

8. Drugs not covered by the Medicaid Pharmacy program.

E. Any items or service not covered in the per diem rate must be billed outside the per diem rates and include:

1. Items and services covered by Medicare Part B or any other third party.

2. Any service or supply billed directly to Medicaid for swing bed residents including:

   a) Lab services,

   b) X-rays,

   c) Drugs covered as specified in Part 214,

   d) Therapy services as specified in Part 213, or

   e) Durable Medical Equipment as specified in Part 209.

Source: Omnibus Budget Reconciliation Act of 1987 (OBRA 87) Pub. L. 97-35, Section 2153 ; Miss. Code Ann. § 43-13-121.

Rule 3.5: Documentation Requirements

A. The Division of Medicaid requires providers of swing bed services to maintain auditable records that substantiate the services provided. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3. At a minimum, the records must contain the following on each beneficiary:

   1. Date of service,

   2. History and physical exam, with update if necessary,

   3. Physician's progress notes,

   4. Medical indication,

   5. Results and finding of all diagnostic and lab procedures,

   6. Treatment rendered,

   7. Provider's signature or initials,

   8. Documentation of services consisting of skilled nursing care and related services for patients requiring medical or nursing care,

   9. Documentation of rehabilitation services for the rehabilitation of injured, disabled or sick persons, and

   10. Frequent documentation of health related care and services to individuals who, because of their medical status, require care and services above the level of room and board which can be made available only through institutional facilities.

Source: Miss. Code Ann. §§ 43-13-121, 43-13-117, 43-13-118.

Part 202 Chapter 4: Organ Transplants

Rule 4.1: Transplant Provider Requirements

Providers of transplant services must:

A. Complete the requirements for participation in the Mississippi Medicaid program.

B. Meet the following facility criteria:

1. Solid organ transplant procedures must be performed in a facility which meets the Centers for Medicare and Medicaid Services (CMS) requirements for Conditions of Participation approved as a transplant facility unless otherwise authorized by the Division of Medicaid, and

2. Bone marrow and stem cell transplant procedures must be performed in a facility accredited by a CMS-deemed national accreditation organization.

C. Obtain prior authorization from a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity for the inpatient hospital admission and for outpatient services, if required, for the transplant procedure as soon as it is determined that the beneficiary may be a potential candidate for the transplant.

1. The prior authorization request must include, but is not limited to the following:

a) A description of the medical condition which necessitates the transplantation,

b) Diagnostic confirmation by clinical laboratory studies of the underlying pathological process,

c) A history of other treatments which have been tried and treatments which have been considered and ruled out, including an explanation as to why the treatment was ruled out,

d) Comprehensive assessments:

1) Examination, evaluation and recommendations completed by a board-certified or board-eligible specialist in a field directly related to the beneficiary's condition which necessitates the transplantation,

2) Psycho-social evaluation including a comprehensive history of substance abuse and compliance with any medical treatment of:

(a) The beneficiary, and

(b) The parents or guardian/legal representative if the beneficiary is less than eighteen (18) years of age,

e) Psychiatric evaluation of the beneficiary if the beneficiary has a history of mental illness,

f) Infectious disease evaluation of a beneficiary with a recent or current suspected infectious episode,

g) Evaluation of a beneficiary diagnosed with cancer that includes staging of the cancer, laboratory tests, and imaging studies, and

h) Any other medical evidence needed to evaluate possible contraindications for the type of transplantation being considered.

2. Prior authorization is not required for transplants when the beneficiary has Medicare coverage.

3. Prior authorization is required for transplants when the beneficiary has third party coverage and the hospital intends to bill Medicaid for any transplant related hospital charges.

D. Ensure that the transplant procedure is performed at the facility requesting prior authorization for the transplant procedure.

E. Submit documentation for a concurrent review for beneficiaries not enrolled in a Coordinated Care Organization (CCO) to a UM/QIO, the Division of Medicaid, or designated entity if a beneficiary's length of stay exceeds nineteen (19) days.

F. Provide the appropriate medical records, progress or outcome reports as requested by a UM/QIO, the Division of Medicaid, or designated entity.

Source: 42 U.S.C. § 1320b-8; 21 C.F.R. Parts 1270 and 1271; 42 C.F.R. Part 121, 42 C.F.R. §§ 441.35, 482.12, 482.68-104; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2017; Revised eff.10/01/2012.

Rule 4.2: Covered Services

A. The Division of Medicaid covers the following solid organ transplant services when medically necessary and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity:

1. Single organs:

a) Heart, according to current criteria of the International Society for Heart and Lung Transplantation,

b) Intestine, according to current criteria of the American Gastroenterological Association and American Society of Transplantation,

c) Liver, according to current criteria of the American Association for the Study of Liver Diseases and the American Society of Transplantation,

d) Single lung, according to current criteria of the Pulmonary Transplantation Council of the International Society for Heart and Lung Transplantation, and

e) Bilateral lung, according to current criteria of the Pulmonary Transplantation Council of the International Society for Heart and Lung Transplantation,

2. Multiple-organs which meet the current criteria according to the respective single organ criteria in Rule 4.2.A.:

a) Heart-lung,

b) Intestines with other organs,

c) Kidney-heart,

d) Kidney-pancreas, which only reimburses for the kidney transplant,

e) Liver-kidney, and

f) Other multi-organs.

B. The Division of Medicaid covers kidney transplants when medically necessary with no prior authorization.

C. The Division of Medicaid covers bone marrow transplantations, peripheral stem cell transplantations and cornea transplantations when medically necessary with no prior authorization, meets Medicare coverage guidelines and are not experimental or investigational.

D. The Division of Medicaid covers all facility and physician charges relating to the procurement of an organ, whether from a cadaver or a living donor.

1. The Division of Medicaid covers donor related charges including, but not limited to, the following:

a) A search for matching tissue, bone marrow, or organ,

b) The donor's transportation,

c) Charges for the removal, withdrawal, and preservation/storage of the organ or tissue, and

d) The donor's hospitalization.

2. The Division of Medicaid covers medically necessary follow-up care outside of the transplant inpatient hospital admission for the living donor only if the donor is a Mississippi Medicaid beneficiary.

Source: 42 C.F.R. §§ 441.35, 482.90-104; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2017; Revised eff.10/01/2012.

Rule 4.3: Non-Covered Services

The Division of Medicaid does not cover the following transplant procedures/services including, but not limited to:

A. Transplant procedures/services not medically necessary,

B. Transplant procedures/services still in clinical trials and/or investigational or experimental in nature,

C. Transplant procedures/services performed in a facility not approved by the Division of Medicaid and/or meeting the criteria in Miss. Admin. Code Part 202, Rule 4.1,

D. Inpatient admissions or outpatient procedures, if required, for transplant procedures/services that have not been prior authorized by a UM/QIO, the Division of Medicaid, or designated entity, or

E. Pancreas transplants.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017.

Rule 4.4: Reimbursement

A. All fee-for-service (FFS) transplants performed in the state of Mississippi are paid under the Mississippi All Patient Refined-Diagnosis Related Group (APR-DRG) payment methodology, including a policy adjustor.

B. All FFS transplants available in Mississippi but performed outside the state of Mississippi are paid under the Mississippi APR-DRG payment methodology, including a policy adjustor.

C. Payment for transplant services not available in Mississippi is made under the Mississippi APR-DRG payment methodology including a policy adjustor. If the Mississippi APR-DRG payment limits access to care, a case rate may be set.

1. A case rate is set at forty percent (40%) of the sum of billed charges for transplant services as published in the State Plan according to *Milliman's U.S. Organ and Tissue Transplant Cost Estimates and Discussion*.

2. The *Milliman* categories comprising the sum of billed charges include outpatient services received thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) hospital discharge. Outpatient immunosuppressants and other prescriptions are not included in the case rate.

3. If the transplant hospital stay exceeds the hospital length of stay published by *Milliman*, an outlier per-diem payment will be made for each day that exceeds the hospital length of stay.

4. Reimbursement for transplant services cannot exceed one-hundred percent (100%) of the sum of *Milliman's* billed charges for the categories listed in Miss. Admin. Code Part 202, Rule 4.4.C.2.

5. Provisions listed in Miss. Admin. Code Part 202, Rule 4.4 apply to transplant services on or after October 1, 2012.

6. Transplant services not available in Mississippi and not listed in the *Milliman's U.S. Organ and Tissue Transplant Cost Estimates and Discussion* will be reimbursed using the Mississippi APR-DRG payment methodology. If the Mississippi APR-DRG payment limits access to care, the Division of Medicaid will reimburse what the domicile state pays for the service.

D. All conditions of third party liability procedures must be satisfied.

E. All claims must be submitted according to the requirements of the Mississippi Medicaid program.

F. All charges, both facility and physician, relating to procurement/storage must be billed by the transplant facility on the current uniform billing (UB) claim form with the appropriate revenue code(s).

G. The Division of Medicaid reimburses all facility and physician charges relating to the procurement of an organ, whether from a cadaver or a living donor, to the transplant facility using the appropriate revenue codes.

Source: 42 C.F.R. §§ 441.35, 482.90 - 104; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017; Revised eff. 10/01/2012.

Rule 4.5: Fundraising

A. The Division of Medicaid allows fundraisers to obtain funds needed for transplant costs not covered by the Medicaid program.

B. Fundraising criteria includes, but is not limited to, the following:

1. Prior to accepting donations, arrangements must be made with the Division of Medicaid to deposit donations in a trust fund/special account.

2. The trust fund/special account must be established and administered in compliance with all applicable federal and state rules and regulations.

3. The trust fund/special account must be managed and administered by someone other than the beneficiary or the beneficiary's guardian, legal representative or family member. The beneficiary or the beneficiary's guardian, legal representative or family member cannot have direct access to the trust fund/special account.

4. Trust fund/special account must be maintained separately from personal monies belonging to the beneficiary or the beneficiary's guardian, legal representative or family member.

5. Legible and authentic documentation of income and expenditures must be made available to a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity upon request.

6. The beneficiary must report all sources of income to the Division of Medicaid. Donated funds for the purpose of payment of medical services are considered a third party source.

7. Transplant facilities/providers cannot participate in fundraising for beneficiaries to raise additional funds to pay for the transplant procedure and/or related services.

Source: 42 U.S.C. § 1396p; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017; Revised eff. 10/01/2012.

Rule 4.6: Documentation Requirements

Providers of transplant services must document and maintain records in accordance with requirements set forth in Miss. Admin. Code Part 200, Rule 1.3 on each beneficiary receiving a transplant and must include the following:

A. Comprehensive history and physical.

B. Treatments rendered that were unable to prevent progressive disability and/or death.

C. Use of tobacco, alcohol, and/or illegal drugs within the last six (6) months.

D. Absence of severe and irreversible organ dysfunction in organ(s) other than the organ(s) being transplanted.

E. Relevant diagnostic studies and results including, but not limited to:

1. X-rays,

2. Lab reports,

3. EKG reports,

4. Pulmonary function studies,

5. Psychosocial reports,

6. Nutritional evaluation, and

7. Performance status.

F. Reports, consults or other documentation to substantiate the transplant including documentation of transplant approval by the facility's transplant review team.

G. Copy of informed consent form signed by the beneficiary and/or guardian or legal representative.

Source: 42 C.F.R. § 482.90 -104; Miss. Code Ann. §§ 43-13-117; 43-13-118; 43-13-121.

History: Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017.

Rule 4.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for early and periodic screening, diagnosis, and treatment (EPSDT)-eligible beneficiaries in accordance with Miss. Admin. Code Part 223, without regard to service limitations and with prior authorization.

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

History: Renumbered rule eff. 01/01/2017; Revised eff. 01/01/2013; Revised eff. 10/01/2012.

Part 202 Chapter 5: Hospital Procedures

Rule 5.1: Hyperbaric Oxygen Therapy

A. Hyperbaric Oxygen Therapy (HBOT) is covered in an inpatient or outpatient hospital setting in accordance with current standards of medical practice when the following criteria are met:

   1. The patient's entire body must be placed into the hyperbaric chamber. Note that topical application of oxygen with portable chambers is not covered.

   2. HBOT must be performed in the hospital setting, either inpatient or outpatient.

   3. A physician must order HBOT treatments, document medical necessity, and establish the plan of care specifying the goals for hyperbaric oxygen therapy to accomplish and an estimated number of treatments, with revisions made as appropriate and justification for extending treatments.

   4. A cardiopulmonary resuscitation team and a fully equipped emergency cart must be immediately available where the hyperbaric chamber is located when a patient is receiving HBOT in the event of a complication.

B. Hyperbaric oxygen therapy is covered for the following medical diagnoses only:

   1. Acute carbon monoxide intoxication,

   2. Decompression illness (Caisson disease),

   3. Air (gas) embolism,

   4. Gas gangrene,

   5. Acute traumatic peripheral ischemia, as adjunctive treatment to accepted standard therapeutic measures when function, life, or limb is threatened,

   6. Crush injuries and suturing of severed limbs, as adjunctive treatment to accepted standard therapeutic measures when function, life, or limb is threatened,

   7. Progressive necrotizing infections - necrotizing fasciitis or meleney ulcer also known as pyoderma gangrenosum,

   8. Acute peripheral arterial insufficiency,

   9. Preparation and preservation of compromised skin grafts,

   10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical

management,

11. Osteoradionecrosis, as an adjunct to conventional treatment,

12. Soft tissue radionecrosis, as an adjunct to conventional treatment,

13. Cyanide poisoning, and

14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment.

C. Physician must be in constant personal attendance where the hyperbaric oxygen chamber is located while the patient is receiving HBOT and must not delegate administration of HBOT to hospital staff. Physician's absence during the entire HBOT treatment shall result in reimbursement to the facility only.

D. Documentation of Medical Necessity:

1. Documentation must be legible and available for review if requested.

2. Documentation must include the following:

a) Specific written record that HBOT was performed in a hospital setting, inpatient or outpatient, utilizing a full body hyperbaric chamber;

b) A written physician order, comprehensive history, and physical report detailing the condition/diagnosis(es) requiring HBOT, including prior treatments and their results and additional treatments being rendered concurrently with HBOT;

c) Physician progress notes and consultation reports that describe the patient's response to treatment;

d) Established goals for hyperbaric oxygen therapy to accomplish and an estimated number of treatments, with revisions made as appropriate and justification for extending treatments;

e) Wound description, if applicable, including wound size and appearance, for each day of service billed;

f) Radiology and laboratory reports, including culture and sensitivity studies, to support the diagnosis when applicable;

g) Specific written record of the physician's constant personal attendance where the hyperbaric chamber is located while the patient is undergoing HBOT; and

h) Specific written record of the availability of a cardiopulmonary resuscitation team

and a fully equipped emergency cart where the hyperbaric chamber is located while the patient is undergoing HBOT.

Source: 42 CFR §§ 410.26(a)(2), 410.27(f), 410.32(b)(3)(ii); Social Security Act §§ 1862(a)(1)(A), 1833(e); Miss. Code Ann. § 43-13-121.

History: Moved from Rule 1.5 and revised Rule 5.1.A. eff. 10/01/2013.

Rule 5.2: Chelation Therapy

A. The Division of Medicaid covers only Food and Drug Administration (FDA)-approved chelation in an inpatient or outpatient hospital setting in accordance with current standards of medical practice.

B. Conditions which may be treated with chelation include:

1. Lead poisoning,
2. Iron overload,
3. Metallic mercury poisoning,
4. Copper poisoning,
5. Arsenic poisoning,
6. Gold poisoning,
7. Cystinuria,
8. Wilson's disease, and
9. Severe, active rheumatoid arthritis that has failed to respond to an adequate trial of conventional therapy.

C. Documentation in the medical records of symptoms and/or laboratory tests must support one (1) of the listed diagnoses. Chelation therapy for the treatment of any other conditions is not a covered service.

Source: 21 CFR § 312; Miss. Code Ann. § 43-13-121.

History: Moved from Rule 1.7 and revised Rule 5.2.A. eff. 10/01/2013.

Rule 5.3: Sterilization

A. The Division of Medicaid covers sterilization procedures in an inpatient or outpatient hospital setting in accordance with current standards of medical practice for beneficiaries who:

1. Are male or female,

2. Are non-institutionalized,

3. Are twenty-one (21) years of age or older at the time of consent, and

4. Are mentally competent, able to understand the nature and consequences of the procedure, knowingly and voluntarily request the procedure, and give informed consent to be sterilized.

B. The informed consent form for sterilization:

1. Must be accurate and complete with all required signatures,

2. Must be voluntarily and knowingly signed by the beneficiary,

3. Must be signed by the beneficiary, defined as the individual to be sterilized and not the personal or legal representative,

4. Is valid for one hundred eighty (180) days from the date it is signed by the beneficiary, and

5. Must comply with 42 CFR § 441 *et al*.

C. At least thirty (30) days but not more than one hundred eighty (180) days must have passed between the date of the beneficiary signature on the informed consent form and the date the sterilization will be performed except in the case of premature delivery or emergency abdominal surgery.

1. In the case of premature delivery, defined as a delivery prior to the expected due date, informed consent must have been given at least thirty (30) days before the expected date of delivery.

2. A beneficiary may be sterilized at the time of premature delivery or emergency abdominal surgery if at least seventy-two (72) hours have passed since signing the informed consent form for the sterilization. A Caesarean delivery is not routinely considered emergency abdominal surgery.

3. The physician must justify and describe the circumstance for any premature delivery or emergency abdominal surgery and document the expected date of delivery for premature deliveries in the medical record and further certify that at least thirty (30) days have passed between the date of the beneficiary's signature on the informed consent form and the date the sterilization was performed.

D. The Division of Medicaid covers a subsequent sterilization that is due to a previously failed sterilization. Documentation in the beneficiary's medical record must reflect the date of the first sterilization and the reason for the procedure failure.

Source: 42 CFR § 50.207; 42 CFR §§ 441.251-259; 43 Fed. Reg. 52171; Miss. Code Ann. § 43-13-121.

History: Moved from Rule 1.8 and revised Rule 5.3.A.4, B.3, C.1, C.2, C.3 eff. 10/01/2013.

Rule 5.4: Abortions

A. Notwithstanding any other provision of law to the contrary, no public funds that are made available to any institution, board, commission, department, agency, official, or employee of the State of Mississippi, or of any local political subdivision of the state, whether those funds are made available by the government of the United States, the State of Mississippi, or a local governmental subdivision, or from any other public source, shall be used in any way for, to assist in, or to provide facilities for abortion, except:

   1. When the abortion is medically necessary to prevent the death of the mother, or

   2. When the abortion is being sought to terminate a pregnancy resulting from an alleged act of rape or incest, or

   3. When there is a fetal malformation that is incompatible with the baby being born alive.

B. Medicaid coverage for abortion services is governed by federal law under the Hyde Amendment, which provides that abortion services are reimbursable under Medicaid in an inpatient or outpatient hospital setting in accordance with current standards of medical practice as follows:

   1. When the abortion is medically necessary to prevent the death of the mother, or

   2. When the abortion is being sought to terminate a pregnancy resulting from an alleged act of rape or incest.

C. The physician is required to maintain sufficient documentation in the medical record that supports the medical necessity for the abortion for one of the reasons outlined in Rule 5.4.B.(a)(b).

Source: 42 CFR § 441, Subpart E; Consolidated Appropriations Act, 2008 (H.R. 2764), signed into law Dec. 26, 2007, (Public Law 110-161) Sections 507-508; Miss. Code Ann. § 43-13-121.

History: Moved from Rule 1.9 and revised Rule 5.4. B. eff. 10/01/2013.

Rule 5.5: Trauma Team Activation/Response

Trauma team activation/response payments are covered under the Mississippi Medicaid Program in an outpatient hospital setting in accordance with current standards of medical practice according to the following criteria:

A. The billing hospital must have a complete designation as a Level I, II, III, or IV trauma center through the Mississippi State Board of Health, Office of Emergency Planning and Response; or if out of state, through the responsible governing body of the state in which the beneficiary received services.

B. Payment will be made in accordance with the reimbursement methodology of the Division of Medicaid's inpatient or outpatient hospital services.

C. Trauma activation fees for beneficiaries who are "drive by," or arrive by private vehicle without notification from pre-hospital caregivers, are not covered. The patient must arrive by ambulance and the hospital must be pre-notified by pre-hospital caregivers.

D. Documentation must be maintained in the patient's medical record that supports provision of an organized trauma team response that meets the criteria for the Level I, II, III, or IV service. A facility must not bill and cannot be paid for a level of care above the one (1) which they have been designated by the Mississippi State Department of Health.

E. All patients must have a primary diagnosis that falls within the appropriate International Classification Of Disease (ICD) diagnosis code range plus documentation in the medical record of one (1) of the following situations:

    1. Transfer between acute care facilities, in or out,

    2. Admission to critical care unit, no minimum,

    3. Hospitalization for three (3) or more calendar days,

    4. Death after receiving any evaluation or treatment,

    5. Admission directly from Emergency Department to Operating Room for major procedure, excluding plastics or orthopedics procedures on patients that do not meet the three day hospitalization criteria,

    6. Triaged, in accordance with regional trauma protocols, to a trauma hospital by pre-hospital care regardless of severity, or

    7. Treated in the Emergency Department by the trauma team regardless of severity of injury.

Source: SPA 2012-008; Miss. Code Ann. §§ 43-13-117(A)(2)(c), 43-13-121(A)(1)(d).

History: Moved from Rule 1.10 and revised 5.5 eff. 10/01/2013; Revised to correspond with SPA 2012-008 eff. 10/01/2012.

Rule 5.6: Hysterectomy

A. The Division of Medicaid defines a hysterectomy as the surgical removal of the uterus.

B. The Division of Medicaid covers a hysterectomy when medically necessary in an inpatient or outpatient setting in accordance with current standards of medical practice and when:

1. Prior to the hysterectomy:

   a) The person who secured authorization to perform the hysterectomy has informed the beneficiary and guardian/legal representative, if any, orally and in writing that the hysterectomy will make the beneficiary permanently incapable of reproducing, and

   b) The beneficiary or guardian/legal representative, the person that secured authorization for the hysterectomy, and the physician who performs the hysterectomy have completed and signed the appropriate section(s) of the Hysterectomy Acknowledgement Form;

2. The beneficiary is already sterile before the hysterectomy and the physician certifies in writing on the Hysterectomy Acknowledgement Form that the beneficiary was already sterile at the time of the hysterectomy, and states the cause of sterility; or

3. The beneficiary requires a hysterectomy because of a life-threating emergency situation in which the physician determines that prior acknowledgement is not possible, and the physician certifies in writing on the Hysterectomy Acknowledgement Form that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgement was not possible and documents a description of the nature of the emergency.

C. The Division of Medicaid does not cover a hysterectomy when:

1. It is performed solely for the purpose of rendering a beneficiary permanently incapable of reproducing, or

2. There was more than one (1) purpose to the hysterectomy and it would not have been performed but for the purpose of rendering the beneficiary permanently incapable of reproducing.

Source: 42 CFR § 441.255; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2015; Added Rule 5.6.A., B.1-3, C, D eff. 05/01/2014; Moved from Rule 1.6 and revised eff. 10/01/2013.

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

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Title 23: Division of Medicaid

Part 203: Physician Services

Part 203 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements for Physicians, Osteopaths, Chiropractors, Podiatrists

Physician providers may participate in the Medicaid program upon compliance with provider enrollment requirements outlined in Part 200, Chapter 4, Rule 4.8 in addition to the specific provider type requirements listed below. Physicians, osteopaths, chiropractors and podiatrists must also meet the specific requirements as follow:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES)

B. Copy of licensure card or letter from the appropriate board stating current certification and must be from state of servicing location.

C. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

D. CLIA certificate and completed Certification form, if applicable

E. Copy of specialty certificate(s), if applicable

Source: Miss. Code Ann. § 43-13-121

Rule 1.2: Physician Fees

Effective for dates of services on and after June 1, 2005, and as authorized in House Bill 1104 during the 2005 Legislative Session, Medicaid covers physicians' services at ninety percent (90%) of the rate established on January 1, 1999 and as may be adjusted each July thereafter, under Medicare (Title XVIII of the federal Social Security Act, as amended).

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

Rule 1.3: Medical Visit Editing

Medicaid does not provide separate reimbursement for most Evaluation and Management (E&M) services when a substantial diagnostic or therapeutic procedure is performed.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Physician Office Visits

A. The Division of Medicaid covers twelve (12) physician office visits per state fiscal year whether occurring during or after office hours or provider established office hours.

B. The Division of Medicaid:

1. Defines regularly scheduled office hours as the hours between 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding Saturday, Sunday and federal and state holidays, referred to in Rule 1.4 as "office hours".

2. Permits providers to set regularly scheduled office hours outside of the Division of Medicaid's definition of office hours, referred to in Rule 1.4 as "provider established office hours".

3. Requires providers to maintain records indicating the provider's established office hours and any changes including:

a) The date of the change,

b) The provider established office hours prior to the change, and

c) The new provider established office hours.

C. The Division of Medicaid reimburses a fee in addition to the appropriate Evaluation and Management (E&M) code for a physician office visit when the visit:

1. Occurs during the provider established office hours which are set outside of the Division of Medicaid's definition of office hours, or

2. Occurs outside of office hours or provider established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or provider established office hours.

D. The Division of Medicaid reimburses only the appropriate E&M code for a physician office visit scheduled during office hours or provider established office hours but not occurring until after office hours or provider established office hours.

Source: Miss. Code Ann. § 43-13-121.

History: Removed Miss. Admin. Code Part 203, Rule 1.4.E. with the approval of SPA 2013-032 on 08/08/2014, and SPA 2013-033 on 08/05/2014, eff. 06/01/2015.

Rule 1.5: Hospital Inpatient Visits/ Consultations

A. An initial hospital visit for the beneficiary's attending physician is covered. A subsequent hospital visit is not covered on the same day as the initial visit.

B. Following the date of admission, only one subsequent hospital visit per day is allowed to the attending physician. An exception is made when the patient is in an Intensive Care Unit (ICU) or Coronary Care Unit (CCU) where the limit is two (2) visits per day.

C. An initial inpatient consultation is covered for each consultant of a different specialty if the patient's condition justifies the medical necessity for multiple consultations. Only one (1) initial consultation is allowed per beneficiary, per consultant, per admission.

D. Following the date of the initial inpatient consultation, one (1) subsequent hospital visit per day is allowed to only one (1) consulting physician if the patient's condition justifies the medical necessity for the services of more than one (1) physician of a specialty different from the attending physician.

E. A subsequent hospital visit and a hospital discharge visit on the same date of service are not both covered; only the hospital discharge visit is a covered service.

Source: Miss. Code Ann. § 43-13-121

Rule 1.6: Locum Tenens/Reciprocal Billing Arrangements

A. Locum Tenens: For purposes of this rule a "locum tenens" arrangement is defined when the regular physician retains a substitute physician to take over the practice during an absence. A regular physician is the physician that is normally scheduled to see a patient. The regular physician usually pays the substitute physician a fixed amount per diem, with the substitute physician being an independent contractor rather than an employee.

B. Reimbursement shall be made to the patient's regular physician for covered services of a locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician's offices when all the following criteria are met:

    1. The regular physician is unavailable to provide the services,

    2. The regular physician pays the locum tenens for the services on a per diem or similar fee-for-time basis,

    3. The Medicaid beneficiary has arranged or sought to receive services from the regular physician,

    4. The substitute physician does not provide the services to the Medicaid beneficiary over a continuous period of longer than sixty (60) days,

    5. The locum tenens physician is an enrolled Mississippi Medicaid provider with a valid

Mississippi Medicaid provider number,

6. The regular physician identifies the services as substitute physician services,

7. The claim is billed with the National Provider Identifier (NPI) of the regular physician,

8. The regular physician keeps on file a record of each service provided by the substitute physician, and

9. The regular physician ensures that the locum tenens physician is properly licensed to practice medicine in the state of Mississippi; or, if the regular physician practices in another state, the state in which the regular physician is licensed to practice.

C. Reciprocal Billing Arrangement: Medicaid defines reciprocal billing arrangement when a regular physician or group has a substitute physician provide covered services to a Medicaid beneficiary on an occasional reciprocal basis. A physician can have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

1. Medicaid covers reciprocal billing arrangements when the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if all the following criteria are met:

   a) The regular physician is unavailable to provide the services,

   b) A reciprocal billing arrangement is typically an agreement among physicians that one will cover the other's practice when the regular physician is absent. Physicians can have reciprocal arrangements with more than one physician,

   c) The Medicaid beneficiary has arranged or sought services from the regular physician,

   d) The substitute physician does not provide the services to a Medicaid beneficiary over a continuous period of longer than sixty (60) days,

   e) The substitute physician is an enrolled Mississippi Medicaid provider with a valid Mississippi Medicaid provider number,

   f) The regular physician identifies the services as substitute physician on the appropriate claim form,

   g) The regular physician keeps on file a record of each service provided by the substitute physician, associated with the substitute physician's National Provider Identifier (NPI), and

   h) The regular physician ensures that the substitute physician is properly licensed to practice medicine in the state of Mississippi; or, if the regular physician practices in another state, the state in which the regular physician is licensed to practice.

2. Medicaid does not cover reciprocal services for substitution arrangements among physicians in the same medical group except when a group member provides services on behalf of another group member who is the designated attending physician for a hospice patient.

D. Covered Visit Service - Medicaid covers the submission of claims for a medical group under reciprocal billing arrangements for the covered visit services of a substitute physician who is not a member of the group. Medicaid defines a continuous period of covered visit services that begins with the first day on which the substitute physician provides covered visit services to patients of the regular physician, and it ends with the last day on which the substitute physician provides these services to these patients before the regular physician returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician or are furnished by some other substitute physician on behalf of the regular physician. A new period of covered visit services can begin after the regular physician has returned to work.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Teaching Facilities' Billing for Resident Services

A. Medicaid does not apply Medicare policy related to billing for services performed by residents in a teaching facility. Medicaid does not cover services provided under the direction of the teaching physician.

B. Medicaid covers teaching physicians, who are supervising residents, but requires the teaching physician to physically be present in the room with the beneficiary and requires documentation in the teaching physician medical record that they were physically present in the room with the beneficiary when services were rendered by the resident.

Source: Miss. Code Ann. § 43-13-121

Rule 1.8: Casting, Splinting, or Strapping in Office Setting

A. Physicians, physician assistants, or nurse practitioners must bill the appropriate procedure evaluation and management code, fracture or dislocation codes, or application of casts and strapping code to be reimbursed professional fees for application of casts, splints, or strapping performed in the office setting. Providers must follow the procedure coding guidelines for selection of the appropriate code.

B. For casting, splinting, or strapping supplies provided by a physician, physician assistant, or nurse practitioner in the office setting, the provider must bill the procedure codes for the cost of the supplies.

C. The coding criteria listed above apply to replacement casts, splints, or strapping.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: Removal of Impacted Cerumen

A. Medicaid covers the removal of impacted cerumen only for symptoms directly related to the presence of impacted cerumen. Symptoms include, but are not limited to, the following:

    1. Earache,

    2. Itching of the ear,

    3. Feeling that the ear is plugged,

    4. Partial hearing loss,

    5. Ringing in the ear, or

    6. Otorrhea

B. Medicaid does not cover simple removal of non-impacted cerumen and is considered incidental to an evaluation and management service.

C. Medicaid requires documentation to support occlusion, impaction or blockage, of the external auditory canal secondary to cerumen. The presence of earwax, without symptoms, is not sufficient to support need for removal and symptoms of wax impaction.

Source: Miss. Code Ann. § 43-13-121

Rule 1.10: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 2: Physician-Administered Drugs and Implantable Drug System Devices

Rule 2.1: Covered Services

A. The Division of Medicaid covers medically necessary physician-administered drugs and implantable drug system devices defined as a drug other than vaccines, diagnostic or therapeutic radiopharmaceutical, contrast imaging agent, biological or implantable drug system device covered under the Social Security Act § 1927(k)(2) that:

    1. Are administered by a medical professional in a physician's office or other outpatient

clinical setting,

2. Are incident to physician services that are separately billed to the Division of Medicaid,

3. Qualifies for rebate in accordance with 42 USC § 1396r-8,

4. Are Food and Drug Administration (FDA) approved or follows medically accepted indications and dosing limits supported by one (1) or more of the official compendia as designated by the Centers for Medicare and Medicaid Services (CMS), and

5. Are not considered cosmetic, investigational, experimental or unproven.

B. The Division of Medicaid reimburses for discarded drugs or biologicals up to the dosage amount indicated on the single-use vial or package label minus the administered dose(s) if:

1. The drug or biological is supplied in a single use vial or single–use package,

2. The drug or biological is actually administered to the beneficiary to appropriately address his/her condition and any unused portion is discarded,

3. The amount wasted is recorded in the beneficiary's medical record,

4. The provider has written policy and procedures regarding single-use drugs and biologicals and bills all payers in the same manner, and

5. The amount billed to the Division of Medicaid as a discarded drug is not administered to another beneficiary or patient.

C. The Division of Medicaid does not reimburse for discarded drugs or biologicals when:

1. A beneficiary misses an appointment,

2. A multi-use vial or package is used,

3. The actual dose of the drug or biological administered is less than the billing unit,

4. The drug or biological is administered during an inpatient stay, or

5. The extra amount of the drug is provided to account for wastage in a syringe hub.

D. The Division of Medicaid defines an implantable drug system device as an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent or other similar or related article, including a component part, or accessory which is:

1. Recognized in the official National Formulary, the United States Pharmacopoeia or any supplement to one of these, or

2. Intended for use in the diagnosing of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease.

E. The Division of Medicaid covers the insertion and removal of a Food and Drug Administration (FDA) approved implantable drug system device if it:

1. Is medically necessary,

2. Is in compliance with its approved uses, specifications and restrictions, and

3. Meets all other applicable coverage requirements.

F. The Division of Medicaid does not cover:

1. Services related to the use of a non-covered medical device, or

2. Implantable drug system devices that are considered experimental or investigational.

Source: 42 USC § 1396r-8; Miss. Code Ann. § 43-13-121.

History: Added Miss. Admin. Code Part 203, Rule 2.1.A.5. eff. 05/01/2016. Emergency Filing eff. 03/02/2016. Revised eff. 07/01/2014.

Rule 2.2: Drug Rebates

A. In accordance with federal regulations, the Division of Medicaid collects Medicaid drug rebates from manufacturers on physician-administered drugs per the following:

1. Effective for all drugs administered on and after January 1, 2008, providers must submit the National Drug Code (NDC) of the drug administered in addition to the appropriate drug code for physician-administered drugs on claims.

   a) An NDC is not required for vaccines or other drugs as specified by CMS.

   b) The NDC of the drug administered must contain eleven (11) digits in the five (5) four (4) two (2) grouping and, if applicable, include “leading zeros (0)” to constitute an eleven (11) digit NDC code.

   c) The NDC of the drug administered must be matched against a database to ensure its validity.

2. Providers reimbursed based on a fee-for-service must submit the NDC of the drug administered with the appropriate code(s) including, but not limited to, ambulances, independent radiology clinics, free-standing and hospital based dialysis facilities, nurse practitioners, optometrists, individual physicians, physician groups, physician assistants, and podiatrists.

3. Providers reimbursed based on a per diem, encounter or other type of rate are not required to submit the NDC or appropriate code(s) for drugs administered/dispensed by providers including, but not limited, to outpatient hospitals, federally qualified health centers (FQHC), rural health clinics (RHC), ambulatory surgical centers (ASC), home health agencies, nursing homes or other long term-term care facilities.

4. The Division of Medicaid only reimburses for physician administered drugs that are:

   a) Subject to the federal rebate program, and

   b) Not considered Drug Efficacy Study Implementation (DESI) drugs.

5. Providers participating in the 340B program must adhere to all the provisions in Miss. Admin. Code Part 200, Chapter 4, Rule 4.10.

B. The Division of Medicaid has the authority to recoup monies when an audit determines that the incorrect NDC number was billed.

Source: Deficit Reduction Act of 2005; 42 U.S.C. § 1396r–8; Miss. Code Ann. § 43-13-121.

History: Revised eff. 09/01/2015; Revised eff. 07/01/2014.

Rule 2.3: [Refer to Miss. Admin. Code Part 203, Rule 2.1]

Rule 2.4: [Refer to Miss. Admin. Code Part 203, Rule 2.1]

Rule 2.5: [Refer to Miss. Admin. Code Part 203, Rule 2.1]

Rule 2.6: [Refer to Miss. Admin. Code Part 203, Rule 2.1]

Rule 2.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 3: Anesthesia

Rule 3.1: Provider Enrollment

A. Providers of anesthesia services must comply with all requirements set forth in Part 200, Chapter 4, Rule 4.8 for all providers in addition to the specific provider type requirement below:

1. Obtain National Provider Identifier (NPI) with verification from National Plan and Provider Enumeration System (NPPES),

2. Copy of current licensure card,

3. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

4. Copy of approved protocol and practice setting, if applicable, and

5. Copy of specialty certificate(s), if applicable.

B. Anesthesiologists must comply with physician requirements outlined in Part 203, Chapter 1, Rule 1.1.

Source: Miss. Code Ann. § 43-13-121

Rule 3.2: Covered Services

A. Medicaid covers anesthesia services provided by an anesthesiologist/certified registered nurse anesthetists (CRNA).

B. Medicaid covers CRNAs for anesthesia services for surgical procedures using the appropriate anesthesia codes.

C. Medicaid covers administration of anesthesia by a CRNA, without medical direction, at ninety percent (90%) of the calculated payment for anesthesiologists. The appropriate modifier must be used when billing for services that are not medically directed.

D. Medicaid covers medically directed CRNA services at fifty percent (50%) of the allowance for the anesthesiologist. The appropriate modifier should be used when billing for services that are medically directed.

Source: Miss. Code Ann. § 43-13-121

Rule 3.3: Criteria for Medical Direction of Resident

A. Medicaid covers an anesthesiologist who assumes full responsibility for a patient while the anesthesia is being administered by a resident in a teaching facility.

1. Medicaid only covers one anesthesiologist for the professional services.

2. Medicaid covers the appropriate modifier indicating that the anesthesiologist has assumed

full responsibility for the patient while the anesthesia is being administered by a resident in a teaching facility.

3. The medical direction of residents is covered only in a teaching facility.

4. Medicaid covers the anesthesiologist to supervise no more than four (4) residents at any one time.

5. Medicaid does not cover medical direction by CRNAs.

B. Medicaid covers for the medical direction only if the following criteria are met:

1. Anesthesiologist must be present in the immediate area of the operating or delivery suite with the resident and available for immediate diagnosis and treatment.

2. Anesthesiologist must perform and assist the resident in a pre-anesthesia examination and evaluation.

3. Anesthesiologist must prescribe the anesthesia plan for/with the resident.

4. Anesthesiologist must personally participate in the most demanding procedures of the anesthesia plan, including induction and emergence with the resident.

5. Anesthesiologist must ensure that no procedures were performed by a non-qualified anesthetist.

6. Anesthesiologist must monitor the course of anesthesia with the resident.

7. Anesthesiologist must at all times supervise and assist the resident with any procedure being performed by the resident.

8. Anesthesiologist must provide indicated post-anesthesia care with the resident.

C. The anesthesiologist and the resident must sign the anesthesia report.

Source: Miss. Code Ann. § 43-13-121

Rule 3.4: Billing for Procedures

A. Medicaid defines one (1) anesthesia time unit as one (1) minute.

B. Medicaid defines anesthesia time as when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision.

C. Medicaid does not cover additional modifying units for physical status, extreme age, utilization of total body hypothermia or controlled hypotension, or emergency conditions.

D. Medicaid covers additional coverage for the insertion of an arterial line, CVP line, or the insertion/placement of a flow directed catheter such as a Swan-Ganz when the procedures are personally performed by the anesthesiologist/CRNA in conjunction with anesthesia services for a surgical procedure.

Source: Miss. Code Ann. § 43-13-121

Rule 3.5: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 4: Surgery

Rule 4.1: Definitions

A. For purposes of this chapter Medicaid defines the following terms related to surgery as follows:

1. Add-on codes are procedures performed in addition to the primary service/procedure and are never reported as a stand-alone code.

    a) Add-on codes describe additional intra-service work associated with the primary procedure.

    b) Add-on codes are exempt from multiple surgery rules.

2. Assistant surgeon is a licensed physician who actively assists the physician in charge of a case in performing a surgical procedure.

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

4. Co-surgeons are two (2) surgeons, each usually in a different specialty, who are required to perform specific procedures during the same operative setting. Co-surgery also refers to surgical procedures involving two (2) surgeons performing the parts of the procedure simultaneously, such as bilateral knee replacements.

5. Endoscopic procedure is the performance of a procedure on interior organs and cavities of the body through an endoscope.

6. An endoscope is a flexible fiber optic instrument used to visualize the interior of a body cavity or organ.

7. Incidental procedure is a procedure carried out at the same time as a primary procedure, is clinically integral to the performance of the primary procedure or requires little additional physician resources.

8. Multiple deliveries are two (2) or more infants delivered from one (1) pregnancy.

9. Multiple surgeries are separate procedures performed by the same physician on the same patient at the same operative setting. Medicaid applies multiple surgery rules to certain procedure codes except for certain procedures exempt from multiple surgery rules.

10. Mutually exclusive procedures are the separate billing for two (2) or more procedures that are usually not performed for the same patient on the same date of service.

11. Team surgeon is a team of surgeons, more than two (2) surgeons of different specialties, required to perform a specific procedure.

12. Unbundled procedures are the use of two (2) or more procedure codes to describe a procedure or event when a single procedure code exists that comprehensively describes the surgery performed.

Source: Miss. Code Ann. § 43-13-121

Rule 4.2: Assistant Surgeon

A. Medicaid covers an assistant surgeon during major surgery, including all surgical cases performed under spinal or regional anesthesia if the nature of the surgery requires the assistance of a second physician or surgeon. Medicaid covers only one (1) assistant surgeon for any case.

B. Medicaid does not cover interns, residents, fellows, physician assistants, and nurses, including nurse practitioners, as an assistant surgeon.

C. Medicaid covers the services of an assistant surgeon when the following criteria are met:

1. The operation must be a covered surgical procedure, and

2. The operation must be of sufficient difficulty and complexity to require an assistant surgeon, and

3. The assistant surgeon must actively assist in the surgery.

a) Medicaid defines actively assist as the assistant surgeon must assist in the actual

performance of the surgical procedure, and

b) The assistant surgeon, in the event the surgeon is unable to continue, must be able to complete the surgery.

D. Medicaid covers the assistant surgeon's services at sixteen percent (16%) of the surgical fee for that particular surgery.

E. The appropriate modifier in conjunction with the procedure code for services rendered is required to identify an assistant surgeon's services.

F. Medicaid does not cover an assistant surgeon in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and which has a qualified resident available, unless one (1) of the following circumstances exists:

1. The assistant surgeon certifies that his services were medically necessary and no qualified resident was available to perform the services. There may be some instances when no qualified residents are available to assist in surgery due to a number of factors that include, but are not limited to, involvement in other activities, complexity of the surgery, number of residents in the program, or other valid reasons.

2. Exceptional medical circumstances, including emergency, life-threatening situations such as multiple traumatic injuries requiring immediate treatment.

3. The primary surgeon has an across-the-board policy on never involving residents in the preoperative, operative, or postoperative cares of his/her patients.

Source: Miss. Code Ann. § 43-13-121

Rule 4.3: Co-Surgeons

A. Medicaid covers the individual skills of two (2) or more surgeons when 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.

B. Medicaid covers co-surgeons at sixty two and one half percent (62.5%) of the Medicaid coverage for co-surgeon procedures.

C. Medicaid covers the services of two (2) surgeons of the same specialty without regard to the two (2) specialty requirement when the services are justified by medical documentation.

D. Medicaid covers the services of two (2) surgeons in different specialties when performing a specific procedure.

1. This is also applicable when the different procedures are performed through the same

incision.

2. Each surgeon must report the procedure he/she performed.

E. The appropriate modifier in conjunction with the procedure code for services rendered is required to identify a co-surgeon's services.

Source: Miss. Code Ann. § 43-13-121

Rule 4.4: Team Surgeons

A. Medicaid covers two (2) or more surgeons to perform surgery on the same patient during the same operative session.

B. Medicaid covers the surgeons of different specialties performing a different procedure, even if the procedures are performed through the same incision.

C. The appropriate modifier in conjunction with the procedure code for services rendered is required to identify a co-surgeon's services.

Source: Miss. Code Ann. § 43-13-121

Rule 4.5: Multiple Surgeries

A. Part 203, Chapter 4 Rule 4.5.A, B is applicable for assistant surgeon, team surgeon, or co-surgeon services.

B. Medicaid reimburses for the primary procedure at the highest reimbursement rate from the Medicaid Physician Fee Schedule. The primary surgical procedure must be billed first and other procedures must be billed on subsequent lines on the claim.

C. Medicaid covers multiple surgical procedures performed by the same surgeon on the same patient and on the same date of service. The surgical procedures must be billed together on the same claim unless one (1) claim does not accommodate all of the procedures.

D. For multiple surgeries performed on the same day, Medicaid covers the following:

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 unless a second surgical procedure adds significant time, risk, or complexity to patient care which Medicaid will reimburse as follows:

   a) The surgery with the greater Medicaid allowed amount will be reimbursed at the full amount.

b) The second surgery will be reimbursed at one half the Medicaid allowance.

c) The secondary procedure must be billed with the appropriate modifier.

d) 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 covered as follows:

a) The surgery with the greater Medicaid allowance amount will be reimbursed at the full amount.

b) Secondary surgeries, will be paid at one half (1/2) of the Medicaid allowance.

1) These procedures must be identified with the appropriate modifier.

2) No benefits are provided for incidental, mutually exclusive, and unbundled procedures.

3. Secondary procedures must meet all of the following criteria:

a) The secondary procedure is to correct a separate pathological condition,

b) That pathological condition would have required intervention had an incision not already been present, and

c) 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 cover the full-allowed amount for each surgical setting in accordance with multiple surgery criteria.

E. Medicaid covers designated add on codes and other exempt codes from multiple surgery rules and coverage for multiple surgeries do not apply to these codes.

Source: Miss. Code Ann. § 43-13-121

Rule 4.6: Bilateral Procedures

A. Medicaid covers bilateral procedures performed during an operative setting, when reported with the appropriate procedure code and modifier. One (1) procedure will be paid at one hundred percent (100%) of the Medicaid allowable and the second procedure will be paid at fifty percent (50%) of the Medicaid allowable.

B. If the bilateral procedures are both secondary procedures to a primary procedure, the bilateral secondary procedures will each be paid at fifty percent (50%) of the Medicaid allowable.

Source: Miss. Code Ann. § 43-13-121

Rule 4.7: Surgical Modifiers

A. The applicable modifiers for bilateral procedures, multiple procedures, co-surgeons, surgical teams, and assistant surgeons must be utilized on claims for surgery.

B. Medicaid reimburses for surgical care only at eighty-five percent (85%) of the Medicaid allowable. The applicable modifier for this service must be reported with the appropriate surgery procedure codes.

C. Medicaid reimburses for postoperative management only at fifteen percent (15%) of the Medicaid allowable. The applicable modifier for this service must be reported with the appropriate surgery procedure codes.

    1. Medicaid requires a documented agreement for the transfer of care when one (1) physician performs a patient's surgical service and another provides the postoperative management.

    2. The agreement must be in the form of a letter, discharge summary, chart notation, or other written documentation and be retained in each physician' beneficiary's medical record.

D. No separate benefits are allowed for preoperative management as it is inclusive in the allowance for surgical care.

Source: Miss. Code Ann. § 43-13-121

Rule 4.8: Endoscopic Procedures

A. Medicaid considers the following incidental and not covered:

    1. A diagnostic scope and a surgical scope in the same setting,

    2. A diagnostic scope with biopsy and a surgical scope,

    3. A diagnostic scope with or without biopsy done with an endoscope and an open surgical procedure in the same anatomic area, or

    4. A diagnostic scope and diagnostic scope with biopsy unless the verbiage distinguishes the procedure as "with biopsy" versus "without biopsy".

B. Mutually exclusive relationships to endoscopic procedures are based on the following:

1. Complete versus partial,

2. With versus without, and

3. Extensive versus limited.

C. If endoscopic and open surgical procedures are both performed at the same surgical setting, Medicaid covers the clinically more intense procedure.

1. An endoscopic and an open surgical procedure in the same anatomic area are not covered by Medicaid for separate reimbursement.

2. Medicaid covers endoscopic-assisted, open surgical procedures performed on the same anatomic area during the same operative session when additional time, skill, and physician resources are required with the two (2) approaches, rather than a longer, more invasive open procedure, that can minimize morbidity, patient recovery, and scarring.

D. If multiple endoscopic procedures are performed during the same operative session, Medicaid covers the most complex procedure.

Source: Miss. Code Ann. § 43-13-121

Rule 4.9: Post-Operative Pain Management

A. The surgeon is responsible for daily post-operative pain management services except under extraordinary circumstances.

B. Medicaid covers post-operative pain management provided by several means, including, but not limited to:

1. Oral and parenteral administration,

2. Patient controlled analgesia (PCA), and

3. Epidural.

C. Providers must maintain proper and complete documentation to verify the services provided. The provider has full responsibility for maintaining documentation to justify the services provided.

1. At a minimum, the medical record must include, but is not limited to, the following:

a) The medical necessity of providing the service.

b) The daily services provided by the surgeon.

c) The name, strength, dosage, route, date and time, indication for, and the administration of medications administered to the patient.

d) Documentation supporting failure of conservative management.

e) Relevant clinical signs and symptoms.

2. Documentation must be legible and medical records must be available to Medicaid, the fiscal agent, and/or the Utilization Management/Quality Improvement Organization (UM/QIO) upon request.

Source: Miss. Code Ann. § 43-13-121

Rule 4.10: Abdominal Panniculectomy

A. Medicaid covers abdominal panniculectomy (abdominoplasty, abdominodermatolipectomy) only when there is medical documentation that demonstrates the procedure is:

1. Medically necessary,

2. Reconstructive,

3. Performed to alleviate the patient's symptomatology, and

4. Performed to improve function.

B. Abdominal panniculectomy performed in conjunction with a primary abdominal surgical procedure will be considered as part of the primary surgery. No additional reimbursement will be made toward the abdominal panniculectomy.

C. Medicaid recognizes the performance of abdominal panniculectomy as appropriate and medically necessary when performed to relieve clinical signs and symptoms resulting from redundant skin following a massive weight loss, symptomatology related to panniculitis, and/or the facilitation of abdominal surgery for those persons defined as morbidly obese. The surgeon's documentation must include presenting or past occurrences of any of the following signs and symptoms including, but not limited to:

1. Pain to abdominal pannus and/or lower back,

2. Impaired ambulation,

3. Interference with personal hygiene,

4. Signs and symptoms of panniculitis,

5. Large redundant fold of skin and fat hanging below the groin,

6. Recurrent intertrigo to the overhanging pannus resulting in skin infections,

7. Body Mass Index greater than thirty (30),

8. Presence of lymphedema, abscesses or hernias, and

9. Documentation of size and configuration of pannus as evidenced in photographs.

D. Prior approval for abdominal panniculectomy is not required.

1. The surgeon must retain all documentation supporting medical necessity in the medical record.

2. The final determination of medical necessity will be made by the surgeon based on the criteria listed in this Rule.

Source: Miss. Code Ann. § 43-13-121

Rule 4.11: Blepharoplasty

A. Medicaid covers a surgical blepharoplasty when performed by a general surgeon, plastic surgeon or ophthalmologist in the physician's office, inpatient or outpatient facility or an ambulatory surgical center.

B. Medicaid defines:

1. Blepharoplasty as any surgery of the eyelid performed to improve abnormal functions or reconstruct deformities.

2. Cosmetic blepharoplasty as surgery performed to reshape normal structures of, or surrounding, the eye solely for the purpose of improving the patient's appearance or self-esteem.

3. Reconstructive blepharoplasty as surgery performed to correct visual impairment and/or restore normalcy to a structure that has been altered by trauma, infection, inflammation, degeneration, neoplasia or developmental errors.

C. Prior authorization is not required. The determination of medical necessity will be made by the surgeon based on Medicaid's coverage criteria. Documentation of visual fields showing un-taped upper vision at twenty-five (25) degrees or better is interpreted as normal and is considered cosmetic.

D. Medicaid covers blepharoplasty and/or repair of blepharoptosis procedures when performed for the following functional indications. Any indication other than the following are deemed

not medically necessary and will be considered cosmetic and non-covered procedures.

1. Lower eyelid blepharoplasty is considered medically necessary when documentation:

    a) Supports horizontal lower eyelid laxity of medial and lateral canthus resulting in ectropion, dacrystenosis and infection, and/or

    b) Supports massive lower eyelid edema.

2. Upper eyelid blepharoplasty and/or brow lift is considered medically necessary when:

    a) Clinical notes and visual field testing support a decrease in peripheral vision and/or upper field vision,

    b) Photographs document obvious dermatochalasis, ptosis or brow ptosis compatible with the visual field determinations, and

    c) Documentation of visual fields must show upper eyelid taped improvement to greater than twenty-five (25) degrees.

3. Repair of brow ptosis and blepharoptosis are considered medically necessary for the following functional indications:

    a) Clinical notes and visual field testing support a decrease in peripheral vision and/or upper field vision,

    b) Photographs document obvious dermatochalasis, ptosis, or brow ptosis compatible with the visual field determinations, and

    c) Documentation of visual fields must show upper eyelid taped improvement to greater than twenty five (25) degrees.

4. Ptosis Repair is considered medically necessary when:

    a) Pre-operative ptosis results in an eyelid covering of one fourth (1/4) of the pupil or one (1) to two (2) millimeters (mm) above the midline of the pupil, and

    b) Documentation of the visual fields must show upper eyelid taped improvement to greater than twenty five (25) degrees.

E. The medical record must, at a minimum, include:

1. Complete opthalmological history and physical.

2. Documentation of patient complaints which justify functional surgery and are commonly found in patients with ptosis, pseudoptosis or dermatochalasis.

a) This may include interference with vision or visual field, difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin or chronic blepharitis.

b) Both photographic and visual field testing are required.

3. Photographs must demonstrate one or more of the following:

a) The upper eyelid margin approaches to within two and one half (2.5) mm (of the diameter of the visible iris) of the corneal light reflex,

b) The upper eyelid skin rests on the eyelashes, or

c) The upper eyelid indicates the presence of dermatitis.

4. Photographs must be prints, not slides, and must include a frontal and lateral view.

a) The head must be perpendicular, not tilted, to the focal plane of the camera to demonstrate a skin rash or position of the true eyelid margin or the pseudo-eyelid margin.

b) The photos must be of sufficient clarity to show a light on the cornea.

c) If redundant skin coexists with true eyelid ptosis, additional photos must be taken with the upper eyelid skin retracted to show the actual position of the true eyelid margin.

d) Oblique photos may be needed to demonstrate redundant skin on the upper eyelashes when this is the only indication for surgery.

5. Visual field testing must be recorded using either a Goldmann Perimeter (III 4-E object) or a programmable automated perimeter (equivalent to a screening field with a single intensity strategy using a 10db stimulus) to test a superior (vertical) extend of fifty (50) to sixty (60) degrees above fixation with targets presented at a minimum four (4) degree vertical separation starting at twenty four (24) degrees above fixation while using no wider than a ten (10) degree horizontal separation.

6. Each eye must be tested with the upper eyelid at rest and repeated with the eyelid elevated to demonstrate an expected surgical improvement meeting or exceeding the criteria.

Source: Miss. Code Ann. § 43-13-121

Rule 4.12: Circumcisions

A. Medicaid does not cover circumcisions unless medical necessity is documented in the medical record according to the criteria listed below.

   1. A diagnosis which justifies the medical necessity for circumcision including, but not limited to, recurrent balanoposthitis or recurrent urinary tract infections; the diagnosis of phimosis alone is not sufficient documentation of medical necessity,

   2. Failure of the patient to respond to conservative treatment; documentation of conservative treatment must include, but not limited to, teaching about appropriate hygiene and listing of appropriate drug therapy used to treat the condition, and

   3. The recurrent nature of the medical condition.

B. The medical documentation must be included either in the surgeon's report or a beneficiary's attending physician records to justify medical necessity. A pathology report alone is not sufficient as documentation of medical necessity.

C. Documentation must be legible and available for review if requested.

D. Medically necessary circumcisions may be performed in the inpatient hospital setting subject to precertification of all inpatient days, the outpatient hospital setting, the ambulatory surgical center, or a physician's office.

E. Reimbursement for hospital inpatient procedures will be included in the per diem rate of the facility and may be included in the cost report.

   1. Facility charges for procedures performed in the outpatient department of the hospital will be reimbursed according to established Medicaid rates for outpatient hospital services.

   2. Facility charges for procedures performed in an ambulatory surgical center are paid according to the Medicaid Ambulatory Surgical Center procedure schedule.

   3. Physician fees are reimbursed based on the Medicaid Physician Fee Schedule.

F. Appropriate anesthesia, which is considered the standard of care, is covered in accordance with the Division of Medicaid's rules for anesthesia services. Refer to Part 203, Chapter 3.

Source: Miss. Code Ann. § 43-13-121

Rule 4.13: [Refer to Miss. Admin. Code Part 203, Rule 2.1]

Rule 4.14: [Refer to Miss. Admin. Code Part 203, Rule 2.1]

Rule 4.15: Keloids

A. Medicaid covers the initial evaluation consultation to diagnose the condition and/or develop a plan of treatment.

B. Medicaid covers treatment only when there is medical documentation that demonstrates any of the following signs and symptoms:

    1. Pain,

    2. Persistent itching and/or burning sensation,

    3. Ulceration and bleeding,

    4. Limitation of movement of the head or a digit or extremity,

    5. Obstruction of a bodily orifice,

    6. Infection, or

    7. Fast growth.

C. Medicaid covered Keloid treatments include the following:

    1. Intralesional injection, including cortisone injections,

    2. Topical treatment,

    3. Excision (surgery), and

    4. Radiation therapy.

D. Medicaid does not require prior approval for treatment of keloids.

    1. The physician must retain all documentation supporting medical necessity in the record.

    2. Documentation must include size, location and severity of symptoms.

    3. Photographs may also be used to support medical necessity.

Source: Miss. Code Ann. § 43-13-121

Rule 4.16: Male Gynecomastia

A. Medicaid covers mastectomy, including reconstruction if necessary, for gynecomastia when considered medically necessary when the following criteria are met:

    1. The tissue removed is glandular breast tissue and not the result of obesity, adolescence, or

reversible effects of a drug treatment which can be discontinued (this would include drug-induced gynecomastia remaining unresolved six (6) months after cessation of the causative drug therapy),

2. Appropriate diagnostic evaluation has been done for possible underlying etiology,

3. Pain or tenderness directly related to the breast tissue has been refractory to a trial of analgesics, anti-inflammatory agents, etc., for a time period adequate to assess therapeutic effects,

4. The excessive breast tissue development is not caused by non-covered therapies or illicit drug usage such as marijuana, anabolic steroids, etc.,

5. The beneficiary has a physician documented history of two (2) years or more of gynecomastia that has been refractory to conservative treatments,

6. Unclothed preoperative photographs from the chin to the waist, including standing frontal and side views with arms straight down at sides, and

7. The beneficiary is over eighteen (18) years of age, or eighteen (18) months after the end of puberty.

B. Medicaid does not consider mastectomy for gynecomastia to be medically necessary under certain circumstances. Examples of such circumstances Medicaid does not cover include, but are not limited to, the following:

1. The beneficiary has pseudogynecomastia, which is excess adipose tissue in the male breast, but with no increase in glandular tissue,

2. The procedure is for cosmetic purposes, or

3. Only liposuction is used as the surgical procedure.

C. Medical record documentation of medical necessity must include all of the following:

1. A summary of the medical history and last physical exam, including the information specified in Part 203, Chapter 4 Rule 4.15.A,

2. All prior treatments used to manage the beneficiary's medical symptoms,

3. Results from any diagnostic tests pertinent to the diagnosis taken within the last six months,

4. Photo documentation confirming breast hypertrophy taken within the last six months with the beneficiary's name and date on each photo,

5. A surgical treatment plan that outlines the amount of tissue to be removed from each breast and the prognosis for improvement of clinical signs and symptoms pertinent to the diagnosis, and

6. Other pertinent clinical information that Medicaid may request.

D. Providers must maintain proper and complete documentation to verify the services provided. The provider has full responsibility for maintaining documentation to justify the services provided.

Source: Miss. Code Ann. § 43-13-121

Rule 4.17: Otoplasty

A. Medicaid covers otoplasty for the correction of ears that protrude more than twenty (20) millimeters (mm) and at an angle greater than thirty five (35) degrees from the occipital scalp when the following criteria is meet:

1. For the correction of an external ear deformity associated with an abnormality of the external ear canal such as stenosis.

2. When the procedure is intended to improve a hearing impairment.

3. When performed as part of a staged reconstruction for an absent or inadequate external ear.

4. When the reconstruction involves a cochlear implant and the procedure is required for proper functioning of the device.

B. Medicaid does not cover otoplasty when performed solely for the purpose of improving or altering appearance or self-esteem, or to treat psychological symptomatology or psychosocial complaints related to one's appearance. Conditions for which Medicaid considers otoplasty cosmetic include:

1. Prominent/protruding ears defined by Medicaid as minor deformities that are considered an anatomic variance and do not meet the measurements listed under Part 203, Chapter 4, Rule 4.16.A.,

2. Lop ears,

3. Cupped ears, or

4. Constricted ears.

C. Medicaid does not cover otoplasty for children under the age of five (5).

D. The medical record must include the relevant history and physical finding indicating the coverage criteria, and must include the following:

1. Photographs of frontal, lateral, and oblique ear positions. The name of the patient and the date of the photograph must be marked on each photograph.

2. Detailed medical history,

3. Hearing evaluation and test results, if performed, and

4. Physical examination.

Source: Miss. Code Ann. § 43-13-121

Rule 4.18: Reduction Mammoplasty

A. Medicaid covers reduction mammoplasty only when there is medical documentation that demonstrates the procedure is:

1. Medically necessary,

2. Reconstructive, and

3. Performed as a last means of attempting to alleviate a patient's symptomatology and dysfunction due to the excessive breast size.

B. Justification for reduction mammoplasty must be based on the probability of relieving clinical signs and symptoms of macromastia. The surgeon's documentation must include the following criteria:

1. A complete and accurate patient history that includes complaints of pain and restriction of normal activity.

2. Medical necessity for the removal of a minimum of 500 grams of tissue from each breast.

3. Supra sternal notch to nipple measurement of twenty eight (28) cm or greater.

4. Frontal and lateral photographs of the breasts.

C. In addition to the criteria listed in Part 203, Chapter 4 Rule 1.17.B, documentation of the following may support the determination of medical necessity:

1. Documentation of a history of intertrigo, a chronic irritation under or between breasts.

2. A psychological assessment.

3. Documentation of strap marks as evidenced in photographs.

D. Medicaid recognizes the amount of breast tissue removed for relief of symptoms varies with height, weight and bra size and that, in some instances, the removal of less than five hundred (500) grams of tissue is appropriate for the relief of symptoms.

   1. In such instances, it is required that the physician must provide full documentation in the medical record that justifies reduction mammoplasty with removal of less than five hundred (500) grams.

   2. All other medically necessary criteria must be satisfied.

E. Medicaid does not require prior approval for reduction mammoplasty.

F. The surgeon must retain all documentation supporting medical necessity in the medical record.

G. The final determination of medical necessity will be made by the surgeon based on the criteria listed in this rule.

Source: Miss. Code Ann. § 43-13-121

Rule 4.19: Skin Tag Removal

A. Medicaid does not cover removal of benign skin tags that do not pose a threat to health or function.

B. Medicaid covers the removal of skin tags when there is medical documentation that one or more of the following conditions exist:

   1. The skin tag has one or more of the following characteristics: bleeding, itching, pain,

   2. The skin tag has physical evidence of inflammation such as purulence, oozing, edema, erythema,

   3. The skin tag obstructs an orifice,

   4. The skin tag clinically restricts vision,

   5. There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on the skin tag appearance, or

   6. A prior biopsy suggests or is indicative of malignancy.

C. Medicaid requires documentation to include the patient's signs and symptoms and skin tag physical findings including size, location, appearance, number, duration and changes over

time, tissue diagnosis report, operative note with detail to support the surgical procedure performed.

Source: Miss. Code Ann. § 43-13-121

Rule 4.20: Uvulopalatopharyngoplasty (UPPP/UP3)

Medicaid covers uvulopalatopharyngoplasty for the treatment of obstructive sleep apnea syndrome if all of the following are present:

A. Documented obstructed sleep apnea (OSA) with apnea hypopnea index (AHI) or respiratory disturbance index (RDI) which meets the following parameters in a) or b) below:

   1. UPPP/UP3 as sole procedure: with AHI/RDI greater than fifteen (15) and less than forty (40), or AHI/RDI ten (10) to fifteen (15) with one (1) or more of the conditions listed below:

      a) Hypertension,

      b) Cardiac arrhythmias predominately during sleep,

      c) Pulmonary hypertension,

      d) Documented ischemic heart disease,

      e) Impaired cognition or mood disorders,

      f) History of stroke, or

      g) Excessive daytime sleepiness, as documented by either a score of greater than ten (10) on the Epworth Sleepiness Scale or inappropriate daytime napping such as during driving, conversation, or eating, or sleepiness that interferes with daily activities.

   2. UPPP/UP3 as part of a planned staged or combined surgery aimed at also relieving retro lingual obstruction such as genioglossal advancement, hyoid myotomy and suspension: with AHI/RDI greater than fifteen (15), or AHI/RDI ten (10) to fifteen (15) with one (1) or more of the conditions listed below:

      a) Hypertension,

      b) Cardiac arrhythmias predominately during sleep,

      c) Pulmonary hypertension,

      d) Documented ischemic heart disease,

e) Impaired cognition or mood disorders,

f) History of stroke, or

g) Excessive daytime sleepiness, as documented by either a score of greater than ten (10) on the Epworth Sleepiness Scale or inappropriate daytime napping, (e.g., during driving, conversation, or eating) or sleepiness that interferes with daily activities.

B. Continuous positive airway pressure (CPAP) has been tried with well-supported follow-up and clearly failed or is not tolerated.

C. Pre-operative evaluation including fiber optic endoscopy suggest retro-palatal narrowing is the primary source of airway obstruction if UPPP/UP3 is the sole procedure or a combined surgery aimed at also relieving retro lingual obstruction.

Source: Miss. Code Ann. § 43-13-121

Rule 4.21: Ventricular Assist Devices (VAD)

A. Medicaid covers medically necessary procedures for the insertion or removal of FDA-approved ventricular assist devices (VAD) in accordance with its FDA approved uses as follows:

1. Post-cardiotomy procedures for insertion/removal of a VAD performed during the period following open-heart surgery.

2. Bridge-to-transplant procedures for insertion/removal of a VAD performed during the period prior to heart transplant when the patient is at imminent risk of dying before donor heart procurement.

3. Destination therapy procedures for insertion/removal of a VAD performed as a permanent mechanical cardiac support for individuals with severe New York Heart Association (NYHA) Class IV heart failure, and who are not eligible for heart transplantation.

B. Medicaid does not cover procedures using non-FDA approved devices and/or done for indications other than those approved by the FDA including, but not limited to:

1. Procedures using devices that are considered experimental, investigational, or part of clinical trials.

2. Procedures for replacement of the human heart with an artificial heart.

C. Medicaid does not allow separate reimbursement for the ventricular devices.

Source: Miss. Code Ann. § 43-13-121

Rule 4.22: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Rule 4.23: Gastric Electrical Stimulation (GES)

A. The Division of Medicaid covers Gastric Electrical Stimulation (GES) when used for the treatment of chronic intractable (drug-refractory) nausea and vomiting secondary to gastro-paresis of diabetic or idiopathic etiology. The Food and Drug Administration has approved the GES device through a humanitarian exemption.

B. The beneficiary's medical record must contain documentation that the implanting facility's institutional review board (IRB) or equivalent governing body has approved the implantation of the GES for the specific indications listed in Rule 4.23 A.

C. GES is considered medically necessary if a beneficiary has a diagnosis of gastroparesis and meets all of the following criteria:

    1. Is refractory or intolerant of two (2) out of three (3) classes of prokinetic medications and two (2) out of three (3) antiemetic medications,

    2. Has significantly delayed gastric emptying as documented by standard scintigraphic imaging of solid food,

    3. Has a poor nutritional status and enteral feedings or total parental nutrition (TPN) is medically necessary, and

    4. Is age eighteen (18) through seventy (70).

D. All other indications including, but not limited to, the treatment of obesity, are considered investigational and not medically necessary.

E. GES is not covered for beneficiaries who are:

    1. Pregnant,

    2. Suffering from chemical dependency,

    3. Undergoing peritoneal dialysis, or

4. Terminal with a limited life expectancy based on a diagnosis of cancer.

F. Prior authorization by the UM/QIO is required.

Source: Miss. Code Ann. § 43-13-121

History: 04\01\2013

Part 203 Chapter 5: Chiropractor

Rule 5.1: Covered Services

A. Medicaid covers chiropractic services for manual manipulation of the spine to correct a subluxation.

B. 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.

Source: Miss. Code Ann. § 43-13-121

Rule 5.2: Reimbursement

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.

Source: Miss. Code Ann. § 43-13-121

Rule 5.3: Coverage Criteria

A. A chiropractor must use the appropriate procedure code for manual manipulation of the spine to correct subluxation. Medicaid coverage will be provided for one (1) procedure code that encompasses the entire treatment for any given day.

B. Necessity of treatment must be documented by use of the appropriate diagnosis code to report all of the following:

   1. Treatment area as denoted by the appropriate primary diagnosis code.

   2. Symptoms associated with subluxation as denoted by the appropriate second diagnosis code.

   3. Complicating factors as denoted by the appropriate third diagnosis code.

C. An x-ray is required to demonstrate that a subluxation exists unless the patient is:

   1. Pregnant,

2. Suspects pregnancy which has not yet been confirmed, or

3. A child age twelve (12) years or less.

D. The date of the x-ray or the exception(s) must be properly documented in the medical record including the:

1. Date of the x-ray which must be within twelve (12) months of the date of service.

2. Expected date of delivery if the patient is pregnant.

3. Date of last menstrual period if pregnancy is suspected but not confirmed.

4. Child's date of birth when the child is twelve (12) years of age or less. The x-ray is at the discretion of the chiropractor.

E. Medicaid applies the appropriate procedure codes for chiropractic services and x-ray procedures toward the seven hundred dollars ($700) per fiscal year (July 1 - June 30) per beneficiary.

Source: Miss. Code Ann. § 43-13-121

Rule 5.4: Dual Eligibles

A. For beneficiaries covered under Medicare and Mississippi Medicaid (dual eligibles), chiropractic providers must not file a claim with Medicaid for the manipulation of the spine procedures not covered by Medicare. Mississippi Medicaid benefits are not available for services that do not satisfy Medicare's medical necessity criteria.

B. For beneficiaries covered under Medicare and Medicaid (dual eligibles), chiropractic providers may file a claim with Medicaid for those specified codes not covered by Medicare.

C. The six (6) month timely filing limitation for filing crossover claims is applicable with no exceptions.

Source: Miss. Code Ann. § 43-13-121

Rule 5.5: Documentation Requirements

A. The chiropractor must maintain auditable records that substantiate the services provided. At a minimum, the records must contain the following on each patient:

B. The dates of services provided.

C. The patient's presenting complaint.

D. Date of the x-ray which must be within twelve (12) months of the date of service.

E. Expected date of delivery if the patient is pregnant.

F. Date of last menstrual period if a pregnancy is suspected but not confirmed.

G. Child's date of birth when the child is twelve (12) years of age or less. (The x-ray is at the discretion of the chiropractor).

H. The results/findings of all diagnostic studies.

I. The patient's history and physical findings.

J. The treatment rendered, including:

   1. Frequency,

   2. Proposed length,

   3. Progress, and

   4. Prognosis.

K. The chiropractor's signature.

Source: Miss. Code Ann. § 43-13-121

Rule 5.6: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 6: Podiatry

Rule 6.1: Covered Services

Medicaid covers the following podiatry services:

A. Laboratory services required for care of a systemic condition are covered only to the MD/DO supervising the systemic condition or to a laboratory to which the MD/DO has referred the specimen.

B. Physical therapy services that are medically necessary and appropriate for the treatment of the foot condition.

C. Radiology services provided in an office setting that are medically necessary and include both the technical and professional components of the service if provided.

D. Foot care required as a result of or associated with systemic conditions limited to once every sixty (60) days.

E. Surgical treatment of ingrown toenails. Localized pathology of the soft tissue surrounding the nail must demonstrate that it is severe enough to require professional intervention.

F. Debridement if gross contamination requires prolonged cleansing.

G. Surgical debridement of mycotic nails with a manual or electric grinder method if the following conditions exists:

   1. Clinical evidence of mycosis of the toenail.

   2. Documentation of the severity of the condition and if patient ambulatory have marked limitation of ambulation, pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate and for non-ambulatory patients must suffer pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

H. Debridement of mycotic nails once every sixty (60) days.

I. Correction of hammertoe.

J. Definitive treatment of viral or plantar warts.

K. Medical or surgical treatment of subluxation of the ankle joint (talocrural joint). Services that are medical or surgical, diagnosis, or treatment for medical conditions that have resulted from or associated with partial displacement of structures.

L. Treatment of paronychia for stages A and B when avulsion or debridement is provided.

M. Foot care in the presence of metabolic, peripheral, or neurological disease including the following:

   1. Diabetes Mellitus,

   2. Arteriosclerosis obligerans,

   3. Buerger’s disease,

4. Chronic thrombophlebitis, or

5. Peripheral neuropathies involving feet that are associated with malnutrition, alcoholism, malabsorption, or pernicious anemia, peripheral neuropathies

Source: Miss. Code Ann. § 43-13-121

Rule 6.2: Non-covered services

Medicaid does not cover the following:

A. Identification of culture of fungi in the toenail clippings is not covered.

B. Local anesthesia, digital blocks, or topical anesthesia done with a specific surgical procedure.

C. Cast applications/strapping/splinting charged separately from the initial surgery or fracture care on same day as initial surgery or fracture care.

D. Removal of casts/straps/splints.

E. Ultrasound on patients with diabetes.

F. Foot massage.

G. Whirlpool for mycotic nail treatment.

H. Surgical trays.

I. Supplies.

J. Biopsies performed in conjunction with a surgical procedure.

K. Services for treatment of flat foot.

L. Services not medically necessary for the diagnosis and treatment of the condition of the foot.

M. Laboratory services performed by the DPM (Doctor of Podiatric Medicine) or referred to an independent laboratory by the DPM.

N. Services performed for conditions above the ankle unless within the scope of the podiatrist license.

O. Office visits with routine foot care procedures.

P. Routine foot examinations on all patients in a skilled nursing facility on a routine basis for screening purposes.

Q. Orthopedic shoes, any other type shoe, and/or supportive devices.

R. Routine foot care with debridement of nails on same date of service. Routine foot care may not be substituted for debridement of nails when the once every sixty day limit has been utilized.

S. Doppler (other than hand held Doppler), non-vascular diagnostic testing pertaining to a systemic disease.

T. Evaluation and advice for proper care of feet when the only service rendered for the management of paronychia. Debridement and avulsion may not be done on the same date of service.

U. Surgical or nonsurgical treatments provided for the sole purpose of correcting a subluxated structure in the foot as an isolate entity.

V. Palliative treatment of viral or plantar warts.

W. Routine foot care, in the absence of systemic conditions, including the following:

1. The cutting or removal or corns or calluses,

2. The trimming of nails, including the cutting, clipping, or debridement of ingrown toenails, club nails, or mycotic nails,

3. Fungal infections of the nail plates or mycotic nails with little or no symptomatology,

4. Avulsing small chips after trimming of the thickened/elongated nails that are painful, under the diagnosis of ingrown toenail,

5. Other hygienic and preventive maintenance care and any other service provided in the absence of localized illness, injury, or symptoms involving the foot, or

6. Routine soaking and application of topical medication.

Source: Miss. Code Ann. § 43-13-121

Rule 6.3: Anesthesia

A. Medicaid does not cover local infiltration, metacarpal/ metatarsal/ digital blocks, or topical anesthesia outside the specific surgical procedure performed.

B. Medicaid covers the cost of drugs used for IV sedation and must be billed with the appropriate HCPCS code

Source: Miss. Code Ann. § 43-13-121

Rule 6.4: Documentation

Medicaid requires podiatry providers to maintain auditable records that will substantiate the services provided. At a minimum, the records must contain the following on each patient:

A. Date(s) of service,

B. Patient's presenting complaint(s),

C. Patient's history and physical findings,

D. Treatment rendered, including: frequency of treatment, proposed length of treatment, and progress reports documenting the patient's progress with the treatment, and prognosis,

E. Narrative or operative report specific for procedure, type of anesthesia used for the procedure,

F. Clinical evidence of all conditions,

G. Accurate diagnosis codes to reflect all conditions,

H. X-rays ordered or obtained,

I. Full name and address of the MD/DO treating patient for a systemic condition and date of last visit with that MD/DO and must be within last six (6) months. Medical necessity must document the local pathology of the foot that requires professional intervention, identify complicating factors,

J. Full description of the clinical symptoms of the systemic condition,

K. Site of each wart, size, method of treatment or surgical removal,

L. Medical necessity of therapy, specific modality, or procedure, frequency of therapy, proposed length of therapy, and progress reports of patient's therapy,

M. Complicating conditions of the nail that limits ambulation, pain, or secondary infection result in thickening and dystrophy of the infected toenail plate,

N. Warts removed by cautery must include the number of lesions removed, their location, size and type of cautery used. If removed by surgical excision the operative note and pathology report on the excised tissue including number of specimens, their location, size, and any/all microscopic findings,

O. Nerve block injections must be reasonable and medically necessary and must indicate that a

more conservative therapy has not been effective, must describe patient's clinical state, history , physical findings, laboratory and other tests, identification of the problem, including diagnosis, precipitating events, quantity and quality of pain, test results, response to previous therapy, the procedure performed, including area injected, the substance(s) injected, and the dosage of the substance(s),

P. Diagnosis(es) to substantiate all treatments/procedures,

Q. The name, strength, dosage, route (intramuscular, intravenous, subcutaneous, oral, and topical, etc.), date and time, indication for, and the administration of all medications administered to the patient,

R. Patient's or guardian's refusal of services, if applicable,

S. Photographs, if applicable, must be prints, not slides, and include the patient's name and date of service, to document severe paronychia, persistent, recurrent infections, clinical evidence of systemic conditions related to the foot, mycotic nails, severity of ulcers of the foot and progression of ulcer(s), deformities such as hammertoe, traumatic injuries, severity of ingrown toenails or ingrown toenail condition on toes other than big toe,

T. Description(s) of wound(s), ulcer(s), etc., if applicable, including size, appearance, and location for each date of service, and

U. Podiatrist signature.

Source: Miss. Code Ann. § 43-13-121

Rule 6.5: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 7: Nurse Practitioner

Rule 7.1: Provider Enrollment

A. Certified Nurse Practitioners, certified by the state in which they practice may participate in the Mississippi Medicaid Program upon compliance with provider enrollment requirements outlined in Part 200, Chapter 4, Rule 4.8 in addition to the following specific provider requirements:

B. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES)<

C. Copy of current licensure card,

D. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9,

E. Copy of approved protocol and practice setting, if applicable, and

F. Copy of specialty certificate(s), if applicable.

Source: Miss. Code Ann. § 43-13-121

Rule 7.2: Nurse Practitioner Services

A. Medicaid covers Certified Nurse Practitioners, certified by the state in which they practice, for services rendered within the scope of practice allowed by their protocol.

B. Medicaid does not reimburse a nurse practitioner as an assistant surgeon. Medicaid reimbursement for nurse practitioners is ninety percent (90%) of the amount allowed by physicians for procedures.

C. No reimbursement shall be made for services rendered by a physician and a nurse practitioner for the same patient encounter. Payment will be made for one or the other, not both.

Source: Miss. Code Ann. § 43-13-121

Rule 7.3: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 8: Physician Assistant

Rule 8.1: Physician Assistant Enrollment Requirements

A. Physician assistants, who are licensed by the Mississippi State Board of Medical Licensure, and are practicing with physician supervision under regulations adopted by the board, are required to provide:

B. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration

System (NPPES),

C. Copy of current licensure card,

D. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9,

E. Copy of approved protocol and practice setting, if applicable, and

F. Copy of specialty certificate(s), if applicable.

Source: Miss. Code Ann. § 43-13-121

Rule 8.2: Physician Assistant Reimbursement

A. Physician assistants may bill Medicaid for the covered services within the scope of practice allowed by their protocol.

B. The Current Procedure Terminology manual should be used to determine the appropriate procedure code for these services. All services and procedures provided by physician assistants should be billed in the same manner following the same rules and guidelines as physician services.

C. Mississippi Medicaid does not reimburse a physician assistant as an assistant surgeon.

D. The reimbursement for physician assistants will be ninety percent (90%) of the amount allowed physicians for procedures.

E. Reimbursement will not be made for a physician and a physician assistant for the same patient encounter. Payment will be made for one or the other, not both.

Source: Miss. Code Ann. § 43-13-121

Rule 8.3: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 9: Psychiatric Services

Rule 9.1: Provider Qualifications

Psychiatric services described in this chapter must be provided by a licensed physician (medical doctor or doctor of osteopathy) who is board-certified in psychiatry or by a licensed Psychiatric Mental Health Nurse Practitioner (PMHNP). Rules included in this chapter do not apply to psychologists.

Source: Miss. Code Ann. § 43-13-121

Rule 9.2: General Requirements

A. All services must be personally and directly provided by the psychiatrist or PMHNP who requests reimbursement for the service.

B. Services must be based on beneficiary need and not the convenience of the beneficiary, the beneficiary's family or the provider.

C. A provider may bill only for the actual time spent in service delivery.

Source: Miss. Code Ann. § 43-13-121

Rule 9.3: Covered Services

The following psychiatric services are eligible for reimbursement by Medicaid only when they have been personally and directly provided by a licensed physician (medical doctor or doctor of osteopathy) who is board-certified in psychiatry or by a licensed Psychiatric Mental Health Nurse Practitioner (PMHNP):

A. Evaluative Services which include a psychiatric interview ok an interactive psychiatric interview.

B. Therapeutic Services which include individual, family, and group psychotherapy.

C. Other psychiatric services/procedures including

    1. Medication evaluation, and

    2. Electroconvulsive therapy.

Source: Miss. Code Ann. § 43-13-121

Rule 9.4: Non-Covered Services

A. Services are not eligible for reimbursement unless they are personally and directly provided by the servicing provider.

B. Educational interventions of an academic nature are not eligible for Medicaid reimbursement.

C. Medicaid will not reimburse more than once for the same service provided to any beneficiary on any given date, regardless of the setting(s) in which the service was provided. It is the provider's responsibility to coordinate services with the beneficiary and/or his/her family member to insure that services are not duplicated.

Source: Miss. Code Ann. § 43-13-121

Rule 9.5: Service Limits

A. The Division of Medicaid defines service limits as the maximum quantity of services per beneficiary that are eligible for reimbursement by the Division of Medicaid within a given time frame, either daily or yearly.

B. The following daily service limits apply to beneficiaries, regardless of the setting, hospital/residential or community-based, in which the services are provided:

1. Individual and Family Therapy - No more than one (1) service in any of the categories of individual psychotherapy or family psychotherapy is eligible for reimbursement by Medicaid on any given day.

2. Group Therapy

a) Generally, one (1) service of group therapy can be billed per day.

b) Two (2) services in group psychotherapy may be eligible for reimbursement on any given day when the following criteria are met:

1) Two (2) distinct sessions, each having mutually exclusive goals and objectives, are provided, and

2) Two (2) sessions per day are medically necessary, and

3) Two (2) sessions per day are appropriate and in accordance with the standards of medical practice, and

4) Documentation in the clinical record substantiates that the above criteria were met.

C. The following yearly service limits apply to adult beneficiaries aged twenty-one (21) years and older:

1. Psychiatric Outpatient Services - Beneficiaries are limited to twelve (12) covered psychiatric services/procedures per fiscal year (July 1-June 30). This psychiatric service benefit is available separate from the twelve (12) covered outpatient physician visits

allowed for each adult Medicaid beneficiary.

2. Hospital Inpatient Services

   a) Inpatient hospital psychiatric services are reimbursed under the APR-DRG methodology and are available only if the services are determined to be medically necessary by the Utilization Management/Quality Improvement Organization (UM/QIO). Day outlier payments may be made for mental health long lengths of stay for exceptionally expensive cases.

   b) Prior authorization is required upon admission and for lengths of stay greater than nineteen (19) days.

   c) One (1) covered psychiatric service/procedure is eligible for reimbursement per beneficiary per certified day in a general hospital or acute freestanding psychiatric facility.

Source: Miss. Code Ann. § 43-13-121.

History: Revised - 10/01/2012.

Rule 9.6: Documentation

A. Physicians are required to maintain auditable records that will verify any or all services provided and billed under the Medicaid program.

   1. Records must, be made available to representatives of the Division of Medicaid or Office of the Attorney General in substantiation of claims.

   2. Records must be maintained for a minimum of five (5) years in order to comply with all state and federal regulations and laws. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.

B. It is expected that the initial psychiatric service provided to any beneficiary must be of an evaluative nature. Documentation of the evaluation must be in the case record and must include, at a minimum:

   1. Dates, including beginning and ending session times, and the amount of time spent,

   2. Chief complaint,

   3. Referral source,

   4. History of present illness,

   5. Past psychiatric history,

6. Past medical history,

7. List of the beneficiary's current medications including prescription, non-prescription and over-the-counter,

8. Social and family history,

9. Comprehensive mental health status examination,

10. Treatment plan formulation/prognosis,

11. Assessment of the patient's ability to adhere to the treatment plan,

12. A multi-axial diagnosis,

13. Identification of the clinical problems that are to be the focus of treatment,

14. Treatment modalities and/or strategies that will be employed or are recommended to address each problem. If medications are prescribed, documentation must include the name of the drug, strength and dosage. The method of administration must be included for injectable medications. Medication prescriptions must be identified as issued in writing, electronically, or by telephone, and

15. The signature of the person who provided and documented the service. Any note that is "signed" by computer must be initialed by hand.

C. A treatment plan must be developed and implemented for each beneficiary no later than the date of the third (3rd) therapy session.

1. The treatment plan must include, at a minimum:

   a) A multi-axial diagnosis,

   b) Identification of the beneficiaries' and/or family's strengths,

   c) Identification of the clinical problems, or areas of need, that is to be the focus of treatment,

   d) Treatment goals for each identified problem,

   e) Treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement,

   f) Specific treatment modalities and/or strategies that will be employed to reach each objective, and

g) Date of implementation and signatures of the provider and the beneficiary or parent/legal guardian.

2. Treatment plans must be kept in the case record and must be reviewed and revised as needed, or at least every three (3) months. Each review must be verified by the dated signatures of the provider and beneficiary/parent/legal guardian. The physician, nurse practitioner, psychologist, and clinical social worker must sign the treatment plan for the services each will provide to the beneficiary.

D. A clinical note for each therapeutic service provided must be in the case record and must:

1. Include the date of service, type of service provided, the length of time spent delivering the service, who received or participated in it, as well as a brief summary of what transpired. If medications are prescribed, documentation must include the name of the drug, strength and dosage. The method of administration must be included for injectable medications. Medication prescriptions must be identified as issued in writing, electronically, or by telephone.

2. Indicate whether Evaluation and Management services are provided.

3. Relate to the problems identified in clinical record.

4. Identify whether the service occurs in an inpatient or outpatient setting.

5. Be authenticated by the signature of the person who provided and documented the service. Any note that is "signed" by computer must be initialed by hand.

Source: Miss. Code Ann. § 43-13-121.

Rule 9.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

Part 203: Chapter 10: Implantable Medical Devices

Rule 10.1: Skin and Soft Tissue Substitutes

A. The Division of Medicaid defines skin and soft tissue substitutes as types of wound coverage materials composed of human tissue, non-human tissue, synthetic materials, or a composite of these materials which mimic or substitute for some aspect of the skin's structure, either permanently or temporarily, for the treatment of acute and chronic non-healing wounds and

soft tissue grafting.

B. The Division of Medicaid covers skin and soft tissue substitute procedures, products, and services for medically accepted conditions and indications approved by the Food and Drug Administration (FDA) when medically necessary and when the procedures, products, and services are:

   1. Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs,

   2. Safely applied within the scope of FDA indications and according to manufacturer's instructions, and

   3. No equally effective or more conservative or less costly treatment is available statewide.

C. The Division of Medicaid covers skin and soft tissue substitutes for the following, including, but not limited to:

   1. Acute wounds,

   2. Chronic non-healing wounds,

   3. Soft tissue grafting,

   4. Second and third degree burns,

   5. Dermatological conditions which involve large areas of skin breakdown,

   6. Post-surgical states in which skin coverage is inadequate or ability to heal is compromised,

   7. Diabetic foot ulcers, and

   8. Venous stasis ulcers.

D. The Division of Medicaid does not cover skin and soft tissue substitutes for experimental, investigational uses or clinical trials or for the following conditions or circumstances, including, but not limited to:

   1. Infected ulcers,

   2. Wounds or ulcers healing with traditional wound care dressings and treatment,

   3. Underlying osteomyelitis,

   4. Surrounding cellulitis,

5. Uncontrolled diabetes,

6. Vasculitis,

7. Eschar or any necrotic material,

8. Wound bed with exposed bone,

9. Uncontrolled rheumatoid arthritis, rheumatoid ulcers, or both,

10. Known hypersensitivity to:

    a) Collagen,

    b) Bovine-derived products, or

    c) Porcine-derived products,

11. Active Charcot's arthropathy of the ulcer extremity,

12. Arterial disease with an ankle brachial index (ABI) of less than .65 in respect to venous stasis ulcers or a lack of pedal pulses in respect to diabetic foot ulcers,

13. Ulcers with sinus tracts or tunnels,

14. Uncontrolled collagen vascular diseases,

15. Radiation and/or chemotherapy treatment within the month immediately preceding proposed skin substitute treatment, or

16. Current treatment with high-dose corticosteroids or immunosuppressants.

E. The provider must maintain auditable records that substantiate the services provided which must include, but are not limited to, the following:

1. The diagnosis supporting medical necessity,

2. Previous conservative wound management which has failed to induce healing,

3. Exact location, size, including width, length, circumference, and depth, of the wound prior to initial treatment and prior to each subsequent treatment,

4. Response to wound treatment,

5. Appropriate adjunctive wound care measures,

6. The handling, application, and immobilization of the product in accordance with the manufacturer's instructions,

7. Amount of skin or soft tissue product used and wasted, and

8. Manufacturer's serial/lot/batch or other unit identification number of graft material, or documentation sufficient to demonstrate that the manufacturer does not supply unit identification.

Source: Social Security Act §§ 1862(a)(1)(A) and (D); 21 CFR Part 1271.

History: New Rule eff. 10/01/2014.

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 204
Dental Services

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Title 23: Division of Medicaid

Part 204: Dental Services

Part 204 Chapter 1: General

Rule 1.1: Dental Programs

The Division of Medicaid is authorized to furnish:

A. Dental care that is an adjunct to treatment of an acute medical or surgical condition,

B. Services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone, and

C. Emergency dental extractions and treatment related thereto. Medicaid defines a dental emergency as a condition that requires treatment and that causes pain and/or infection of the dental apparatus and/or contiguous structures.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.2: Provider Enrollment

A. Dentists must comply with all requirements set forth in Miss. Admin. Code Part 200, Chapter 4, 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, driver's license if it notes the social security number, 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.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.3: Covered Services

A. Covered dental services include:

    1. Limited oral evaluation, problem-focused,

    2. Radiographs,

3. Gingivectomy and/or gingivoplasty for Dilantin therapy only,

4. Oral surgery,

5. Extractions, and

6. Alveoloplasty.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.4: Non-covered Services

A. Non-covered dental services include, but not limited to, the following:

1. Comprehensive oral evaluation,

2. Preventive services,

3. Amalgams, composites, and crowns,

4. Endodontics,

5. Dentures, and

6. Orthodontia.

B. The Division of Medicaid does not cover for scheduling/rescheduling for any dental or oral surgical procedure in any treatment setting.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.5: Dental Benefit Limits

A. The Division of Medicaid covers dental expenditures, excluding orthodontia-related services, up to twenty five hundred dollars ($2,500.00) per beneficiary per state fiscal year.

B. All American Dental Association (ADA) dental procedure codes, except orthodontia-related services, are applied to the $2,500 annual limit.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.6: Prior Authorization

A. The Division of Medicaid requires prior authorization, except for emergencies, from the Utilization Management/Quality Improvement Organization (UM/QIO) of the following dental services:

1. Surgical access of an unerupted tooth,
2. Radical resection of mandible with tooth bone graft,
3. Arthrotomy,
4. Complicated suture greater than five (5) cm,
5. Osteoplasty – for orthognathic deformities,
6. Osteotomy – mandibular rami,
7. Osteotomy – mandibular rami with bone graft, includes obtaining the graft,
8. Osteotomy – segmented or subapical – per sextant or quadrant,
9. Osteotomy –body of mandible,
10. Lefort I (maxilla – total),
11. Lefort I (maxilla – segmented),
12. Lefort II or Lefort III (osteoplasty of facial bones for midface hypoplasia),
13. Repair of maxillofacial soft and hard tissue defect,
14. Closure of salivary fistula,
15. Coronoidectomy,
16. All procedures billed under unspecified dental procedure codes, and
17. The following types of analgesia and sedation for dental office-based procedures:
    a. Analgesia, anxiolysis, inhalation of nitrous oxide,
    b. Non-Intravenous conscious sedation,
    c. Deep sedation/general anesthesia, and
    d. Intravenous conscious sedation/analgesia.

B. In the case of an emergency, documentation justifying the medical necessity for the emergency procedure must be provided to the UM/QIO to receive a Treatment Authorization Number (TAN) for billing purposes.

C. Denied procedures will be marked and the prior authorization will apply only to those procedures on the treatment plan which were approved.

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

History: Added Miss. Admin. Code Part 204, Rule 1.6.A.17. eff. 05/01/2014.

Rule 1.7: Laboratory Services, Diagnostic Casts and Photographs

The Division of Medicaid covers lab and pathology services if the provider performs the service in their office and must have a Clinical Laboratory Improvement Amendment (CLIA) certificate number on file with Medicaid.

Source: Miss. Code Ann. §§ 43-13-171, 43-13-121.

Rule 1.8: Radiographs

A. The Division of Medicaid covers the following types of dental radiographs:

1. Intraoral - complete series, including bitewings,

2. Intraoral – periapical,

3. Bitewings, and

4. Panoramic film.

B. The Division of Medicaid requires radiographs be of sufficient quality to be readable.

C. The Division of Medicaid covers an intraoral complete series radiograph or panorex only once every two (2) years per beneficiary per provider.

1. The Division of Medicaid requires that two (2) years must have elapsed from the date the previous intraoral complete series radiograph or panorex was given before the same provider can be covered for the next intraoral complete series radiograph or panorex.

2. The Division of Medicaid requires an intraoral complete series radiograph to include fourteen (14) to twenty-two (22) periapical and posterior bitewing images.

3. The Division of Medicaid does not cover for both intraoral complete series radiograph and panorex on the same day.

4. The Division of Medicaid does not cover additional radiographs if an emergency extraction is performed on the day that an intraoral complete series radiograph or panorex is taken.

5. The Division of Medicaid covers the following exceptions to this limit if one (1) of the following conditions is documented:

    a) Documented trauma to head or mouth area,

    b) Orthodontic evaluation, or

    c) Rule out malignancy.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.9: Periodontic Procedures

The Division of Medicaid covers gingivectomy or gingivoplasty for beneficiaries only if the beneficiary is on Dilantin therapy. Documentation relating to the beneficiary's Dilantin therapy must be retained in the dental record.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.10: [removed]

History: Removed eff. 05/01/2014.

Rule 1.11: Dental Services Provided at a Hospital and Ambulatory Surgical Center (ASC)

A. The Division of Medicaid covers medically necessary dental treatment in the outpatient hospital or Ambulatory Surgical Center (ASC) setting when:

    1. Quality, safe, and effective treatment cannot be provided in an office setting or is not medically necessary for inpatient hospitalization, and

    2. Prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), Division of Medicaid, or designee for certain procedures.

B. The Division of Medicaid covers medically necessary dental treatment in the inpatient hospital setting when:

    1. The beneficiary's age, medical or psychological needs, and the extent of treatment necessitate hospitalization, and

    2. Prior authorized by a UM/QIO, the Division of Medicaid or designee.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 09/01/2015.

Rule 1.12: Oral Evaluations

The Division of Medicaid defines a limited oral evaluation as an evaluation or re-evaluation limited to a specific oral health problem.

A. The Division of Medicaid covers limited oral evaluations four (4) times per state fiscal year.

B. This may require interpretation of information acquired through additional diagnostic procedures.

C. The Division of Medicaid covers definitive procedures to be performed on the same date as the evaluation according to this rule.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.13: Consultations

The Division of Medicaid covers consultation services for dentists or dental specialists.

A. The Division of Medicaid does not cover the visit or exam on the same day as the initial consultation by the consulting dentist or dental specialist.

B. The Division of Medicaid covers diagnostic and therapeutic procedures on the same or different dates of services as the consultation.

C. The appropriate dental procedure code is required for reimbursement.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.14: Anesthesia

A. The Division of Medicaid defines a topical anesthetic as an agent used to temporarily anesthetize or numb the tiny nerve endings located on the surfaces of the oral mucosa. The Division of Medicaid does not cover the cost of the topical anesthetic and the application of the topical anesthetic separately from the procedure performed.

B. The Division of Medicaid defines a local anesthetic as an agent used to temporarily prevent the conduction of sensory impulses such as pain, touch, and thermal change from a body part along nerve pathways to the brain. The Division of Medicaid does not cover local anesthesia separately from the procedure performed.

C. The Division of Medicaid defines conscious sedation as an anesthetic, including oral, intravenous and intramuscular, administered to place the beneficiary in a relaxed state, which

helps control fear and anxiety, but the beneficiary can still respond to speech or touch. The Division of Medicaid covers conscious sedation for dental and oral procedures using the appropriate dental procedure code.

D. The Division of Medicaid defines deep sedation/general anesthesia as a controlled state of depressed consciousness induced by an anesthetic and accompanied by a partial or complete loss of protective reflexes, including the inability of the beneficiary to maintain an airway without assistance or support. The Division of Medicaid covers deep sedation/general anesthesia for dental and oral procedures using the appropriate dental code.

E. All forms of sedation and anesthesia administered in a dental office-based setting must comply pursuant to Miss. Code Ann. § 73-9-13 to insure that beneficiaries are provided with the benefits of anxiety and pain control in a safe and efficacious manner.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121, 73-9-13; MS State Board of Dental Examiners, Board Regulation 29.

History: Revised Miss. Admin. Code Part 204, Rule 1.14.C. and added D. and E.

Rule 1.15: Bone Replacement Graph

A. The Division of Medicaid defines a bone replacement graft as a procedure which involves the use of osseous autografts, osseous allografts, or non-osseous grafts to stimulate bone formation or periodontal regeneration when the disease process has led to a deformity of the bone. This procedure does not include flap entry and closure. The Division of Medicaid defines the following as:

    1. Osseous autograft as a graft taken from one part of the body and placed in another site on the same individual.

    2. Osseous allograft as a graft between two or more individuals allogenic at one or more loci.

    3. Non-osseous as a graft not composed of bone such as tendon or ligament tissue, and the material can be artificial, synthetic or natural.

B. Providers must bill the appropriate dental procedure code when providing this service.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.16: Documentation Requirements

Dental providers must maintain auditable records containing documentation that substantiate the services provided in accordance with requirements set forth in Miss. Admin. Code Part 200, Chapter 1, Rule 1.3. including, but not limited to:

A. Date of service,

B. History taken on initial visit,

C. Chief complaint on each visit,

D. Test, radiographs and results must have the beneficiary's name, the date, must be legible, and must be maintained on file with the beneficiary's dental records.

E. Diagnosis,

F. Treatment, including prescriptions,

G. Signature or initials of dentist after each visit, and

H. Copies of hospital and/or emergency room records if available.

Source: Miss. Code Ann. § 43-13-121

Rule 1.17: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Miss. Admin. Code Part 223, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

Part 204 Chapter 2: Oral Surgery

Rule 2.1: Simple Extractions

Medicaid covers for simple extractions and the fee includes local anesthesia and routine post-operative care.

A. Medicaid covers for alveoloplasties with the simple extraction of three (3) or more adjacent teeth in the same quadrant.

B. Medicaid requires for an alveolopasty by quadrant to be covered, a minimum of five (5) teeth in the quadrant must be done.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.2: Supernumerary Tooth Extractions

Medicaid requires prior authorization for the extraction of a supernumerary tooth.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.3: Surgical Extractions

A. The Division of Medicaid defines an impacted tooth as one where its eruption is partially or wholly obstructed by bone, soft tissue or other teeth.

B. The Division of Medicaid covers surgical extractions and removal of impacted teeth.

C. The Division of Medicaid does not cover for the extraction of an unerupted third molar unless medically necessary including, but not limited to:

    1. Radiographic evidence that a third molar will be severely impacted, or

    2. Evidence of infection.

D. The fee for all surgical extractions and removal of impacted teeth includes:

    1. Local anesthesia,

    2. Smoothing the socket site,

    3. Suturing, and

    4. Routine post-operative care.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 12/01/15.

Rule 2.4: Alveoloplasty

The Division of Medicaid covers alveoloplasty as a separate procedure from extractions or in conjunction with extractions when there is a need for significant bone re-contouring in the quadrant to prepare the ridge for a prosthetic appliance if there:

A. Are three (3) or more tooth spaces present per quadrant, or three (3) or more teeth extracted per quadrant, or

B. Are less than three (3) tooth spaces present per quadrant, or less than three (3) teeth extracted per quadrant if prior authorized as medically necessary by the Utilization Management/ Quality Improvement Organization (UM/QIO), or designee.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 02/01/2015.

Rule 2.5: Root Tips

Medicaid does not cover for the surgical removal of residual tooth roots with an extraction separately. The appropriate code for surgical removal of residual tooth roots (cutting procedures) must be used to bill the surgical removal of residual roots when a tooth has been broken off by natural means or when the beneficiary seeks follow-up care from a practitioner other than the dentist or oral surgeon who performed the original extraction.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.6: Complicated Sutures

Medicaid covers complicated suturing only in instances of trauma where simple sutures cannot be placed or simple suturing is not possible. Medicaid does not pay separately when done with extractions of unerupted teeth or when the dentist creates the flap or incision. Medicaid requires detailed documentation of the traumatic event in the dental record.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 205
Hospice Services

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Title 23: Division of Medicaid

Part 205: Hospice Services

Part 205 Chapter 1: Program Overview

Rule 1.1: General

A. For purposes of this rule a hospice shall be defined as a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals.

B. Treatment shall be palliative or management of a terminal illness, except for children under age twenty-one (21). Medicaid defines palliative as the relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

C. Terminal illness is defined as an illness with a medical prognosis of life expectancy of six (6) months or less.

D. Persons enrolled in Home and Community-Based Services (HCBS) waivers who elect to receive hospice care may not receive HCBS waiver services which are duplicative of any services rendered through hospice. Persons may receive non-duplicative HCBS waiver services in coordination with hospice services.

Source: 41 USC § 1395x(dd); PPACA, Pub. L. No. 111-148, § 2302, 124 Stat. 119 (2010); Miss. Code Ann. §§ 41-85-1 et seq., 43-13-121.

History: Revised Miss. Admin. Code Part 205, Rule 1.1.D. eff. 06/01/2016.

Rule 1.2: Provider Enrollment Requirements

Providers of hospice must meet the following criteria:

A. Meet the conditions of participation set forth in 42 CFR, Chapter IV Centers for Medicare & Medicaid Services, Department of Health and Human Services, Part 418,

B. Be licensed and certified for participation by the State survey agency, Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification (HFLC), and

C. Enter into a provider agreement with the Mississippi Division of Medicaid.

D. Hospice providers applying for enrollment as Medicaid providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider

type specific requirements:

1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

2. Written confirmation from the IRS confirming your tax identification number and legal business name,

3. Copy of current Medicare certification or Tie-In Notice,

4. EOMB is not acceptable and must be from Medicare Intermediary, and

5. Copy of current license or certification letter and must be from state of servicing location

Source: Miss. Code Ann. § 43-13-121

Rule 1.3: Physician Certification/Re-Certification

A. Admission to hospice and subsequent re-enrollment periods must be certified through the Division of Medicaid Utilization Management and Quality Improvement Organization. All certification/recertification requirements under CFR 42, Part 418 must be met except as otherwise noted below:

1. Initial Certification to Hospice

   a) The written initial certification statement must be signed by the medical director of the hospice OR the physician member of the hospice interdisciplinary group, AND the beneficiary's attending physician. The written certification must include a statement that the beneficiary's medical prognosis is six (6) months or less, and that hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

   b) The attending physician must be a doctor of medicine or osteopathy and must be identified by the individual at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

   c) The medical director of the hospice or physician member of the hospice interdisciplinary group and the beneficiary's attending/certifying physician MUST be different physicians. Medical certification is required by the individual's attending physician; however, if the beneficiary's primary attending physician and the hospice interdisciplinary physician or the hospice medical director is the same person, the documentation must be provided to show that this person has been treating the beneficiary for the end of life illness prior to admission.

2. The written re-certification statement must be signed by the medical director of the

hospice or the physician member of the hospice interdisciplinary group. The written certification must include a statement that the beneficiary's medical prognosis is six (6) months or less and that hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

B. The physician signing the written certification/re-certification statement can be held liable for causing false claims to be submitted. A written certification must be obtained before billing for hospice services.

C. The hospice must retain the certification/re-certification statement in the beneficiary's medical record. This must be maintained at the hospice site issued the provider license and Division of Medicaid provider number.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Election, Enrollment, and Revocation

A. The Division of Medicaid shall reimburse the hospice provider when the beneficiary/legal representative elects to receive the palliative care of the hospice services rather than active treatment of the terminal condition.

B. Eligibility to elect hospice care under Medicaid requires:

1. Certification of the beneficiary as being terminally ill with a life expectancy of six (6) months or less,

2. Documentation of a diagnosis consistent with a terminal stage of six (6) months or less, and

3. Completion of an Election Package.

C. The hospice benefit is divided into distinct periods, which stand alone and once used is no longer available. The maximum number of days in each election period is as follows:

1. 1st – ninety (90) days,

2. 2nd – ninety (90) days, and

3. 3rd – sixty (60) days - unlimited increments.

D. The election to receive hospice care is considered continuous for each election period as long as the beneficiary remains under the care of the hospice program, does not revoke the election, and continues to meet Medicaid eligibility requirements.

E. Election of Hospice option causes the beneficiary to forfeit all other Medicaid program benefits provided for in the State Plan or through Home and Community-Based Services

(HCBS) waivers that may also be available under the hospice benefit related to treatment of the beneficiary's terminal illness, except for children under the age of twenty-one (21).

F. Change in hospice designations can be made once per election period and is not considered a revocation of the election.

G. Election of hospice care can be revoked at any time by the beneficiary/legal representative. Disenrollment from hospice is required for, but not limited to, the following:

1. Death,

2. Hospitalization unrelated to terminal illness,

3. Beneficiary is seeking treatment other than palliative in nature, or

4. Beneficiary no longer meets program requirements.

H. The Division of Medicaid will not reimburse for the date of discharge, transfer or the date of death.

Source: Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 205, Rule 1.4.E. eff. 06/01/2016.

Rule 1.5: Election of Hospice Care

A. The beneficiary must waive all rights to Medicaid payments for the duration of the election of hospice care for the following services:

1. Hospice care provided by a hospice other than the hospice designated by the beneficiary/legal representative (unless provided under arrangements made by the designated hospice), and

2. Any Medicaid services that are related to the treatment of the terminal condition or a related condition for which hospice care was elected or that are equivalent to hospice care except:

a) Services provided (either directly or under arrangement) by the designated hospice.

b) Services provided by the beneficiary’s attending physician, if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

c) Services provided as room, board, and services by a nursing facility if the beneficiary is a resident at the time the hospice election is made and Medicaid was paying for that service.

B. Waiver of Medicaid services ceases and all Medicaid benefits to the limits permitted, are available at the completion of a hospice benefit period or at the revocation of remaining days.

Source: Miss. Code Ann. § 43-13-121

Rule 1.6: Covered Services

A. Covered services provided through hospice include core hospice services such as physician services, nursing care, medical social services, and counseling services in addition to special coverage services such as continued home care, respite care, bereavement counseling and general inpatient care. All personnel must meet applicable state and federal licensing/certification requirements.

B. Core Services

1. Physician services must be performed by a physician as defined in 42 CFR 418. Exception are the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy).

2. Nursing care must be provided by a registered nurse (RN).

3. Medical social services must be provided by a licensed social worker who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education, and who is working under the direction of a physician.

4. Counseling services with respect to the care of the terminally ill individual and adjustment to death shall be provided to the terminally ill beneficiary and the family members or other persons caring for the beneficiary at home.

5. Medical appliances and supplies, drugs, and biologicals.

6. Hospice aide services must be furnished by qualified aides and homemaker services.

7. Physical therapy, occupational therapy, and speech-language pathology services.

8. Providers and practitioners who furnish hospice services must meet all requirements in accordance with the rules and regulations as defined in the Minimum Standards of Operation for Hospice per the Mississippi State Department of Health.

C. Continuous Home Care shall be provided only during a period of crisis.

1. The hospice must provide a minimum of eight (8) hours of care by a Registered Nurse (RN) during a twenty-four (24) hour day that begins and ends at midnight.

2. Continuous home care may not be provided when the hospice beneficiary is a nursing

home resident or an inpatient of a free-standing hospice.

D. Respite Care

1. Respite care shall be provided to relieve family members or other persons caring for the beneficiary at home and shall not be reimbursed for more than five (5) consecutive days at a time.

2. Respite care shall not be provided when the hospice beneficiary is a nursing home resident is an inpatient of a free-standing hospice, or the services are a duplication of any other like services being delivered to the beneficiary.

E. Bereavement Counseling shall be provided to the beneficiary's family after the beneficiary's death up to twelve (12) months.

F. General/Short-term Inpatient Care shall be provided in a participating hospice inpatient unit, hospital, or a participating SNF or NF that additionally meets the special hospice standards regarding patient and staffing areas. Short term inpatient care includes both Respite care and procedures necessary for pain control and acute system management.

Source: Miss. Code Ann. § 43-13-121; §41-85-1 through 41-85-25(1972, as amended)

Rule 1.7: Transportation

A. The provider shall provide:

1. Transportation for medical services relating to the terminal illness must be provided and paid for by the hospice provider.

2. Transportation from the hospital to the beneficiary's residence or to a freestanding hospice facility during a period of hospitalization after election of the hospice benefit.

B. Transportation shall be non-covered when:

1. The hospice beneficiary calls 911 for ambulance/medical assistance,

2. The hospice beneficiary requests transportation for services that are not palliative in nature. The hospice provider must arrange non-emergency transportation through the Medicaid non-emergency transportation program. (Part 201, Chapter 2)

3. The hospice beneficiary requires or seeks transportation for medical services unrelated to the terminal illness.

Source: Miss. Code Ann. § 43-13-121

Rule 1.8: Reimbursement

A. Medicaid reimbursement for hospice care is made at one of four (4) predetermined rates for each day that the beneficiary is under the care of the hospice with the exception of payment for attending physician services.

   1. Routine Home Care- Medicaid shall reimburse the hospice the routine home care rate for each day the beneficiary is under the care of the hospice. The rate will be reimbursed without regard to the volume or intensity of services provided on any given day if a beneficiary is a nursing facility resident.

   2. Continuous Home Care- Medicaid shall reimburse the hospice an hourly rate for continuous home care which includes a minimum of eight (8) hours of care rendered by a registered nurse. Every hour or part of an hour of continuous care will be reimbursed at the hourly rate up to twenty-four 24) hours per day. The rate is not payable when the hospice beneficiary is a resident of a nursing facility or an inpatient of a free-standing hospice.

   3. Inpatient Respite Care- Medicaid shall reimburse the hospice an inpatient respite care rate for each day the beneficiary stays in an approved inpatient respite facility. Inpatient respite care is limited to a maximum of five (5) consecutive days at a time. This rate is not payable when the hospice beneficiary is a resident of a nursing facility or an inpatient of a free-standing hospice.

   4. General Inpatient Care- Medicaid shall reimburse the hospice at the general inpatient care rate for each day such care is consistent with the patient's plan of care.

B. Medicaid shall reimburse the hospice for **r**espite and general inpatient days. The hospice must reimburse the facility that provides inpatient care.

C. Medicaid will not reimburse for the date of discharge or the date of death.

D. Medicaid does not reimburse the hospice separately for hospice physician services, except for coinsurance payments that result from Medicare approved claims. Medicaid will pay the claims of attending physicians for direct patient care services to beneficiaries that elect the hospice option as long as such services are not routinely provided to the hospice's patients on a voluntary basis.

E. Reimbursement for Beneficiaries in a Nursing Facility

   1. Division of Medicaid does not reimburse the hospice provider for nursing facility bed-hold days.

   2. Room and board shall be reimbursed to the hospital at 95% of the nursing home’s established Medicaid per diem.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: Documentation Requirements

A. Hospice medical records must be maintained at the hospice site issued the provider license and provider number by Division of Medicaid. Each record must contain the following for each beneficiary:

   1. The Election Package.

   2. The original Disenrollment/Transfer Form signed by the beneficiary/legal representative and the hospice provider, as required.

   3. An interdisciplinary Plan of Care that supports each hospice service rendered including needs, care, services and goals.

   4. Treatment rendered including:

      a) Each discipline's visit or contact of the treatment or intervention rendered at the frequency ordered on the plan of care.

      b) Documentation to show relationship of the treatment plan and medications to the terminal illness, and

      c) Provider's signature or initials on all medical records.

   5. A medication list, updated monthly, for each month of certification that clearly indicates the medications the hospice paid related to the terminal illness. The list must contain the name and strength of the drugs and the name and address of the pharmacies that provided the medications to the hospice beneficiary.

   6. A monthly updated list of medical appliances and supplies related to the terminal illness paid for by the hospice; and the names and address(s) of the providers paid.

B. Documentation must be maintained in accordance with requirements set forth in Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121

Rule 1.10: Dual Eligibles

The hospice benefit shall be used simultaneously under Medicare and Medicaid with Medicare providing primary coverage for dual eligible beneficiaries. The hospice benefit, and each period therein, is available only once in a lifetime for dual eligible beneficiaries.

Source: Miss. Code Ann. § 43-13-121

Administrative Code

Title 23: Medicaid
Part 206
Mental Health Services

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Title 23: Division of Medicaid

Part 206: Mental Health Services

Part 206 Chapter 1: Community Mental Health Services

Rule 1.1 General

A. Purpose

The purpose of these regulations is to set forth the minimum requirements for providers who provide described mental health services to Medicaid beneficiaries in a community mental health setting. These regulations also provide for the maximum number of services that may be provided to a beneficiary daily and annually. Any service that requires prior authorization by the Division of Medicaid is so specified. The regulations have been prepared for the information and guidance of providers of services participating in the Mississippi Medicaid program.

It is the provider's responsibility to assure that the business's employees at all locations are knowledgeable of the Medicaid program requirements and have access to Medicaid regulation, requirements, and other information pertinent to the performance of their duties.

B. Legal Authority

The Division of Medicaid is authorized to promulgate these rules under and by virtue of Section 43-13-121 of the Mississippi Code of 1972, as amended.

As specified in 43-13-117 (16) of the Mississippi Code of 1972, as amended, Community Mental Health Services described in these regulations are approved therapeutic and case management services provided by (a) an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health (DMH) to be an approved mental health/retardation center if determined necessary by DMH, using state funds which are provided from the appropriation to DMH and used to match federal funds under a cooperative agreement between the division and the department, or (b) a facility certified by DMH to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior authorization of the Division to be eligible for reimbursement under this section. Any facility described in paragraph (b) must be certified by DMH as a community mental health center and matching funds for services will be funded by DMH.

C. Coverage Criteria

1. The Division of Medicaid will provide coverage for covered mental health services when it is determined that the medically necessary criteria and guidelines listed below are met.

"Medically necessary" or "medical necessity" shall mean health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a) Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the patient's medical condition,

b) Compatible with the standards of acceptable medical practice in the United States,

c) Provided in a safe, appropriate and cost-effective community-based setting given the nature of the diagnosis and the severity of the symptoms,

d) Not provided solely for the convenience of the beneficiary or family, or the convenience of any health care provider,

e) Not primarily custodial care,

f) There is no other effective and more conservative or substantially less costly treatment service and setting available,

g) The service is not experimental, investigational or cosmetic in nature, and

h) All Mississippi Medicaid regulations, program rules, exclusions, limitations, and service limits, etc., apply. The fact that a service is medically necessary does not, in itself, qualify the service for reimbursement.

2. Reimbursement is available only for beneficiaries who have Medicaid eligibility for the date the service is provided.

3. Mental Health Services in this Chapter are covered for adult or child beneficiaries of Mississippi Medicaid. Services available to targeted populations only are specified under the appropriate Rule.

D. General Service Requirements

1. Services provided must comply with rules, guidelines and regulations established by the Division of Medicaid.

2. All providers enrolled as community mental health providers must be certified for the provision of the mental health services they provide by the Department of Mental Health on the date of service.

3. Staff providing mental health services must meet minimum qualifications as established by the Division of Medicaid. A staff member must hold at a minimum, a bachelor's degree in a mental health field, in order to provide services billed to Medicaid unless

specifically stated in a rule defining a service. Bachelor's level staff shall not provide therapy services.

4. There must be clear evidence provided in the documentation that services are based on beneficiary need and not convenience of the staff.

5. Beneficiaries shall not be required to participate in services that are not medically necessary or there is no identified need. Beneficiaries shall not be required to participate in one service in order to get another. Determination of needed services must be person-centered.

6. An individual staff member can bill only for the actual time spent in service delivery, not to exceed the amount of total time the staff member actually worked. Staff may not spend the least amount of time possible to equal a billing unit in order to bill nine (9) hours per day when only eight (8) hours were worked.

7. Where there are conflicts between this Administrative Rule, the Division of Medicaid provider manuals and fee schedules or the DMH Standards, the Division of Medicaid Administrative Rule supersedes all else.

8. Interpretations to the Medicaid rules and regulations, including the Mississippi Medicaid Administrative Rule, must be received in writing from the Division of Medicaid. The Division of Medicaid is the only agency that has the authority to render a decision on Medicaid Administrative Rule or other guidance documents.

E. Documentation Requirements

1. All services billed to Medicaid must be included in the treatment plan and must be approved by a licensed independent practitioner in accordance with the appropriate scope of practice. These practitioners are limited to: a Mississippi licensed Physician who holds a specialty in psychiatry, a Mississippi licensed physician with minimum of five (5) years experience in mental health, a Mississippi licensed Psychologist, a Mississippi Licensed Certified Social Worker (LCSW), a Mississippi Licensed Professional Counselor (LPC), a Mississippi Licensed Marriage and Family Therapist (LMFT), a Psychiatric Mental Health Nurse Practitioner under an approved protocol, or a Physician Assistant.

2. For the purpose of this rule, a treatment plan may be referred to as the plan of care, individualized service plan, wraparound plan or person-centered plan depending on the service. It is the plan that directs the treatment of the Medicaid beneficiary.

3. Each initial and updated treatment plan must be reviewed, signed and dated by an approved practitioner as listed in E.1.

4. Each service provided and billed to Medicaid must have corresponding documentation to substantiate the claim, be in the case record and must, at a minimum, include the following documentation:

a) Type of service provided (group therapy, family therapy, individual therapy, etc.),

b) Date (DD/MM/YYYY) of service,

c) Length of time (00:00) spent delivering the service,

d) Time session began and time session ended,

e) Identification of individual (s) receiving or participating in the service,

f) Summary of what transpired in the session,

g) Evidence the session relates to the goals and objectives established in the treatment plan,

h) Name and title of staff who provided the service,

i) Signature and credentials of the person who provided and documented the service, and

j) Legible documentation that can easily be read by reviewers.

5. Community Mental Health services must be documented according to the DMH Record Guide in effect on the date of service for a particular service.

F. Non-covered services

1. The following activities are ineligible for reimbursement by Medicaid:

a) Paperwork completed outside of a direct service provision.

b) Telephone contacts, unless specified in the service definition.

c) Field trips and routine recreational activities.

d) Educational intervention.,

e) Staff travel time.

f) Transportation of individuals receiving mental health services.

g) Beneficiary travel time to or from any CMH service.

h) Failed and/or canceled appointments. The provider is prohibited from billing the Medicaid beneficiary for the missed appointment.

i) Evaluation or review of beneficiary progress outside of treatment team or as a function of targeted case management.

j) CMH services when a beneficiary is an inpatient in an inpatient facility (ex: a medical hospital, an acute freestanding psychiatric facility, or a psychiatric residential treatment facility).

k) Service provided simultaneous with any other Medicaid-covered service, unless specifically allowed in the service definition.

l) Services provided to more than one beneficiary at a time, unless specifically allowed in the service definition.

m) Services in a nursing facility if not approved by the Appropriateness Review Committee as part of the Preadmission Screening and Resident Review Process required by 42 CFR 483, Subpart C.

2. Providers are strongly cautioned not to submit claims for ineligible activities.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.2 Psychosocial Assessment and Psychological Evaluation

A. Assessment is the securing, from the beneficiary and/or collateral, of the beneficiary's family background/ educational/vocational achievement, presenting problem(s), problem history, history of previous treatment, medical history, current medication(s), source of referral and other pertinent information in order to determine the nature of the individual's or family's problem(s), the factors contributing to the problem (s), and the most appropriate course of treatment for the beneficiary.

1. A completed Biopsychosocial Assessment form, which includes the signature and credentials of the staff member who conducted the assessment, must be present in the case record.

2. Psychosocial assessment may be completed at the time of intake and as needed for reassessment.

3. All psychosocial assessments must be provided by a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

4. Those who are provisionally certified must be supervised by a licensed professional or a credentialed DMH Certified Mental Health Therapist, DMH Certified Intellectual and Development Disabilities Therapist or DMH Certified Addiction Therapist.

    a) The supervisor must be of the same discipline as those they supervise (i.e. Mental Health = Mental Health; IDDD= IDDD; Addiction Therapist = Addiction Therapist)

    b) The signature of credentialed supervisor is required on documentation of all services provided.

5. Psychosocial assessment is limited to four (4) assessments per state fiscal year.

B. Psychological Evaluations are the assessment of a beneficiary's cognitive, emotional, behavioral, and social functioning by a licensed psychologist using standardized tests, interviews, and behavioral observations.

1. A psychological evaluation may be eligible for Medicaid reimbursement when one (1) or more of the following conditions exist:

    a) There is a history of unexplained treatment failures.

    b) There are questions regarding diagnosis and/or treatment that a psychological evaluation might help to answer.

    c) Evaluation is required by the Division of Medicaid for admission to a psychiatric residential treatment facility (PRTF).

2. Reasons a psychological evaluation may be eligible for reimbursement include, but are not limited to the following:

    a) The need to confirm or rule out the existence of a major diagnosis, such as depression, psychosis, mental retardation, or Attention Deficit Hyperactivity Disorder (ADHD) when behavioral observation and history supports the suspected diagnosis.

    b) The existence of a pattern of inability to learn, but not to the extent that the beneficiary qualifies for evaluation for Special Education services.

    c) The need to assess a beneficiary's potential for success in a certain type of program.

3. A psychological evaluation is not eligible for reimbursement through Medicaid when any of the following conditions apply:

    a) It is provided as a routine procedure or requirement of any program or provider, including pre-commitment hearings.

b) It is to determine educational needs/problems when such assessment is the responsibility of the school system where the child is enrolled.

c) It is within one (1) year of a previous psychological evaluation, unless necessary for admission to a Medicaid-certified PRTF or community based alternatives to PRTF or if needed to assess progress in a beneficiary with an evolving condition (i.e., head injury, severe depression).

4. Provider Requirements - Psychological evaluations must be completed in their entirety by a psychologist who is licensed to practice independently by the Mississippi Board of Psychology or the licensing board for psychologists in the state the service is provided.

5. Psychological evaluations are limited to four (4) hours per state fiscal year.

6. In order for a psychological evaluation to be eligible for Medicaid reimbursement, the psychologist completing the psychological evaluation must ensure that all of the following occur:

   a) Psychological testing is indicated by the referral question. If it is not, it is the responsibility of the psychologist to educate the referral source as to those circumstances in which testing is or is not indicated.

   b) An initial session must be held with the beneficiary and beneficiary's family before any testing is initiated. It may occur immediately preceding the psychological testing. The purpose of this session is to determine the medical necessity of psychological evaluation and to gather background information. Collateral contact may be included in the background and information gathering session, and the time spent with those collateral contacts is eligible for Medicaid reimbursement only when that contact is face-to-face. If it becomes apparent during the session that the beneficiary and/or family would benefit from certain strategies/interventions (e.g., bibliotherapy, behavioral approaches for beneficiaries with attention difficulties), these interventions should be implemented and their effectiveness evaluated before the necessity of testing is reconsidered. Though part of the evaluation process, the background and information gathering session should be billed as either a biopsychosocial assessment or family therapy (with or without the beneficiary, as appropriate).

   c) The psychologist has appropriate training, experience and expertise to administer, score and interpret those instruments used.

   d) The instruments used are psychometrically valid and appropriate to the referral question, the beneficiary's age and any special conditions presented by the beneficiary and/or the testing situation. In those instances in which more than one instrument could be used (e.g., IQ testing), the psychologist chooses the most psychometrically sound one unless otherwise indicated by the unique characteristics of the test-taker (e.g., the beneficiary is non-English speaking, physically unable to manipulate materials).

e) Unless doing so would present a hardship to the beneficiary and family, the beneficiary's family and, when appropriate, the beneficiary are provided with face-to-face (when possible) verbal feedback regarding test results, interpretation and recommendations within fourteen (14) calendar days of the written report. The referral source is included if requested at the time of the referral. The beneficiary's family and the beneficiary shall be given adequate opportunity to ask questions and give their input regarding the evaluation feedback. If face-to-face feedback is not possible, feedback is provided through alternative means. However, as part of the evaluation process, the feedback session should be billed as family therapy, with or without the beneficiary present, as appropriate.

7. Documentation Requirements

a) If/when testing is indicated, the testing process and the written report must document the medical necessity, adequately address the referral question, and reflect an understanding of the background strengths, values and unique characteristics of the beneficiary and family.

b) A written report must be generated within thirty (30) calendar days of completion of the assessment. However, if the beneficiary's treatment needs indicate an earlier report deadline, the report is generated as soon as possible. The report synthesizes the information gathered through interviews, observation, and standardized testing, including a discussion of any cautions related to testing conditions or limitations of the instruments used.

c) The written report must provide practical recommendations for those working with the beneficiary. These recommendations should reflect recognition of the beneficiary and family's strengths as well as their areas of need.

d) If computer-generated scoring or interpretation reports are used as one source of data, they must be integrated into the report as whole. Reports that include computer generated feedback without this integration are unacceptable.

e) Concrete plans are made for follow-up based on evaluation recommendations and feedback from the referral source, the family and, when appropriate, the beneficiary (e.g., therapy appointment is made, the family is given information about mentoring programs), and these plans are documented in writing.

f) Information obtained from collateral contacts is included in the report.

g) Documentation of evaluative services must include the dates and amount of time spent, including beginning and ending session times, in assessment/testing and the amount of time spent preparing a report. Evaluation reports must be dated and signed by the provider who conducted the evaluation.

C. Treatment Plan Review is the process through which a group of clinical staff meets to discuss with the beneficiary and his/her family members the individual's treatment plan. The review will utilize a strengths-based approach and shall address strengths and natural resources, presenting symptoms/problems, diagnostic impressions, and initiate/update a plan of treatment that includes goals, objectives and treatment strategies.

1. Treatment plan reviews must be provided by a team which includes a licensed independent practitioner in accordance with the appropriate scope of practice. These practitioners are limited to: a Mississippi licensed Physician who holds a specialty in psychiatry, a Mississippi licensed Physician with five (5) years experience in mental health, a Mississippi licensed Psychologist, a Mississippi Licensed Certified Social Worker (LCSW), a Mississippi Licensed Professional Counselor (LPC), a Mississippi Licensed Marriage and Family Therapist (LMFT), a Psychiatric Mental Health Nurse Practitioner under an approved protocol, or a Physician Assistant.

2. Treatment plan reviews are limited to four (4) per state fiscal year.

D. Documentation requirements for Treatment Planning

1. The case record must contain documentation of an initial treatment plan developed and reviewed by the treatment team within thirty (30) days of completion of the biopsychosocial assessment, and subsequent reviews as individual case circumstances require, and at least annually. The more frequently any case is reviewed; the documentation must be stronger in the case record justifying the frequency of review.

2. The treatment plan form must be present in the case record and must include, at a minimum:

   a) A multi-axial diagnosis (all five (5) axes addressed).

   b) Identification of the beneficiaries and/or family's strengths.

   c) Identification of the clinical problems or areas of need which are to be the focus of treatment.

   d) Treatment goals for each identified need.

   e) Treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement.

   f) Specific services, objectives and activities that will be employed to reach each objective.

   g) Date of implementation and signatures of the provider and beneficiary.

   h) The date of the treatment plan review meeting.

i) The length of time spent in reviewing/planning treatment for the beneficiary.

j) A written report of treatment recommendations/changes resulting from the meeting.

k) The signature of each staff member present when the case was reviewed.

l) Length of meeting time that exceeds one (1) service unit per case must be clearly justified in the case record.

3. Initial treatment plan and all subsequent treatment plans must be reviewed by treatment team and recommendations clearly documented.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.3 Psychotherapeutic Services

A. Psychotherapeutic services are defined as intentional, face-to-face interactions (conversations or non-verbal encounters, such as play therapy) between a mental health therapist and a beneficiary (an individual, family or group) where a therapeutic relationship is established to help resolve symptoms of the beneficiary's mental and/or emotional disturbance.

B. Individual Therapy is defined as one-on-one psychotherapy that takes place between a mental health therapist and a beneficiary. Individual therapy is limited to thirty-six (36) sessions per state fiscal year.

C. Family Therapy is defined as psychotherapy that takes place between a mental health therapist and a beneficiary's family members, with or without the presence of the beneficiary. Family therapy may also include others (Department of Human Services (DHS) staff, foster family members, etc.) with whom the beneficiary lives or has a family-like relationship. This service includes family psychotherapy, psychoeducation, and family-to-family training. Family therapy is limited to twenty four (24) sessions per state fiscal year.

D. Group Therapy is defined as psychotherapy that takes place between a mental health therapist and at least two (2) but no more than ten (10) children or at least two (2) but no more that twelve (12) adults at the same time. Possibilities include, but are not limited to, groups that focus on relaxation training, anger management and/or conflict resolution, social skills training, and self-esteem enhancement.

1. Group therapy is not eligible for Medicaid reimbursement on the same day as any psychosocial rehabilitation service, day support, day treatment service, acute partial hospitalization or crisis residential.

2. Group therapy is limited to forty (40) sessions per state fiscal year.

E. Multi-Family Group Therapy is defined as psychotherapy that takes place between a mental health therapist and family members of at least two (2) different beneficiaries, with or without the presence of the beneficiary, directed toward the reduction/resolution of identified mental health problems so that the beneficiaries and/or their families may function more independently and competently in daily life. This service includes psychoeducational and family-to-family training. Multi-family therapy is limited to forty (40) sessions per state fiscal year and that limit includes group therapy and multi-family group therapy.

F. Provider Requirements

1. All services under this category must be provided by a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

2. Those who are provisionally certified must be supervised by a licensed professional or a credentialed DMH Certified Mental Health Therapist, DMH Certified Intellectual and Development Disabilities Therapist or DMH Certified Addiction Therapist.

   a) The supervisor must be of the same discipline as those they supervise (i.e. Mental Health = Mental Health; IDDD= IDDD; Addiction Therapist = Addiction Therapist)

   b) The signature of credentialed supervisor is required on documentation of all the services provided.

3. If evidence–based practices (EBP) or evidence-informed best practices such as Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) are employed in the course of treatment, they must be provided by a Master's degree therapist who holds a professional license or DMH certification and has completed appropriate training in that evidence-based practice.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.4 Day Programs

A. Psychosocial Rehabilitation is an active treatment program designed to support and restore community functioning and well-being of an adult Medicaid beneficiary who has been diagnosed with a serious and persistent mental disorder. Psychosocial rehabilitation programs must use systematic, curriculum based interventions for skills development for participants. Its purpose is to promote recovery in the individual's community by alleviating psychiatric decompensation, confusion, anxiety, feelings of low self-worth, isolation and withdrawal. Program activities aim to improve reality orientation, social adaptation, physical

coordination, daily living skills, coping skills, effective management of time and resources, task completion and activities to incorporate the individual into independent community living. It is oriented toward empowerment, recovery and competency.

1. Psychosocial Rehabilitation may be provided to adults with a serious and persistent mental illness.

2. Psychosocial Rehabilitation must be provided in a program certified by the Department of Mental Health.

3. Psychosocial Rehabilitation is the most intensive day program available for adults. It is designed to support individuals who require extensive clinical services to support community inclusion and prevent re-hospitalization.

4. Psychosocial Rehabilitation must be provided by a program which has at least one (1) clinical staff member present during the time of program operation.

    a) Clinical staff member is defined as a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

    b) Those who are provisionally certified must be supervised by a licensed professional or a credentialed DMH Certified Mental Health Therapist, DMH Certified Intellectual and Development Disabilities Therapist or DMH Certified Addiction Therapist.

        1) The supervisor must be of the same discipline as those they supervise (i.e. Mental Health = Mental Health; IDDD= IDDD; Addiction Therapist = Addiction Therapist)

        2) The signature of credentialed supervisor is required on documentation of all services provided.

5. Beneficiaries may participate in psychosocial rehabilitation up to five (5) hours per day, up to five (5) days per week.

6. Psychosocial Rehabilitation services must be prior authorized by the Division of Medicaid or its designee, effective for dates of service on or after July 1, 2012.

7. Psychosocial Rehabilitation services are not eligible for Medicaid reimbursement on the same day as group therapy, day support, senior psychosocial rehabilitation, crisis residential or acute partial hospitalization.

8. Documentation Requirements

   a) The case record must contain a monthly progress summary for each beneficiary that includes:

      1) Notation of each date the service was provided,

      2) The length of time the service was provided on each date, and

      3) A summary of the beneficiary's progress that relates to the goals and objectives established on the Treatment Plan.

B. Day Support is a program of structured clinical activities in a group setting designed to support and enhance the role functioning of adult Medicaid beneficiaries who are able to live fairly independently in the community through the regular provision of structured therapeutic support. Program activities aim to improve beneficiaries' reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, and task completion as well as to alleviate such psychiatric symptoms as confusion, anxiety, isolation, withdrawal and feelings of low self-worth. The activities provided must include, at a minimum, the following: group therapy, individual therapy, social skills training, coping skills training, and training in the use of leisure-time activities. Day Support programs must provide active clinical treatment in a group setting.

1. Beneficiaries may participate in Day Support for a maximum of five (5) hours per day, a maximum of five (5) days per week. This program is the least intensive psychosocial rehabilitation service available.

2. Day Support Services may be provided to individuals with a Serious and Persistent Mental Illness or Substance Abuse diagnosis. It may be provided to individuals with intellectual and developmental disabilities through June 30, 2012.

3. Day Support must be provided by a program which has at least one clinical staff member responsible for planning and directly supervising program operation.

   a) Clinical staff member is defined as a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

   b) Those who are provisionally certified must be supervised by a licensed professional or a credentialed DMH Certified Mental Health Therapist, DMH Certified Intellectual and Development Disabilities Therapist or DMH Certified Addiction Therapist.

(1) The supervisor must be of the same discipline as those they supervise (i.e. Mental Health = Mental Health; IDDD= IDDD; Addiction Therapist = Addiction Therapist)

4. The signature of credentialed supervisor is required on documentation of all services provided.

5. Day Support services must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

6. Day support services are not eligible for Medicaid reimbursement on the same day as group therapy, clubhouse, senior psychosocial rehabilitation, crisis residential or acute partial hospitalization.

7. Documentation Requirements

   a) The case record must contain a progress summary for each beneficiary that includes:

      1) Notation of each date the service was provided,

      2) The length of time the service was provided on each date, and

      3) A summary of the beneficiary's progress that relates to the goals and objectives established on the Treatment Plan.

C. Senior Psychosocial Rehabilitation is a program of structured activities designed to support and enhance the ability of senior Medicaid beneficiaries to function at the highest possible level of independence in the most integrated setting appropriate to their needs. The activities target the specific needs and concerns of the senior while aiming to improve beneficiaries' reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, task completion and other areas of competence that promote independence in daily life. Activities are designed to alleviate such psychiatric symptoms as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

1. Beneficiaries may participate in Senior Psychosocial Rehabilitation for a maximum of five (5) hours per day, a maximum of five (5) days per week.

2. Senior Psychosocial Rehabilitation may be provided to adults age fifty (50) and older with a diagnosis of a serious and persistent mental illness. It may be provided to individuals with intellectual and developmental disabilities through June 30, 2012.

3. Senior Psychosocial Rehabilitation must be provided by a program which has at least one clinical staff member present during the time of program operation.

a) Clinical staff member is defined as a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

b) Those who are provisionally certified must be supervised by a licensed professional or a credentialed DMH Certified Mental Health Therapist, DMH Certified Intellectual and Development Disabilities Therapist or DMH Certified Addiction Therapist.

(1) The supervisor must be of the same discipline as those they supervise (i.e. Mental Health = Mental Health; IDDD= IDDD; Addiction Therapist = Addiction Therapist)

(2) The signature of credentialed supervisor is required on documentation of all services provided.

4. Senior Psychosocial Rehabilitation services provided in a nursing facility must also be authorized through the Preadmission Screening and Resident Review (PASRR) rules.

5. Senior psychosocial rehabilitation services provided in the community for individuals who are not residents of a nursing facility must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

6. Elderly psychosocial services are not eligible for Medicaid reimbursement on the same day as group therapy, day support, psychosocial rehabilitation, crisis residential or acute partial hospitalization.

7. Documentation Requirements

a) The case record must contain a progress summary for each beneficiary that includes:

(1) Notation of each date the service was provided,

(2) The length of time the service was provided on each date, and

(3) A summary of the beneficiary's progress that relates to the goals and objectives established on the Treatment Plan.

D. Day Treatment is a behavioral intervention program, provided in the context of a therapeutic milieu, which provides primarily school age children/adolescents with serious emotional disturbances (SED) the intensity of treatment necessary to enable them to live in the community. The program is based on behavior management principles and includes, at a minimum, positive feedback, self-esteem building and social skills training. Additional

components are determined by the needs of the participants in a particular program and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution. The most important element of Day Treatment is the consistency and qualifications of the staff providing the service. Day Treatment is the most intensive outpatient program available to children and adolescents. It provides an alternative to residential treatment or acute psychiatric hospitalization and/or serves as a transition from these services.

1. Beneficiaries may participate in the program a maximum of five (5) hours per day, five (5) days per week with a minimum of four hours per week.

2. Day Treatment may be provided to children with SED.

3. No less than four (4) individuals may participate in a Day Treatment program in order to achieve a therapeutic milieu.

4. No Day Treatment room shall have more than ten (10) individuals with emotional and/or behavior disorders participating in the program at any time.

   If programs are developed for individuals with a diagnosis of Autism/Asperger's are developed around youth who meet medical necessity criteria, there shall be no more than four (4) individuals with a diagnosis of Autism/Asperger's per program.

5. In order to participate in the Day Treatment program, a child or youth must be on the permanent roster for the program. They shall not participate on an intermittent basis.

6. Day Treatment must include involvement of the family or individuals acting in loco parentis as often as possible, but not less than twice per month, in order to achieve improvement that can be generalized across environments.

7. Day Treatment Services are not eligible for Medicaid reimbursement on the same day as group therapy, crisis residential or acute partial hospitalization.

8. Day Treatment must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

9. Day Treatment services must be provided by a non-case management staff member who holds a Master's Degree and professional license (ex: Licensed Certified Social Worker, Licensed Marriage & Family Therapist, Licensed Professional Counselor, Psychologist, Licensed Master Social Worker, or a Medical Doctor) or who is a DMH Certified Mental Health Therapist or DMH Provisionally Certified Mental Health Therapist.

10. The staff person providing day treatment services must also provide other therapy services for the children and youth in day treatment, which are deemed medically necessary whenever possible.

11. Documentation Requirements

a) The case record must contain progress notes for each beneficiary.

b) The progress notes must include:

1) Date the service was provided,

2) Length of time the service was provided on each date, and

3) A summary of the beneficiary's progress that relates to the goals and objectives established on the Treatment Plan.

E. Acute Partial Hospitalization is a program that provides medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to beneficiaries who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. Acute Partial Hospitalization is designed to provide an alternative to inpatient hospitalization for such beneficiaries or to serve as a bridge from inpatient to outpatient treatment. Program content may vary based on beneficiary need but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.

1. Acute Partial Hospitalization may be provided to children with SED or adults with SPMI.

2. Acute Partial Hospitalization must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

3. Acute Partial Hospitalization programs must be certified by the Department of Mental Health.

4. Acute Partial Hospitalization programs must have medical supervision and nursing services immediately available during hours of operation.

5. Acute Partial Hospitalization is limited to one hundred (100) days per state fiscal year.

6. Documentation requirements:

a) The case record must contain a physician order for the service stating that inpatient care would be necessary without the service.

b) The case record must contain a daily progress summary for each beneficiary which meets the documentation criteria for acute partial hospitalization services.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.5 Crisis Services

A. Crisis Response Services

1. Crisis Response Services - Time limited intensive intervention, available twenty-four (24) hours a day, seven (7) days a week. Crisis response services allow for the assessment of the crisis and ability to activate a mobile crisis team. Trained crisis response staff provides crisis stabilization and treatment of a Medicaid eligible individual directed toward preventing hospitalization. Children or adults requiring crisis services are those who are experiencing a significant emotional/behavioral crisis. A crisis situation is defined as a situation in which an individual's mental health and/or behavioral health needs exceed the individual's resources, in the opinion of the mental health professional assessing the situation.

   a) Crisis Response services are considered community based services and must be available face-to-face whenever the beneficiary and their family is in need of crisis response services. Initial crisis response may be provided by telephone.

   b) Crisis Response services are available to adults exhibiting symptomology indicating a serious and persistent mental illness or children and youth exhibiting symptomology indicating a serious emotional disturbance.

   c) Crisis Response services may be provided in the emergency department of a hospital.

   d) Crisis Response services may be provided prior to an individual being "admitted" to services with a service provider. Individuals needing crisis services will not be required to have an "intake" or "biopsychosocial assessment" prior to receiving crisis services. They may be "admitted" to services secondary to a crisis response service.

2. Provider requirements

   a) All services under this Rule must be provided by a staff member who holds a Master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist.

      The Division of Medicaid does not provide reimbursement for crisis response services provided by provisionally certified staff.

   b) Medical professionals must be available by phone to the staff member providing crisis response services including, at a minimum, a licensed registered nurse and psychiatry professional who is licensed as one of the following:

      1) Board-certified Psychiatrist, or

2) Psychiatric mental health nurse practitioner, or

3) Physician assistant with two (2) years' experience in the practice of psychiatry.

c) All staff members providing crisis response services must obtain and maintain certification in a professionally recognized method of crisis intervention and de-escalation, such as Techniques for Managing Aggressive behavior, the Mandt system or Nonviolent Crisis Intervention.

3. Documentation requirements

Progress notes must clearly document that the crisis services provided are necessary to maintain the child or adult in the least restrictive and most appropriate, environment.

B. Crisis Residential is a residential program that provides medical supervision, nursing services, structured therapeutic activities, and intensive psychotherapy (individual, family and/or group) at a facility based site. Services are provided to beneficiaries who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. Crisis Residential is designed to prevent inpatient hospitalization, address acute symptoms, distress, and further decomposition, and also help transition from hospitalization to community based services. Program content may vary based on beneficiary need but must include close observation/supervision and intensive support with the focus on reduction/elimination of acute symptoms.

1. Crisis residential may be provided to children or youth with serious emotional/behavioral disturbance or adults with a serious and persistent mental illness.

2. Crisis residential must be ordered by a psychiatrist, psychiatric mental health nurse practitioner or licensed psychologist.

3. Crisis residential must be prior authorized by the Division of Medicaid or its designee for dates of service on or after July 1, 2012.

4. Services must be provided at a facility licensed to service no more than sixteen (16) individuals at a time.

5. Medicaid reimbursement for crisis residential does not include room and board costs.

6. Crisis residential is limited to sixty (60) days per state fiscal year.

7. A psychiatrist, psychiatric mental health nurse practitioner or psychologist must be at the location of the crisis residential program and immediately available if needed.

8. Documentation Requirements

a) Medical services must be documented according to industry standard for medical hospitals.

b) Other clinical services must be documented according to the DMH Record Guide.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.6 Community Support Services

A. Community Support Services (CSS) provides an array of support services delivered by community based mobile professionals. Services address the individualized mental health needs of the client. They are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CSS is to provide specific, measurable, and individualized services to each person served. CSS should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family and integration and contributions within the community. This service replaces the direct services historically provided as case management in Mississippi.

1. Community Support Services are services that can be provided to/for the individual by the CSS Specialist in any setting within the community absent from being involved in any other Medicaid reimbursable service simultaneously. The CSS Specialist not only assists the individual in gaining access to needed services necessary for community integration and sustainability within the community, but may also provide some of those direct services themselves, such as supportive counseling/reality orientation, skills training, enlisting social supports, financial management counseling, monitoring physical and mental health status, etc.

   a) Community support services are defined as services that are specific, measurable, and individualized that focus on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work, and family and integration and contributions within the community. These shall include the following as clinically indicated:

      1) Identification of strengths which will aid the individual in their recovery and the barriers that will challenge the development of skills necessary for independent functioning in the community.

      2) Individual therapeutic interventions with a beneficiary that directly increase the acquisition of skills needed to accomplish the goals set forth in the Individual Service Plan.

      3) Monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and program toward goals.

4) Psychoeducation on the identification and self-management of prescribed medication regimen and communication with the prescribing provider.

5) Direct interventions in deescalating situations to prevent crisis.

6) Assisting the beneficiary and natural supports in implementation of therapeutic interventions outlined in the Individual Service Plan.

7) Relapse prevention and disease management strategies.

8) Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the individual.

9) Facilitation of the Individual Service Plan which includes the active involvement of the beneficiary and the people identified as important in the person's life.

2. Community support services are limited to four hundred (400) units (15 minute unit) per state fiscal year and six (6) per day.

3. Provider requirements

   a) Community Support Services must each be provided by a staff member who holds a minimum of at least a Bachelor's Degree in mental health.

   b) The provider of this service must be provisionally certified by the DMH as a Certified Community Support Specialist within six (6) months of their hire date. The professional who provides these services will be known as the Community Support Specialist (CSS). The DMH certification for Case Management Professionals will be accepted for dates of service prior to January 1, 2013.

   c) Supervision for services under this Rule must be provided by a staff member who holds a Master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided). Supervision may not be provided by a staff member who is provisionally certified.

4. Documentation Requirements

   Progress notes must clearly document that the Community Support Services provided are medically necessary to maintain the child or adult in the least restrictive, yet appropriate environment within the community and must relate back to the treatment plan/service plan.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.7 Peer Support Services

A. Peer Support Services are person-centered services with a rehabilitation and recovery focus designed to promote skills for coping with and managing psychiatric symptoms while facilitating the utilization of natural resources and the enhancement of community living skills. Peer Support Service is a helping relationship between peers and/or family member(s) that are directed toward the achievement of specific goals defined by the consumer. It may also be provided as a family partner role.

1. Peer Support Services are face-to-face interventions with the consumer or family present.

2. Provider Requirements

a) Services must be rendered by a peer specialist certified by the Department of Mental Health using a certified curriculum.

b) Peer support specialists must receive annual training in a recognized peer training program recognized by DMH.

c) Peer support specialists must possess a high school diploma or GED equivalent. For young adults ages sixteen to twenty (16-20) years, peer support specialists must be enrolled and attending school or in the process of obtaining a Test of General Education Development (GED).

d) Peer support specialists must be a current or former consumer/first degree family member of an individual who has received treatment for and self-identify as a current or former mental health consumer and/or family member.

e) Staff must have completed an appropriate training program, such as family-to-family or Family Time Out.

f) Peer support specialists will have, during the last year, demonstrated a minimum of six (6) months in self-directed recovery.

g) Peer support services are limited to two hundred (200) units (15 minute unit) per state fiscal year.

h) Peer support services must be supervised by a Peer Support Services Supervisor with a minimum of a Master's degree and who has received basic Peer Specialist training specifically developed for supervision within the Peer Specialist program, as provided by DMH.

3. Documentation Requirements

Peer Support Services must be included in and coordinated with the individual's treatment plan with a specific planned frequency for patients who the physician and/or mental health professional believes would benefit from this recovery support process.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.8 Wraparound Facilitation

A. Wraparound Facilitation is the creation and facilitation of a child and family team for the purpose of developing a single plan of care to address the needs of youth with complex mental health challenges and their families. The child and family team will meet regularly to monitor and adjust the plan of care if necessary or progress is not being made. Wraparound facilitation is intended to serve individuals who have serious mental health challenges that exceed the resources of a single agency or service provider, experienced multiple acute hospital stays, at risk of out-of-home placement or have been recommended for residential care or have had interruptions in the delivery of services across a variety of agencies due to frequent moves, failure to show improvement, lack of previous coordination by agencies providing care, or reasons unknown.

   Wraparound facilitation must be provided in accordance with high fidelity and quality wraparound practice.

   1. Services are comprised of a variety of specific tasks and activities designed to carry out the wraparound process, including:

      a) Engaging the family,

      b) Assembling the child and family team,

      c) Facilitating a child and family team meeting at minimum every thirty (30) days,

      d) Facilitating the creation of a plan of care, which includes a plan for anticipating, preventing and managing crisis, within the child and family team meeting,

      e) Working with the team in identifying providers of services and other community resources to meet family and youth needs,

      f) Making necessary referrals for youth,

      g) Documenting and maintaining all information regarding the plan of care, including revisions and child and family team meetings,

      h) Presenting plan of care for approval,

i) Providing copies of the plan of care to the entire team including the youth and family/guardian,

j) Monitoring the implementation of the plan of care and revising if necessary to achieve outcomes,

k) Maintaining communication between all child and family team members,

l) Monitoring the progress toward need met and are the referral behaviors decreasing,

m) Leading the team to discuss and ensure the supports and services the youth and family are receiving continue to meet the caregiver and youth's needs,

n) Educating new team members about the wraparound process, and

o) Maintaining team cohesiveness.

2. Child and family team membership must include:

   a) The wraparound facilitator,

   b) The child's service providers, any involved child serving agency representatives and other formal supports, as appropriate,

   c) The caregiver/guardian,

   d) Other family or community members serving as informal supports, as appropriate, and

   e) Identified youth, if age nine (9) or above, unless there are clear clinical indications this would be detrimental. Such reasons must be documented clearly throughout the record.

3. Wraparound facilitation is limited to one hundred (100) units (15 minute unit) per state fiscal year and eight (8) units per day.

4. Provider requirements

   a) Wraparound facilitators and supervisors of the process must have completed Introduction to Wraparound 3-day training.

   b) Wraparound facilitators and supervisors must participate in ongoing coaching and training as defined by the Division of Medicaid.

c) The provider organization or CMHC providing Wraparound facilitation must be participating in the wraparound certification process through the Division of Medicaid or its designee.

d) Providers must ensure case load size for wraparound facilitators is maintained at an average of not more than ten (10) cases per wraparound facilitator.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.9 Medical Services

A. Medication Evaluation & Monitoring

1. Medication Evaluation & Monitoring is the intentional face-to-face interaction (including telehealth transmisssions) between a physician, physician assistant, or a nurse practitioner and a beneficiary for the purpose of:

   a) Assessing the need for psychotropic medication,

   b) Prescribing medications, and

   c) Regular periodic monitoring of the medications prescribed for therapeutic effect and medical safety.

2. Medication Evaluation & Monitoring Services must be provided by a:

   a) Licensed physician,

   b) Doctor of osteopathy,

   c) Psychiatric mental health nurse practitioner, or

   d) Physician assistant with two (2) years psychiatric training

3. Medical monitoring of psychotropic medications must include lab testing for medical side effects as recommended in package insert and as is the standard of care.

4. Medication evaluation & management may be provided by the use of telehealth.

5. Medication evaluation & management is limited to a total of seventy-two (72) services per state fiscal year when combined with the psychiatric interview and therapy with medication management.

6. Documentation Requirements

Medication(s) prescribed must be documented on the Medication Profile sheet in the case record.

B. Nursing Assessment

1. Nursing Assessment takes place between a registered nurse and a beneficiary for the purpose of assessing extra-pyramidal symptoms, medication history, medical history, progress on medication, current symptoms, progress or lack thereof since last contact and providing education to the beneficiary and the family about the illness and the course of available treatment.

2. Nursing assessment is limited to one hundred forty-four (144) units (15 minute units) per state fiscal year and four (4) units per day.

3. Provider requirements

   a) Nursing Assessment must be provided by, at a minimum, a registered nurse.

   b) A physician, doctor of osteopathy, nurse practitioner, physician assistant, and psychiatric mental health nurse practitioner are also eligible providers.

4. Current medication(s) must be documented on the Medication Profile sheet in the case record.

C. Injectable medication is provided in a physician's office or community mental health center for the purpose of restoring, maintaining or improving the beneficiary's role performance and/or mental health status.

1. Mississippi Medicaid provides coverage for injectable drugs when they are administered in a clinically appropriate manner. If a portion of the drug in a single use or multiple dose use vial must be discarded, DOM will not reimburse for the discarded amount of the drug.

2. Providers may not bill Mississippi Medicaid beneficiaries for the discarded drug.

3. Injections shall be administered by a licensed physician, psychiatric mental health nurse practitioner, physician assistant, registered nurse or licensed practical nurse.

4. Documentation Requirements

   a) The case record must contain a specific physician's order for the service.

   b) The case record must contain documentation of the following:

      1) The date of each injection,

2) The name of the medication,

3) The dosage, and

4) The site of injection.

5. The documentation must be authenticated by the signature and credentials of the person who gave the injection.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.10 Program of Assertive Community Treatment

A. Assertive Community Treatment

Assertive Community Treatment (ACT/PACT) is a multi–disciplinary, self-contained clinical team approach providing comprehensive mental health and rehabilitative services. Team members provide long-term intensive care in natural community settings. The team provides all mental health services rather than referring individuals to different mental health providers, programs, and other agencies. Major activities under ACT/PACT may include: client specific treatment team planning – team meets daily to plan services, assesses individuals community status and share information to coordinate services; individual supports – for activities of daily living, financial management, skills training, medication support; coordination with collaterals – sharing information with healthcare and other providers; individual clinical interventions – therapy, diagnosis and assessment.

1. Program of Assertive Community Treatment (PACT) is defined as therapeutic programs provided in the community in which individuals live that would traditionally need inpatient care and treatment can be maintained in a less restrictive/community based setting.

2. The aim of PACT is to address the varied needs of adults with serious and persistent mental illness in a mobile treatment team approach/ environment.

3. PACT services include a self-contained treatment milieu based on the level of need of the individual.

4. PACT services allow concurrent service provision by more than one PACT staff member when clinically indicated and substantiated in the documentation.

5. PACT services are limited to sixteen hundred (1600) units (15 minute unit) per state fiscal year and forty (40) units per day.

6. PACT services must be prior authorized by the Division of Medicaid or its designee, for dates of service on or after July 1, 2012.

7. Services include:

   a) Psychiatric service/assessment/treatment (including telepsychiatry);

   b) Nursing;

   c) Peer support;

   d) Medication monitoring/evaluation;

   e) Vocational;

   f) Transportation;

   g) Housing;

   h) Employment services; and

   i) Administrative case management.

8. Provider requirements

   a) ACT/PACT Teams must be certified by the Department of Mental Health and maintain all standards set forth by the Department of Mental Health.

   b) ACT/PACT Services must be provided by staff members who are certified/qualified/ credentialed/ licensed to provide the service required.

9. Non-covered services

   a) Beneficiaries enrolled in ACT/PACT programs cannot receive community based mental health services from any provider other than an ACT/PACT provider.

   b) Beneficiaries enrolled in ACT/PACT may not receive psychosocial rehabilitation, senior psychosocial rehabilitation, or day support.

10. Documentation Requirements

   a) All documentation must meet the requirements set forth by the DMH minimum standards.

   b) The case record must also contain:

      1) A daily progress summary for each beneficiary which meets the documentation criteria for PACT daily total of time spent with the beneficiary.

2) The case record must contain a physician's order for the service stating that inpatient care would be necessary without the service.

3) A written report of treatment recommendations/changes resulting from a treatment plan review and the signature of each staff present when the case was reviewed.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.11: Intensive Outpatient Psychiatric Services

A. Intensive Outpatient Psychiatric (IOP) services are:

1. An all-inclusive, psychiatric clinical suite of multifaceted services acting as a wrap-around to families with children/youth with serious emotional disturbances (SED) for family stabilization in the home and community.

2. To diffuse the current crisis, stabilize the living arrangement and offer the family and children/youth alternatives to being in crisis.

3. To safely intervene with families that request treatment but cannot commit to the intensity of MYPAC services in their home and:

   a) Can safely manage the crisis with clinical professional services and support two (2) to four (4) hours, three (3) to five (5) days per week,

   b) Have sufficiently stabilized following ninety (90) days of MYPAC services and request or choose less intensive interventions than MYPAC to safely address and stabilize,

   c) Have children/youth discharging from PRTF care greater than one hundred eighty (180) days, and/or

   d) Have children/youth with greater than one (1) acute inpatient admission in the past six (6) months.

B. To receive IOP services a beneficiary must have:

1. A primary focus of symptoms and diagnosis related to the primary psychiatric disorder as defined in the most recent Diagnostic and Statistical Manual (DSM) and symptoms which require rehabilitative services,

2. An evaluating psychiatrist or licensed psychologist advising that the beneficiary needs IOP services,

3. The need for specialized services and supports from multiple agencies including targeted case management and an array of clinical interventions and family supports,

4. A BioPsychoSocial assessment addressing safety in the community, cultural and spiritual aspects of the family within six (6) months of the anticipated admission date if admitted from the community or less intensive outpatient services, and

5. A discharge summary with a recommendation for IOP services if admitted from an inpatient setting.

C. Providers of IOP services must:

1. Hold certification by Department of Mental Health (DMH) to provide case management/community support services,

2. Have a psychiatrist on staff,

3. Have appropriate clinical staff to provide therapy services needed,

4. Inform the Division of Medicaid in writing of any critical incidents (life-threatening, allegations of staff misconduct, abuse/neglect) and describe staff management of the incident,

5. Inform the beneficiary/family of grievance and appeals procedures,

6. Report all grievances and appeals to the Division of Medicaid,

7. Have staff who meet the Division of Medicaid's qualifications for the category of service they provide,

8. Be a qualified provider of wrap-around facilitation, and

9. Have procedures in place for availability and response twenty-four (24) hours a day, seven (7) days a week.

D. IOP services:

1. Require prior authorization by the Utilization Management/Quality Improvement Organization (UM/QIO),

2. Are limited to two hundred seventy (270) days of service provision per state fiscal year,

3. Are only reimbursed for the date a service is provided, and

4. Component parts cannot be separately reimbursed on the same day as the all-inclusive IOP service.

E. Each beneficiary receiving IOP services must have on file:

1. An individualized service plan which describes the following:

   a) Services to be provided,

   b) Frequency of service provision,

   c) Who provides each service and their qualifications,

   d) Formal and informal support available to the participant and family, and

   e) Plan for anticipating, preventing and managing crises.

2. A BioPsychoSocial Assessment which must address:

   a) The family system,

   b) Identify the primary caretaker(s) and supports, and

   c) Identify both the beneficiary's and primary caretaker's functional adaptability for learning and retaining cognitive, behavioral and other therapeutic techniques.

Source: SPA 2012-003, Miss. Code §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2014.

Rule 1.12 Treatment Foster Care

A. Treatment Foster Care (TFC) services are intensive and supportive services provided to children in Department of Human Services (DHS) custody or at-risk of having DHS obtain custody with significant medical, developmental, emotional, or behavioral needs, who with additional resources, can remain in a family setting and achieve positive growth and development. Service includes specialized training, clinical support, and in-home intervention to treatment foster parents and the child, allowing the child to remain in a family home setting. Payment for TFC services are not inclusive of room and board payment.

1. Treatment Foster Care is an intensive community-based program composed of mental health professional staff and trained foster parents who provide a therapeutic program for children and youth with serious emotional disturbances living in a licensed therapeutic foster home.

2. Treatment foster care must be approved by the Department of Human Services

3. Treatment Foster Care must be prior authorized by the Division of Medicaid or its designee.

4. Treatment Foster Care is limited to three hundred sixty five (365) days per state fiscal year.

5. Each licensed TFC home must not have more than (1) child or youth with SED at any given time. Siblings with SED may be placed together in the same TFC home.

6. Provider requirements

   a) Treatment foster care programs must be certified by the Department of Mental Health.

   b) Provider must have available a licensed psychiatrist with experience working with children/youth.

   c) All clinical services must be provided by a staff member who holds a Master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

B. TFC programs must provide mental health services for all children in the program in the following manner and those services are included in the TFC service:

   1. Individual therapy one (1) session per week with child/youth,

   2. A minimum of two (2) family sessions per month with the therapeutic foster parents,

   3. Face-to-face contact with TFC parents at least two (2) times a month, with at least one (1) of the two (2) contacts in the home,

   4. TFC support groups once a month,

   5. Annual psychiatric evaluation, and

   6. Twenty four (24) hour per day and seven (7) days a week emergency services and crisis intervention.

C. Non-covered services

Providers of Treatment Foster Care Services shall not bill Medicaid separately for the component parts of Treatment Foster care listed in 2.4.B of this rule.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.13 Multi-Systemic Therapy

A. Multi-systemic therapy (MST) for youth in the juvenile justice system is an evidence-based practice of a strengths intensive family-and community-based treatment program that focuses on the entire world of chronic juvenile offenders — their homes and families, schools and teachers, neighborhoods and friends. MST interventions work to increase the caregivers' parenting skills, improve family relations, involve the youth with friends who do not participate in criminal behavior, help him or her get better grades or start to develop a vocation, help the adolescent participate in positive activities, such as sports or school clubs, create a support network of extended family, neighbors and friends to help the caregivers maintain the changes.

1. MST Services include:

   a) An initial assessment to identify the focus of the MST intervention,

   b) Individual therapeutic interventions with the youth and family,

   c) Peer interventions,

   d) Case management,

   e) Crisis stabilization, and

   f) Specialized therapeutic interventions to address areas such as substance abuse, sexual abuse, sex offending, and domestic violence, when needed.

2. Services must be available in-home, at school and in other community settings

3. MST services are delivered in a team approach designed to address the identified needs of children and adolescents with significant behavioral problems who are transitioning from out of home placements or are at-risk of out-of-home placement and need intensive interventions to remain stable in the community.

4. MST services must be ordered by a physician, licensed psychologist, physician's assistant or nurse practitioner.

5. MST services allows for collateral contacts and phone contact.

6. MST services must be prior authorized by the Division of Medicaid or its designee.

7. MST services are limited to three hundred twelve (312) units (15 minute unit) per state fiscal year and eight (8) units per day.

8. Provider qualifications:

    a) MST services must be delivered by practitioners employed by an agency.

    b) Within three (3) years of enrollment as a provider, the agency must have achieved national accreditation in MST.

    c) Providers must have the availability of crisis response on a twenty-four (24) hours a day, seven (7) days a week.

    d) Staff providing MST services must participate in MST introductory training and ongoing training and consultation as required by the Division of Medicaid.

    e) The MST program must have a team supervisor who is a Master's level or above professional or has a minimum at least two (2) years of experience in mental health or child welfare services.

    f) MST Therapists must be full-time, MST dedicated Masters-level staff.

    g) MST team member to family ration shall not exceed a one (1) to five (6) ratio.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.14 Targeted Case Management

A. Targeted Case Management is defined as services that provide information/referral and resource coordination to the beneficiary and/or his/her collaterals. Case Management Services are directed towards helping the beneficiary maintain his/her highest possible level of independent functioning. Case managers monitor the treatment plan and ensure team members complete tasks that are assigned to them, that follow up and follow through occur and help identify when the treatment team my need to review the treatment plan for updates if the established plan is not working.

    1. Targeted case management may be provided face-to- face or via telephone.

        a) Targeted case management is not designed to be a mobile service, but there is no prohibition on services being provided in a location other than the community mental health center.

        b) If services are provided at another location, travel time is not a covered service.

2. Targeted case management must be provided by, at a minimum, a licensed social worker (LSW) with two (2) years' experience in mental health or a registered nurse (RN) with two (2) years' experience in mental health.

3. Targeted case management must be included in the individual's treatment plan.

4. The frequency of case management services will be determined by the complexity of the case and the need of the beneficiary, but shall not occur less than once monthly.

5. Targeted case management services are limited to two hundred sixty (260) units (15 minute unit) per state fiscal year.

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.15 School Based Services

A. School Based Services are covered by the Division of Medicaid for dates of service through June 30, 2012. As of July 1, 2012, School-based services as defined in this rule will no longer be covered by Medicaid. Mental health services provided in the school setting will be covered as Community Support Services or other therapy services, as appropriate based on the individual need.

B. School-based services are professional therapeutic services provided in a school setting that is more intensive than traditional case management services. School based services include consultation and crisis intervention. School-Based Services may be provided to SED and MR/DD children.

   1. Consultation is professional advice and support provided by a therapist to a child's teachers, guidance counselors, and other school professionals, as well as to parents, community support providers, treatment teams, court systems, etc. Consultation may be provided as a form of early intervention when no formal treatment process has been established. Parent and/or teacher conferences are included in this service component.

   2. Crisis Intervention is therapeutic engagement at a time of internal or external turmoil in a child's life with a focus on producing effective coping. Crisis intervention strategies may be directed toward alleviating immediate personal distress, assessing the precipitants that produced the crisis, and /or developing preventative strategies to reduce the likelihood of future similar crises. This service may be provided to family members when their involvement relates directly to the identified needs of the child.

   3. All services under this category must be provided by a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified or Provisionally Certified Mental Health Therapist, DMH Certified or Provisionally Certified Intellectual

and Developmental Disabilities Therapist or a DMH Certified or Provisionally Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Rule 1.16 Mental Illness Management Services

A. Mental Illness Management Services are covered by the Division of Medicaid for dates of service through June 30, 2012. As of July 1, 2012, Mental Illness Management Services as defined in this rule will no longer be covered by Medicaid. Mental health services for individuals having more complex mental health needs will be covered as Assertive Community Treatment, Community Support Services or other therapy services, as appropriate based on the individual need.

B. Mental Illness Management Services (MIMS) are intensive case management services with a therapeutic focus. Activities may include symptom evaluation/monitoring, crisis intervention, provision/enhancement of environmental supports, and other services directed towards helping the beneficiary live successfully in the community. MIMS are distinguished from traditional case management services by the higher level of professional expertise/skill of the provider, required by the more complex mental health needs of the beneficiary, of these services. MIMS may be provided in any appropriate community setting. MIMS may be provided to SED and MR/DD children or SPMI and MR/DD adults.

C. All services under this category must be provided by a staff member who holds a master's degree and professional license (ex:, Physician, Psychologist, Licensed Certified Social Worker, Licensed Master Social Worker, Licensed Professional Counselor or Licensed Marriage & Family Therapist) or who is a DMH Certified or Provisionally Certified Mental Health Therapist, DMH Certified or Provisionally Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified or Provisionally Certified Addiction Therapist (when appropriate for the individual receiving service and the service provided).

Source: Section 43-13-117 (16) of the Mississippi Code of 1972, as amended; Section 43-13-121 of the Mississippi Code of 1972, as amended.

Part 206 Chapter 2: Mississippi Youth Programs Around the Clock (MYPAC)

Rule 2.1: Purpose

A. The purpose of Mississippi Youth Programs Around the Clock (MYPAC) services is to provide home and community-based services to beneficiaries up to the age of twenty-one (21) with serious emotional disturbance (SED) that:

   1. Exceed the resources of a single agency or service provider,

2. Experience multiple acute hospital stays,

3. Have been recommended for residential care,

4. Have had interruptions in the delivery of services across a variety of agencies due to frequent moves, failure to show improvement, lack of previous coordination by agencies providing care, or reasons unknown,

5. Are at immediate risk of requiring treatment in a Psychiatric Residential Treatment Facility (PRTF), or

6. Are receiving services in a PRTF and are ready to transition back to the community.

B. The Division of Medicaid defines MYPAC services as all-inclusive home and community based services that assist beneficiaries and their families in gaining access to needed mental health services as well as medical, social, educational and other services regardless of the funding source for those other services and includes service coordination that involves finding and organizing multiple treatment and support services.

Source: Miss. Code Ann. §§ 43-13-117(46), 43-13-121, 43-14-1; Public Law 99-660 (1986), 101-639 (1990), 102-321 (1992); OBRA Section 4755.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.2: Eligibility

A. Beneficiaries must meet clinical and age criteria to receive MYPAC services.

1. The Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid reviews and prior authorizes the provision of services based on all the following clinical criteria. A beneficiary:

   a) Must be diagnosed by a psychiatrist or licensed psychologist in the past sixty (60) days with a mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria for Serious Emotional Disturbance (SED) specified within the Diagnostic and Statistical Manual (DSM) on Axis I,

   b) Must have a full scale IQ of sixty (60) or above, or, if IQ score is lower than sixty (60), there is substantial evidence that the IQ score is suppressed due to psychiatric illness, and

   c) Is currently a resident of a PRTF or acute care facility who continues to meet the LOC for residential treatment but can be transitioned into the community with MYPAC services or meets the same level of care (LOC) for admission to a PRTF but can be diverted to MYPAC as an alternative to residential treatment.

2. A beneficiary must be admitted prior to his/her twenty-first (21st) birthday; however, if a beneficiary is already receiving MYPAC services prior to age twenty-one (21), he/she may remain in MYPAC until treatment is completed or the beneficiary's twenty-second (22nd) birthday, whichever occurs first.

B. MYPAC services are provided to eligible beneficiaries under the:

1. 1915(c) demonstration waiver, which enrollment ended on September 30, 2012, per Centers for Medicare and Medicaid Services (CMS), or

2. State Plan Rehabilitation Option Intensive Outpatient Psychiatric Services.

Source: Miss. Code Ann. §§ 43-13-117(46), 43-13-121, 43-14-1; 42 CFR §§ 441, Subpart D, 483.352; 42 USC 1396a(a)(10)(A); OBRA Section 455.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.3: Provider Participation Requirements

A. Providers of MYPAC services must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8.

B. MYPAC service providers must also meet the following provider specific requirements:

1. Submit a completed proposal package and enter into a provider agreement with the Division of Medicaid to provide services under the State Plan Rehabilitation Option Intensive Outpatient Psychiatric Services.

2. Provide MYPAC services by mental health providers who meet the Mississippi Department of Mental Health (DMH) certification requirements.

3. Have a current Medicaid provider number.

4. Hold certification by DMH to provide:

   a) Case management services under the 1915(c) demonstration waiver, or

   b) Wraparound facilitation services under the State Plan Rehabilitation Option Intensive Outpatient Psychiatric Services.

5. Have a psychiatrist on staff.

6. Have appropriate clinical staff to provide needed therapy services.

7. Provide the Division of Medicaid with a written description of any critical incidents as well as staff interventions, responses and management of the critical incident. A critical

incident is an occurrence or situation that creates a significant risk or serious harm to the physical or mental health, safety or well-being of a beneficiary including, but not limited to life-threatening events, allegations of staff misconduct, or abuse/neglect.

8. Inform the beneficiary/family of grievances and appeals procedures.

9. Report all grievances and appeals to the Division of Medicaid.

10. Employ staff who meets the Division of Medicaid qualifications for the category of service they provide.

11. Conduct Quality Assurance activities to regularly review each beneficiary's Individualized Service Plan (ISP) and treatment outcomes.

12. Have procedures in place for availability and response twenty-four (24) hours a day, seven (7) days a week.

13. Notify the Division of Medicaid of changes in the Administrative/Program Director, Medical Director/Psychiatrist or Clinical Director, and Regional Supervisor within seventy-two (72) hours of the effective change.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129; 42 CFR §§ 441, Subpart D, 441.151(a)(2).

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.4: MYPAC Service Requirements

A. The Division of Medicaid covers one hundred fifteen (115) units during a three hundred and sixty-five (365) day period of MYPAC services.

~~B~~. MYPAC services include, but are not limited to:

1. Mental health services using evidence-based practices which include intensive in-home therapy, crisis outreach, medication management and psychiatric services,

2. Social services to ensure basic needs are met, provide family support, and develop age appropriate independent living skills.

3. Physical health and welfare services that include assistance to the family in obtaining screenings from the Early Periodic Screening, Diagnosis, and treatment (EPSDT) services.

4. Educational and/or vocational services to assist with school performance and/or provide support for employment,

5. Recreational activities to identify skills and talents, enhance self-esteem, and increase opportunities for socialization, and

6. Other supports and services as identified by the beneficiary, family, and child and family team.

C. MYPAC providers are required to provide or arrange for the provision of wraparound facilitation defined as the creation and facilitation of a child and family team for the purpose of developing a single individual service plan (ISP) to address the needs of the beneficiary with complex mental health challenges and their families. Wraparound facilitation must be provided in accordance with high fidelity and quality wraparound practice and include the following:

1. Engaging the family,

2. Assembling the child and family team which includes:

   a) The wraparound facilitator,

   b) The beneficiary's service providers, any involved beneficiary serving agency representatives and other formal supports, as appropriate,

   c) The caregiver/guardian,

   d) Other family or community members serving as informal supports, as appropriate, and

   e) Other identified youth, unless there are clear clinical indications this would be detrimental which are documented clearly throughout the medical record.

3. Facilitating the child and family team meeting, at a minimum, once a month,

4. Facilitating the development of an ISP through decisions made by the child and family team during the child and family team meeting, including a plan for anticipating, preventing and managing crisis,

5. Working with the child and family team in identifying providers of services and other community resources to meet the family and beneficiary's needs,

6. Making necessary referrals for beneficiaries,

7. Documenting and maintaining all information regarding the ISP, including revisions and child and family team meetings,

8. Presenting ISP for approval to the child and family team,

9. Providing copies of the ISP to the entire team including the beneficiary and family/guardian,

10. Monitoring the implementation of the ISP and revising as necessary to achieve outcomes,

11. Maintaining communication between all child and family team members,

12. Evaluating the progress toward needs being met to ensure the referral behaviors have decreased,

13. Leading the child and family team to discuss and ensure the supports and services continue to meet the caregiver and the beneficiary's needs,

14. Educating new team members about the wraparound process,

15. Maintaining team cohesiveness,

16. Meeting face-to-face with a MYPAC beneficiary once a week,

17. Meeting face-to-face with the family twice a month,

18. Meeting with other collateral contacts related to ISP implementation at least three (3) times a week, and

19. Ensuring MYPAC beneficiaries on medication(s) used in the treatment of the beneficiary's SED visit a doctor every ninety (90) days for medication management and monitoring, at a minimum.

D. Intensive case management is provided to beneficiaries in MYPAC only under the 1915(c) Demonstration waiver and is defined by the Division of Medicaid as services that assist MYPAC participants and families in gaining access to needed mental health services, as well as medical, social, educational and other services, regardless of the funding source for the services in which access is gained and includes service coordination that involves finding and organizing multiple treatment and support options. Refer to the Rule 2.2.B.1.

E. Respite care is provided to MYPAC beneficiaries only under the 1915(c) demonstration waiver and is defined by the Division of Medicaid as a planned break for families to give the parent/caregiver temporary relief from caregiving. Refer to the Rule 2.2.B.1. The two (2) types of respite care are:

1. In-home, or home and community-based respite care provided by responsible adults or trained counselors, and

2. Out-of-home or institutional respite care provided by direct clinical staff in a PRTF or short-term treatment and crisis stabilization in an inpatient psychiatric hospital.

F. MYPAC staff must be appropriately trained or professionally qualified to provide services for which they are responsible.

1. A psychiatrist:

   a) Must participate in the development of the ISP and is a child and family team member.

   b) Is responsible for medication management, which is defined by the Division of Medicaid as medication treatment and monitoring services which include the prescription of psychoactive medications by a physician/psychiatrist that are designed to alleviate symptoms and promote psychological growth and includes:

      1) Prescribing medication(s) to treat SED,

      2) Educating the child and family_team concerning the effects, benefits, and proper use and storage of any medication prescribed for the treatment of SED,

      3) Assisting with the administration or monitoring of the administration, of any medication prescribed for the treatment of SED, and

      4) Arranging for any physiological testing or other evaluation necessary to monitor the participant for adverse reactions to, or for other health-related issues that might arise in conjunction with, the taking of any medication prescribed for the treatment of SED.

   c) Must be in a practice agreement with and supervise any licensed/certified Psychiatric Mental Health Nurse Practitioner (PMHNP) who assists with their responsibilities.

   d) Must meet face-to-face or by telepsychiatry with the beneficiary and family at the frequency documented in the ISP.

2. A master's level mental health therapist who:

   a) Provides psychotherapy defined by the Division of Medicaid as the intentional, face-to-face interaction between a mental health professional and a beneficiary which establishes a therapeutic relationship to resolve symptoms of the beneficiary's mental and/or emotional disturbance.

   b) MYPAC psychotherapy includes the following:

      1) Family Therapy is defined by the Division of Medicaid as psychotherapy between a mental health therapist and a beneficiary's family members or guardians, with or without the presence of the beneficiary, and

i) Promotes psychological and behavioral changes within families and meets on a regular basis.

ii) Can include Department of Human Services (DHS) representatives or foster family members, acting in loco parentis, for beneficiaries in the custody of the DHS,

2) Group Therapy is defined by the Division of Medicaid as psychotherapy between a mental health therapist and at least two (2), but no more than eight (8), individuals at the same time, and promotes psychological and behavioral changes with groups typically meeting on a regular basis and includes, but not limited to, focusing on relaxation training, anger management and/or conflict resolution, social skills straining and self-esteem enhancement.

3) Individual Therapy is defined as psychotherapy that takes place between a mental health therapist and a beneficiary reliant upon interaction between therapist/clinician and beneficiary to promote psychological and behavioral change.

3. Wraparound Facilitators who:

a) Are identified as only one (1) MYPAC provider staff for each beneficiary and family and ensures appropriate coordination of services are identified and accessed.

b) Facilitates the development of the ISP through decisions made by the wraparound team.

c) Facilitates the child and family team meetings and assures all team members have the opportunity to participate.

d) Assists the beneficiary and family team in identifying goals and interventions based on the strengths and needs of the child and family.

e) Ensures needed resources are in place for the family.

f) Receives training to identify different levels of intervention on an Individualized Crisis Management Plan (ICMP), the different stages of crisis, and how a crisis may be defined differently by each family.

g) Accesses and links identified services to the beneficiary and family which must be completed before the beneficiary is discharged from MYPAC in order to achieve a successful transition.

h) Available twenty-four (24) hours a day, seven (7) days a week to a beneficiary and family for assistance.

i) Has completed the Introduction to Wraparound Three (3)-day training.

j) Must participate in ongoing coaching and training as defined by the Division of Medicaid or its designee.

4. A Wraparound Facilitator supervisor who:

a) Has completed the Introduction to Wraparound three (3)-day training,

b) Must participate in ongoing coaching and training as required by the Division of Medicaid, and

c) Supervises staff providing services to beneficiaries and families a minimum of four (4) hours of clinical supervision per month provided through a combination of individual supervision, group supervision, peer consultation and participation in wraparound meetings. Documentation must clearly identify the supervision component.

5. A Provider Organization providing wraparound facilitation which:

a) Must participate in the wraparound certification process through the Division of Medicaid or its designee, and

b) Must ensure the wraparound facilitator's case load does not exceed ten (10) cases.

Source: Miss. Code Ann. §§ 43-13-117(16), 43-13-117(46), 43-13-121, 43-14-1; 42 CFR §§ 441, Subpart D, 441.151(a)(2).

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.5: Individual Service Plans (ISP)

A. For the purpose of this rule, an ISP may be referred to as the treatment plan, wraparound plan, or case management plan depending on the service which directs the treatment of the beneficiary.

B. The Division of Medicaid defines the ISP as a written, detailed document that is integral to the wraparound process and is beneficiary/family driven. An ISP must be developed by the child and family team, and is individualized for each MYPAC beneficiary.

1. The ISP must include the following:

a) Services to be provided,

b) Frequency of service provision,

c) Staff providing each service and their qualifications,

d) Formal and informal supports available to the beneficiary and family, and

e) Plans for anticipating, preventing and managing crises.

2. Each ISP must include an Individualized Crisis Management Plan (ICMP) which:

a) Is developed during the child and family team meeting based on the individualized preferences of the beneficiary and family.

b) Identifies triggers that may lead to potential crisis or risk and interventions and strategies to mitigate the risk that can be implemented to avoid the crisis.

c) Identifies natural supports that may decrease the potential for a crisis to occur.

d) Identifies specific needs of families and tailors the level of intervention.

e) Provides responses that are readily accessible at any time to the beneficiary and family.

f) Contains contact information for those involved at all levels of intervention during the crisis.

g) Provides for crisis debriefing after the crisis has been resolved.

h) Provides a copy of the ISP, ICMP and contacts to the beneficiary and family.

3. The wraparound facilitator monitors the ISP continuously through face-to-face visits with the beneficiary and family.

a) The child and family team reviews the ISP at least every thirty (30) days through a child and family team meeting.

b) The ISP is updated or revised when warranted by changes in the beneficiary's needs.

c) The full child and family team must participate in the development of the initial ISP, revisions of the ISP, and the discharge ISP.

d) A licensed clinical staff member must attend each child and family team meeting and is responsible for submitting the ISP to the psychiatrist for review following the meeting at least every ninety (90) days.

Source: Miss. Code Ann. §§ 43-13-117(46), 43-13-121, 43-14-1; 42 CFR § 441, Subpart D.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.6: Clinical Documentation Requirements

A. Beneficiary records must be complete, accurate, accessible and organized.

   1. Clinical documents must include begin time and end time for each contact.

   2. Records must be maintained for a period of five (5) years after the beneficiary reaches the age of twenty-one (21).

   3. Refer to Maintenance of Records Part 200, Chapter 1, Rule 1.3.

B. Records must contain the following categories:

   1. Administrative Documentation must include:

      a) Demographic information that includes date of birth, gender, and race,

      b) Copy of the participant's birth certificate and/or social security card,

      c) Copy of any legal documents verifying custody or guardianship of the beneficiary, when the responsible party is anyone other than the beneficiary's legal parent(s),

      d) Name, address and phone number of the party bearing legal responsibility for the beneficiary should be clearly identified, along with his/her relationship to the beneficiary,

      e) Assigned county of custody and the caseworker identified as an agent of DHS if the beneficiary is in the custody of DHS, and

      f) Documents signed and dated by the beneficiary and/or family that inform them of:

         1) Beneficiary's rights and responsibilities,

         2) Consent for treatment,

         3) Complaints and grievances procedures, and

         4) Appeals and right to fair hearing.

   2. Assessments must include:

      a) Independent psychiatric or psychological evaluation and IQ testing.

      b) Bio-psychosocial assessment that includes:

1) Developmental profile,

2) Behavioral assessment,

3) Assessment of the potential resources of the beneficiary's family,

4) Medical history,

5) Current educational functioning, and

6) Family and beneficiary strengths and needs

3. Treatment Planning must include:

a) ISP signed and dated by the child and family team and in place within fourteen (14) days of enrollment in MYPAC, and reviewed with wraparound team every thirty (30) days,

b) ICMP included in the ISP,

c) Documentation treatment planning is occurring in the child and family team meetings, and

d) Treatment Planning is directed by the MYPAC beneficiary and family.

4. Services provided must include:

a) Wraparound facilitation progress notes which document:

1) The relationship of services to identified needs of family and beneficiary as stated in the ISP,

2) Detailed narration from face-to-face meetings with the beneficiary and/or family, or collateral contacts, including setting, crisis, barriers and successes, and

3) Date and signature of wraparound facilitator.

b) Child and family team meeting notes which document:

1) The purpose and results of services provided that are consistent with the needs outlined in the ISP,

2) Changes to ISP, including dates and reason for changes,

3) Treatment successes,

4) Implementation of the ICMP and outcome, if used,

5) Names and positions or roles of each team member, and

6) Dates and signatures of participating team members.

c) Medication management and monitoring documentation must include:

1) Evidence the treating psychiatrist has managed all beneficiary SED medication(s) at least every ninety (90) days, including but not limited to, reviewing, revising, adjusting, discontinuing and monitoring.

2) If the family chooses a different physician to prescribe medication(s) used in the treatment of the beneficiary's SED, the psychiatrist employed by the MYPAC provider as Medical Director must provide feedback on the implementation of the ISP.

3) Medication(s) to treat the beneficiary's SED are accurately administered by the family in accordance with the physician or PMHNP's orders.

4) Informed consent for medication(s) used in the management of the beneficiary's SED is signed by the parent/guardian and beneficiary, if age appropriate, identifying the symptoms the medications target and evidence education has been provided.

5) Effectiveness of medication(s) to treat the beneficiary's SED.

6) Current medication(s) to treat the beneficiary's SED as reflected in the medication profile sheet.

7) Assistance to family with obtaining, administering and monitoring any medication(s) prescribed for the treatment of the beneficiary's SED.

8) Assessment for side effects of medication(s) to treat beneficiary's SED including physiological testing or other evaluations necessary to monitor for adverse reactions or other health related issues that might arise from taking medication(s) to treat beneficiary's SED.

9) Regular monitoring of medication(s) to treat the beneficiary's SED by the MYPAC provider and reporting any inconsistencies to the treating psychiatrist.

d) Psychotherapy notes must include:

1) Date of session,

2) Time session began and time session ended,

3) Specify if therapy is individual, family or group,

4) Person(s) participating in session,

5) Clinical observations about the beneficiary and/or family, including demeanor, mood, affect, mental alertness, and thought processes,

6) Content of the session,

7) Therapeutic interventions attempted and beneficiary/family's response to the intervention,

8) Beneficiary's response to any significant others who may be present in the session,

9) Outcome of the session,

10) Statement summarizing the beneficiary and/or family's degree of progress toward the treatment goals,

11) Signature, credentials and printed name of therapist, and

12) Notes for each session. Monthly summaries are not acceptable in lieu of psychotherapy session notes.

5. Discharge planning documentation must include:

   a) Discharge planning began the first (1st) day of admission.

   b) Discharge planning is done with the beneficiary and family through the wraparound process.

   c) A signed copy of the final discharge plan with signatures of the MYPAC beneficiary and caregiver/guardian at the time of discharge.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129; 42 CFR § 441, Subpart D.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.7: Special Procedures

A. The use of special procedures, including restraints or seclusion, for participants in a community setting is prohibited.

B. If a participant enrolled in MYPAC is admitted to a PRTF for respite under the 1915(c) demonstration waiver, Medicaid rules and State and Federal regulations must be followed. Refer to Part 207, Chapter 4.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 441. Subpart D, 483, Subpart G.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.8: Discharge/Transition Planning

A. For all beneficiaries receiving MYPAC services, discharge planning must begin at the time of admission and the MYPAC provider is responsible for assisting the family with transition plans through the wraparound process.

B. The wraparound facilitator must access and link appropriate services to the beneficiary and family prior to discharge from MYPAC services.

C. Discharge from MYPAC services occurs when the beneficiary ;

1. Reaches twenty-two (22) years of age or "ages out",

2. If applicable, or family utilizes their freedom of choice to end MYPAC services,

3. Moves out of state,

4. No longer meets the criteria or needs the intensity of services provided by MYPAC, or

5. Admits to an acute care facility or PRTF.

D. At the time of the beneficiary's discharge from MYPAC services, the discharge/transition plan should be amended to include any of the following, if there is a change:

1. MYPAC services begin and end date,

2. Reason for discharge,

3. The name of the person or agency that cares for and has custody of the beneficiary,

4. The physical location/address where the beneficiary resides,

5. A list of the beneficiary's diagnoses,

6. Detailed information about the beneficiary's prescribed medication(s) to treat the beneficiary's SED including the names, strengths and dosage instructions in layman's language and any special instructions, including but not limited to, lab work requirements,

7. Information connecting the beneficiary and family with community resources and services, including but not limited to:

    a) Address of where follow-up mental health services will be obtained with contact name and phone number.

    b) Name and address of the school the beneficiary will attend with name and contact information of identified educational staff.

    c) Other recommended resources, including recreational, rehabilitative, or other special programs including the corresponding contact information.

    d) Date, time, and location of any scheduled appointments.

8. Detailed and specific recommendations in writing about the beneficiary's participation in the MYPAC program including successful techniques in areas of behavior management, mental health treatment and education, and

9. The offer of a full array of community-based mental health services for beneficiaries.

E. At the time of the beneficiary's discharge from MYPAC, the provider must give the parent/guardian:

    1. A written copy of the final discharge plan, and

    2. A written prescription for a thirty (30) day supply of all medications used for the management of the beneficiary's SED if the current supply does not exceed thirty (30) days.

F. The provider must obtain signed consent from the beneficiary and family to provide copies of the final discharge plan to the providers of follow-up mental health, education and other agreed-upon services to be provided after discharge.

Source: Miss. Code Ann. §§ 43-13-117(46), 43-13-121, 43-14-1; 42 CFR 441, Subpart D.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.9: Grievances, Appeals and Fair Hearings

A. The Division of Medicaid defines grievances as a complaint filed about unfair treatment.

    1. MYPAC providers must:

        a) Maintain records of all grievances received,

b) Track grievances and responses, and

c) Establish a grievance system that includes written policies and procedures,

2. MYPAC providers must report to the Division of Medicaid:

a) All grievances by beneficiaries and/or family members or third parties on behalf of beneficiaries within two (2) business days of receipt, and

b) Submit a quarterly summarization of each grievance, either on-going or resolved, reported during the quarter.

B. The Division of Medicaid defines an appeal as a formal request to change an adverse decision by the MYPAC provider who must:

1. Have a written appeal process with policies and procedures which includes a Notice of Action defined as a notification to the beneficiary/family within ten (10) days before the date of termination, suspending or reducing any services by the MYPAC provider,

2. Forward any formal appeal requests including the Notice of Action to the Division of Medicaid within two (2) business days of receipt,

3. Submit a quarterly report to the Division of Medicaid summarizing each appeal, either on-going or resolved, that was received during the quarter, and

4. Participate, at the provider's sole expense, in any review, appeal, fair hearing or litigation involving issues related to MYPAC at the request of the Division of Medicaid.

C. The Division of Medicaid defines a fair hearing as a process initiated when a beneficiary or family disagrees with an adverse decision following an appeal to the MYPAC provider.

1. The beneficiary or family must request an appeal and receive an adverse decision from the provider prior to requesting a fair hearing.

2. Refer to Part 300 Appeals, Chapter 1: Appeals, Rule 1.3: Administrative Hearings for Beneficiaries.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 438 Subpart F, 431 Subpart E.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.10: Critical Incidents Occurrences

A. The Division of Medicaid defines critical incidents as any occurrence that results in injury, abuse, neglect or exploitation of a MYPAC beneficiary. MYPAC providers must have

written policies for documenting and reporting all critical incidents/occurrences which must include the following:

1. Reporting of critical incidents in writing within one (1) business day to the Division of Medicaid.

2. Reporting any suspected abuse or neglect to the Mississippi Department of Human Services (DHS) and participate in investigations.

3. A written description of events and actions.

4. Documentation that explains follow-up, resolution, and debriefing.

B. Certain critical incidents that must be reported include, but are not limited to:

1. Life-threatening injuries,

2. Allegations of staff misconduct,

3. Allegations of sexual activity between MYPAC beneficiaries and providers,

4. Allegations of abuse or neglect of a beneficiary, and/or

5. Runaway of a participant.

Source: Miss. Code Ann. § 43-13-1.

History: Revised to correspond with SPA 2012-003 (eff. 07/01/2012) eff. 12/01/2013.

Rule 2.11: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

History: Added eff. 12/01/2013.

Administrative Code

Title 23: Medicaid
Part 207
Institutional Long Term Care

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Title 23: Division of Medicaid

Part 207: Institutional Long Term Care

Part 207 Chapter 1: Long Term Care Pre-admission Screening

Rule 1.1: Clinical Eligibility Determination

A. All elderly and physically disabled applicants applying for or being recertified for the Division of Medicaid's long term care services must complete a Pre-admission Screening (PAS) for clinical eligibility determination and placement into the following long term care service settings/programs:

   1. Nursing Facility (NF),

   2. Assisted Living Waiver (AL),

   3. Elderly and Disabled Waiver (E&D),

   4. Independent Living Waiver (IL), or

   5. Traumatic Brain Injury/Spinal Cord Injury Waiver (TBI/SCI).

B. Individuals seeking long term care services must meet the Division of Medicaid's defined threshold numerical score, or be approved based on a secondary review, in order to be considered clinically eligible.

C. In addition to the PAS score, a physician must certify clinical eligibility.

D. The PAS must be submitted within thirty (30) days of the physician's certification and expires thirty (30) days from the date of the physician's certification.

E. Individuals enrolled in the Division of Medicaid's long term care program must be recertified annually, with the exception of nursing facility residents. Home and Community Based Services (HCBS) waiver beneficiaries desiring continued waiver services must be recertified by submission of a new PAS at least ten (10) days, but no more than ninety (90) days, prior to date of expiration of the current PAS.

F. An individual seeking nursing facility placement must also meet the Pre-Admission Screening and Resident Review (PASRR) requirements.

G. All individuals who are admitted to a Medicaid certified nursing facility must have a Level I Pre-Admission Screening (PAS) completed to determine whether or not the resident is appropriate for nursing facility placement and to identify indicators of mental illness or mental retardation (MI/MR).

1. The PAS must be completed regardless of the resident's method of payment, either by Medicare, Medicaid or private pay.

2. This requirement is based upon certification of the bed and includes Title 19, or Medicaid only, and Title 18/19, dually or certified for Medicare and Medicaid beds.

3. A PAS is not required for Title 18 or Medicare only beds.

H. Individuals who have or are suspected to have MI/MR or related conditions must not be admitted to a Medicaid certified nursing facility unless approved through a Level II PASRR determination. Refer to Part 300, Chapter 4 Pre-Admission Screening and Resident Review.

Source: Miss. Code Ann. § 43-13-121

Rule 1.2: Exclusions

A. A Pre-Admission Screening (PAS) does not have to be completed on individuals being admitted to a nursing facility (NF) when the following conditions exist:

   1. The individual is discharged from an acute care hospitalization directly into a nursing facility for continued treatment of a condition for a period of less than thirty (30) days. This includes short stay admissions covered under Medicare Part A, as a skilled nursing facility resident.

   2. A PAS application should not be completed for individuals being admitted to a nursing facility that is not a Medicaid-certified Nursing Facility.

B. A PAS is not required for a re-entry to a Nursing Facility when the discharge is due to exhaustion of hospital leave days. However, if an individual is going to a different nursing facility, a PAS must be completed.

Source: Miss. Code Ann. § 43-13-121

Rule 1.3: Qualifications

A. The Pre-Admission Screening (PAS) must be completed by qualified individuals. Qualified individuals include:

   1. Physician,

   2. Nurse Practitioner or Registered Nurse,

   3. Licensed Social Worker,

   4. Rehabilitation Counselor, or

5. Designee by facility/setting.

B. Individuals must adhere to the appropriate program rules regarding specific qualifications.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Documentation of Informed Choice

A. An individual must be advised of all identified placement options funded by the Division of Medicaid as part of ensuring that an informed choice is made regardless of where an individual applies for services. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.

B. The PAS Informed Choice section requires a signature by the applicant or their legal representative.

C. The PAS cannot be processed without the signed Informed Choice section or the signed Physician Certification section.

Source: Miss. Code Ann. § 43-13-121

Rule 1.5: Eligibility Period

A. HCBS waiver beneficiaries desiring continued waiver services must be recertified annually by submission of a new PAS.

B. A PAS must be submitted at least ten (10) days, but no more than ninety (90) days, prior to date of expiration of the current PAS. Documentation must be submitted that provides justification when a new PAS is submitted less than ten (10) days of the expiration date of the current PAS.

Source: Miss. Code Ann. § 43-13-121

Rule 1.6: Appeals

A. Applicants/beneficiaries have the right to appeal long term care eligibility denials. Appeals are processed in accordance with existing state rules for each individual long term care program.

B. A complete PAS must be retained by the screening organization. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.

C. A complete PAS must be available for the Division of Medicaid review upon request.

Source: Miss. Code Ann. § 43-13-121

Part 207 Chapter 2: Nursing Facility

Rule 2.1: General

A. The Division of Medicaid may not execute a provider agreement with a facility for nursing facility services unless the State survey agency or the Centers for Medicare and Medicaid Services (CMS) has certified the facility as having met all of the participation requirements in accordance with Sections 1919 (a), (b), (c), and (d) of the Act. The Mississippi State Department of Health, Division of Health Facilities Licensure and Certification, pursuant to federal law and regulation, certify nursing facilities for participation in the Medicaid program.

B. Medicaid payments may not be made to any nursing facility prior to the date of certification and execution of a valid Medicaid provider agreement.

C. If the Medicaid agency has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement, with a certified facility. A provider agreement is not valid, even though certified by the State survey agency, if the facility fails to meet the civil rights requirements set forth in 45 CFR Parts 80, 84 and 90.

Source: Miss. Code Ann. § 43-13-121; *§ 43-11-1, 42CFR § 442.12; § 483.1; § 442.10;* 45 CFR Parts 80, 84, 90

Rule 2.2: Provider Enrollment Requirements

Nursing facility providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

B. Written confirmation from the IRS confirming the tax identification number and legal name.

C. Copy of license or current certification letter and from the state of servicing location.

Source: Miss. Code Ann. § 43-13-121

Rule 2.3: Termination of Agreements

A. The Division of Medicaid and/or the Centers for Medicare and Medicaid Services (CMS) may terminate any Medicaid participating nursing facility's provider agreement if a nursing facility:

    1. Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present, or

2. Fails to submit an acceptable plan of correction within the timeframe specified by CMS and/or the Division of Medicaid, or

3. Fails to relinquish control to the temporary manager, if that remedy is imposed by CMS and/or the Division of Medicaid, or

4. Does not meet the eligibility criteria for continuation of payment as set forth in 42CFR 488.412(a)(1) and 42CFR 448.456. CMS or Medicaid may terminate the nursing facility's provider agreement or may allow the facility to continue to participate for no longer than six (6) months from the last day of the survey if the facility has not met all requirements under this section.

B. Notice of Termination: Before terminating a provider agreement, CMS and/or Medicaid must provide written notification to the facility and public notification via local and/or general newspaper publication as follows:

1. At least two (2) calendar days before the effective date of the termination for a facility with immediate jeopardy deficiencies, and

2. At least fifteen (15) calendar days before the effective date of termination for a facility with non-immediate jeopardy deficiencies that constitute noncompliance.

C. Reimbursement: When a provider agreement is terminated, federal regulations provide that payments may continue for no more than thirty (30) days from the date the provider agreement is terminated if it is determined that:

1. Reasonable efforts are being made to transfer the residents to another facility, community care, or other alternate care, and

2. Additional time is needed to effect an orderly transfer of the residents.

D. Discharge and Relocation of Residents

1. When the State or CMS terminates a facility's provider agreement, the State will arrange for the safe and orderly transfer of all Medicare and Medicaid residents to another facility. The facility must send written notification to each Medicaid resident, legal representative and/or responsible party, and attending physician, advising them of the impending closure.

2. The resident or the resident's legal representative and/or responsible party must be given opportunity to designate a preference for a specific facility or for other alternative arrangements. A resident's rights/freedom of choice in selecting a facility or alternative to nursing facility placement must be respected. A facility chosen for the relocation of a Medicaid beneficiary must be:

   a) Title XIX certified and in good standing under its provider agreement; and

b) Able to meet the needs of the resident.

E. Resident Trust Fund Accounts maintained by the closing facility must be properly inventoried and receipts obtained for audit purposes by Medicaid. All documentation needed to perform an audit of the residents' trust fund account must be maintained and available for review. This includes, but is not limited to, residents' trial balances, residents' transactions histories, bank statements, vouchers, and receipts of purchases. In addition, the facility must maintain a current surety bond to cover the total amount of funds in the trust fund account.

F. Reinstatement After Termination

1. When a provider agreement has been terminated by the Office of Inspector General (OIG), CMS and/or Medicaid under 42 CFR 489.53, a new agreement with that provider will not be accepted unless it is found that:

   a) The reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur, and

   b) The provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

2. To be considered for re-instatement the Division of Medicaid must receive:

   a) A notification of re-instatement from the appropriate entity,

   b) An application for re-instatement to participate in the Medicaid program, and

   c) The Division of Medicaid has the sole discretion to determine the final retro-eligibility effective date.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483.10; 42 CFR § 489.53; 42 CFR § 488.456; 42 CFR § 488.456; 42 CFR § 489.55; 42 CFR § 488.426; 42 CFR § 483.75; 42 CFR § 489.53; 42 CFR § 488.412 (a)(11)

Rule 2.4: Dual Eligibles

A state is not required to pay for any expenses related to payment for deductibles, coinsurance, or co-payments for Medicare cost sharing for dually eligibles that exceed what the state's Medicaid program would have paid for such service for a beneficiary who is not a dually eligible. When a state's payment for Medicare cost-sharing for a dually eligible is reduced or eliminated, the Medicare payment plus the state's Medicaid payment is considered payment in full; and the dually eligible cannot be billed the difference between the provider's charge and the Medicare and Medicaid payment. Medicare is the primary payor for dually eligible recipients, and providers are obligated to comply with the requirements covering the coordination between

the two programs. Persons eligible for Medicare and Medicaid are entitled to all covered services available under both programs, but a claim must be filed with Medicare, if Medicare covers the service.

Source: Miss. Code Ann. § 43-13-121; 42 U.S.C. 1396u–3; 42 CFR § 447.15; Balanced Budget Act of 1997, Social Security Act 1902 (a) (10)(E)

Rule 2.5: Reimbursement

A. Cost Reports

1. Participating Mississippi facilities must prepare and submit a Medicaid cost report for reimbursement of long term care facilities. All cost reports are due by the end of the fifth (5th) calendar month following the reporting period. Failure to file a cost report by the due date or the extended due date will result in a penalty of fifty dollars ($50.00) per day and may result in the termination of the provider agreement.

2. Medicaid uses a prospective method of reimbursement. The rates are determined from cost reports and resident case-mix assessment data. Standard rates are determined annually with an effective date of January 1. Rates are adjusted quarterly based on changes in the case-mix of the facility.

3. In no case may the reimbursement rate for services exceed an individual facility's customary charges to the general public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.

4. Prospective rates may be adjusted by Medicaid pursuant to changes in federal and/or state laws or regulations.

5. Prospective rates may be adjusted by Medicaid based on revisions to allowable costs or case-mix scores or to correct errors. These revisions may result from amended cost reports, field visit reviews, or other corrections. Facilities are notified in writing of amounts due to or from Medicaid as a result of these adjustments. There is no time limit for requesting settlement of these amounts.

B. The Division of Medicaid conducts periodic field level cost report financial reviews of selected long term care facilities, including nursing facilities, intermediate care facilities for the mentally retarded, and psychiatric residential treatment facilities, to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports.

C. Retention of Records

1. Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the

Medicaid program to keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

2. Providers must maintain adequate documentation, including, but not limited to, financial records and statistical data, for proper determination of costs payable under the Medicaid program. The cost report must be based on the documentation maintained by the facility. All non-governmental facilities must file cost reports based on the accrual method of accounting. Governmental facilities have the option to use the cash basis of accounting for reporting.

3. Documentation of financial and statistical data should be maintained in a manner consistent manner from one (1) period to another and must be current, accurate and in sufficient detail to support costs contained in the cost report.

4. Providers must make available to the Division of Medicaid all documentation that substantiates the information included in the facility cost report for the purpose of determining compliance with Medicaid rules. These records shall be made available as requested by the Division of Medicaid. All documentation which substantiates the information included in the cost report, including any documentation relating to home office and/or management company costs must be made available to Division of Medicaid reviewers as requested by the Division.

Source: Miss. Code Ann. § 43-13-121; 42CFR §447 Subparts B & C; Miss. Code Ann. § 43-13-117

Rule 2.6: Per Diem

A. The nursing facility must provide and pay for all items and services required to meet the needs of a resident.

B. Items and services covered by Medicare or any other third party must be billed to Medicare or the other third party and are considered non-allowable on the cost report. Applicable crossover claims must also be filed with the Division of Medicaid.

C. The following items and services are included in the Medicaid per diem rates and cannot be billed separately to the Division of Medicaid or charged to a resident:

1. Room/bed maintenance services,

2. Nursing services,

3. Dietary services, including nutritional supplements,

4. Activity services,

5. Medically-related social services,

6. Routine personal hygiene items and services,

7. Laundry services including the residents' personal laundry,

8. Over-the-counter (OTC) drugs,

9. Legend drugs not covered by Medicaid drug program, Medicare, private, VA, or any other payor source,

10. Medical supplies including, but not limited to, those listed below. The Division of Medicaid defines medical supplies as medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a resident to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease and appropriate for use in the nursing facility. [Refer to Miss. Admin. Code Part 207, Rule 2.6.D for medical supplies which must be billed outside the per diem rate.]

    a) Enteral supplies,

    b) Diabetic supplies,

    c) Diapers and blue pads, and

    d) Oxygen administration supplies.

11. Durable medical equipment (DME), except for DME listed in Miss. Admin. Code Part 207, Rule 2.6.D. The Division of Medicaid defines DME as an item that (1) can withstand repeated use, (2) primarily and customarily used to serve a medical purpose, (3) is generally not useful to a resident in the absence of illness, injury or congenital defect, and (4) is appropriate for use in the nursing facility.

12. Routine personal hygiene items and services as required to meet the needs of the residents including, but not limited to:

    a) Hair hygiene supplies,

    b) Comb and brush,

    c) Bath soap,

    d) Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection,

e) Razor and shaving cream,

f) Toothbrush and toothpaste,

g) Denture adhesive and denture cleaner,

h) Dental floss,

i) Moisturizing lotion,

j) Tissues, cotton balls, and cotton swabs,

k) Deodorant,

l) Incontinence care and supplies,

m) Sanitary napkins and related supplies,

n) Towels and washcloths,

o) Hair and nail hygiene services, including shampoos, trims and simple haircuts as part of routine grooming care, and

p) Bathing.

13. Private room coverage as medically necessary:

    a) The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room if medically necessary and ordered by a physician. The Medicaid reimbursement for a medically necessary private room is considered payment in full for the private room. The resident, the resident's family or the Division of Medicaid cannot be charged for the difference between a private and semi-private room if medically necessary.

    b) The resident may be charged the difference between the private room rate and the semi-private room rate when it is the choice of the resident or family if the provider informs the resident in writing of the amount of the charge at the time of admission or when the resident becomes eligible for Medicaid.

14. Ventilators. [Refer to Miss. Admin Code Part 207, Rule 2.15.]

D. The following items and services are not included in the Medicaid per diem rates, are considered non-allowable costs on the nursing facility's cost report, and must be billed directly to the Division of Medicaid by a separate provider with a separate provider number from that of the nursing facility:

1. Laboratory services,

2. X-ray services,

3. Drugs covered by the Medicaid drug program,

4. Physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services,

5. Ostomy supplies,

6. Continuous Positive Airway Pressure (CPAP) Devices effective January 2, 2015,

7. Bi-level Positive Airway Pressure (BiPAP) Devices effective January 2, 2015.

8. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident effective January 2, 2015. [Refer to Miss. Admin. Code Part 207, Rule 2.18 for definition and coverage criteria.]

E. Prior authorization from a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity is required for the following:

1. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident, and

2. PT, OT and SLP services.

F. Prior authorization from the Division of Medicaid or UM/QIO is required for ventilators except for those in a Nursing Facility for the Severely Disabled (NFSD).

G. All nursing facilities must prominently display the below information in the nursing facility, and provide to applicants for admission and residents the below information in both oral and written form:

1. How to apply for and use Medicare and Medicaid benefits, and

2. How to receive refunds for previous payments covered by such benefits.

H. The nursing facility must:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid of:

a) The items and services that are included in the nursing facility services under the State Plan and for which the resident may not be charged, and

b) Those other items and services that the nursing facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in Miss. Admin. Code Part 207, Rule 2.6.G.1.

3. Inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

I. The nursing facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for items and services consistent with the notice stated in Miss. Admin. Code Part 207, Rule 2.6.G.

1. The nursing facility's non-Medicaid per diem rate may be set above the Medicaid per diem rate but the items and services included in the non-Medicaid rate must be identical to the items and services included in the Medicaid per diem rate.

2. Items and services available in the nursing facility not covered under Title XVIII or the nursing facility's Medicaid per diem rate must be available and priced identically for all residents in the facility.

J. A nursing facility cannot require a deposit before admitting a card-carrying Medicaid beneficiary.

Source: 42 C.F.R. § 483.10; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Removed Miss. Admin. Code Part 207, Rule 2.6.D.6 (retroactively eff. 01/02/2015) eff. 11/01/2016; Revised eff. 01/02/2015.

Rule 2.7: Admission Requirements

A. A Pre-Admission Screening (PAS) application must be completed to determine clinical eligibility for individuals seeking admission to a Division of Medicaid certified nursing facility on all residents regardless of payment source.

1. The PAS application must be submitted to the Division of Medicaid within thirty (30) days of the physician's certification.

2. An individual must receive a PAS score of fifty (50) or greater to be clinically eligible for nursing facility placement.

3. Individuals with mental illness and/or an intellectual/developmental disability (MI/ IDD) determined to require a nursing facility level of care must receive a Level II evaluation to ensure appropriate placement and the provision of necessary specialized services regardless of payment source.

B. The PAS Section X summary, physician's certification, and Level II evaluation, if required, must be submitted by the admitting nursing facility to the Medicaid Regional Office of the individual's county of residence for determining Medicaid eligibility.

C. Individuals seeking admission to a Nursing Facility for the Severely Disabled (NF-SD) must meet the following additional requirements:

1. Have a diagnosis of spinal cord injury, closed head injury, long-term ventilator dependency or another diagnosis similar or closely related to the severity and involvement of care of those diagnoses, and

2. Be assigned one (1) of the following MDS RUG-IV 48 Grouper categories: ES3, ES2, HE2, HE1, HD2, HD1, HC2, HC1, HB2, HB1, LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1.

Source: 42 USC §§ 1395i-3, 1396r; 42 CFR §§ 435.1010, 483.100-483.106, 483.112; 483.120; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.

History: Revised to correspond to SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.8: Temporary Leave Payment

A. Under the provisions outlined in this section, a temporary absence of a resident from a nursing facility will not interrupt the monthly payments to the facility. The period of leave will be determined by counting the day the resident left the facility as the first (1st) day of leave.

B. An absence from the facility for eight (8) to twenty-four (24) hours constitutes a leave day. The facility must reserve the resident's bed in anticipation of the resident's return. The bed may not be filled with another resident during the covered period of leave. Leave days may not be billed if the facility refuses to readmit the resident under their resident return policy.

C. A refund of payment will be demanded for all leave days taken in excess of the allowable or authorized number of days.

D. The Division of Medicaid pays for the day of admission to a facility. The day of discharge is not paid by Medicaid, unless it is the same day as the date of admission. Facilities may not bill the resident or responsible party for the day of discharge.

E. Each facility is required to maintain leave records and indicate periods of hospitalization and therapeutic leave days on billing forms. All resident hospital and therapeutic leave periods,

regardless of payment source, must be submitted to the Division of Medicaid electronically prior to the close of the quarter in which it occurred.

F. Before the resident departs on therapeutic or in-patient leave, the facility must provide written information to the resident and/or family member or legal representative explaining leave policies. This information must define the period of time during which the resident will be permitted to return and resume residence in the facility. The notice must also state that, if the resident's absence exceeds Medicaid's bed-hold limit, the resident will be readmitted to the facility upon the first availability of a semi-private bed if the resident still requires the services provided by the facility.

G. Home/Therapeutic Leave

1. Residents in a nursing facility may have absences for home/therapeutic leave from the nursing facility other than for in-patient hospital leave. Home/therapeutic leave includes routine outpatient treatments. Outpatient treatment for dialysis and outpatient treatment for catastrophic illnesses, like chemotherapy that occurs two (2) or more days per week will not count as therapeutic leave days.

2. Specific requirements applicable to home/therapeutic leave are as follows:

a) Medicaid coverage of home/therapeutic leave days per State fiscal year, July 1 to June 30, for nursing facilities is fifty-two (52) days in addition to Christmas Day, the day before Christmas, the day after Christmas, Thanksgiving Day, the day before Thanksgiving and the day after Thanksgiving. Thus, a resident may have up to fifty-eight (58) total days in a State fiscal year for home/therapeutic leave.

b) All home/therapeutic leave days must be approved by the attending physician.

c) Fifteen (15) days home/therapeutic leave are allowed each absence. A resident must be discharged from the facility for Medicaid billing if he/she remains on home/therapeutic leave for more than fifteen (15) days.

d) A leave of absence for home/therapeutic leave is broken if the resident returns to the facility for twenty-four (24) hours or longer.

H. Leave for Inpatient Hospital Stay

1. Nursing facility residents are allowed fifteen (15) days hospital leave for each hospital stay. There is no maximum number of hospital leave days each year. Hospital leave applies to acute care hospital stays in a licensed hospital, including geri-psychiatric units.

2. The hospital leave rules apply as follows:

a) A resident must be discharged from the facility for Medicaid billing if he remains in the hospital for more than fifteen (15) days. When the resident is readmitted to the

facility after a hospital stay, readmission certification on a new Pre-Admission Screening (PAS) form is not necessary if the resident has been continuously institutionalized. A leave of absence for hospitalization is broken only if the resident returns to the facility for twenty-four (24) hours or longer.

b) Facilities may not refuse to readmit a resident from in-patient hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires nursing facility services.

c) Facilities which bill Medicaid for fifteen (15) days of in-patient hospital leave, discharge the resident, and subsequently refuse to readmit the resident under their resident return policy when a bed is available, must repay Medicaid for the fifteen (15) days of hospital leave and are subject to additional remedies for failure to comply with the requirements relating to residents' rights.

d) In-patient hospital leave will not be paid for days in which the resident is placed in a Medicare skilled nursing facility (SNF) or a swing bed.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117; 42 CFR §447.40

Rule 2.9: Resident Assessment Instrument (RAI)

A. Nursing facilities must complete the Minimum Data Set (MDS) 3.0, including Section S, which is the Resident Assessment Instrument (RAI) specified by the Division of Medicaid and approved by the Centers of Medicare and Medicaid Services (CMS), on all residents regardless of source of payment.

B. The RAI must:

1. Be conducted or coordinated by a registered nurse who signs and certifies completion of the RAI.

   a) The RAI may be conducted with the participation of other appropriate staff members.

   b) Each staff member who completes a portion of the RAI must sign and certify as to the accuracy of that portion of the RAI.

2. Be maintained in the resident's active clinical record:

   a) Either in handwritten and/or electronic form, consisting of the previous fifteen (15) months of assessments, including the signatures of the facility staff attesting to the accuracy and completion of the assessment, and

   b) After the fifteen (15) month period, the RAI information may be stored in the medical records department provided it is easily retrievable.

3. Include the following assessments for all residents:

   a) Admission, comprehensive,

   b) Annual, comprehensive,

   c) Significant Change in Status, comprehensive,

   d) Quarterly,

   e) Significant Correction to a Prior Comprehensive,

   f) Significant Correction to a Prior Quarterly,

   g) Other Medicare Reasons for Assessment (OMRA), if applicable, and

   h) Discharge, Death, Transfer or Re-entry.

4. Be completed per the current CMS Long-Term Care Facility Resident Assessment Instrument User's Manual.

Source: 42 USC §§ 1395i-3, 1396r; 42 CFR §§ 483.20, 483.315; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond to MS SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.10: Case Mix Reimbursement

A. The Division of Medicaid utilizes a RUG-IV 48 grouper model for case mix calculation for reimbursement.

   1. Each of the forty-eight (48) resident classifications as well as the default classification is assigned case-mix weights.

   2. The classifications are calculated electronically using the MDS assessment data and the RUG-IV calculation program.

B. Clinical documentation must be maintained in the clinical record which supports the MDS 3.0 assessment and substantiates the resources and services needed to provide care to the resident.

C. Documentation for case-mix reimbursement must adhere to the Division of Medicaid's Supportive Documentation Requirements.

Source: 42 CFR § 483.75; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.

History: Revised to correspond to SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.11: Resident Funds

A. Basic Requirements

1. The facility must, upon written authorization by the resident, accept responsibility for holding, safeguarding and accounting for the resident's personal funds. The facility may make arrangements with a federally or state insured banking institution to provide these services, but the responsibility for the quality and accuracy of compliance with the requirements of this section remains with the facility. The facility may not charge the resident for these services, but must include any charges in the facility's basic daily rate.

2. Resident fund accounts are reviewed to assist facilities in developing acceptable systems of accounting for resident funds.

3. Penalties may be assessed on any licensed nursing facility that fails to maintain an auditable system of accounting for residents' funds or has had repeated instances of noncompliance with the provisions of federal law and of the requirements contained in this section.

B. Statement Provided at Time of Admission - The facility must provide each resident and responsible party with a written statement at the time of admission that states the following:

1. All services provided by the facility must be distinguished between the services included in the facility's basic rate and those services not included in the facility's basic rate. The statement must include both the services that may be charged to the resident's personal funds and the amount of such charges.

2. There is no obligation for the resident to deposit funds with the facility.

3. The resident has the right to select how personal funds will be handled. The following alternatives must be included:

   a) The resident's right to receive, retain and manage his/her personal funds or have this done by a legal guardian, if any,

   b) The resident's right to apply to the Social Security Administration to have a representative payee designated for purposes of federal or state benefits to which he/she may be entitled,

   c) The resident's right to designate, in writing, another person to act for the purpose of managing his/her personal funds, and

   d) The resident's right to require the facility to hold, safeguard, and account for such personal funds under a system established and maintained by the facility, if requested

by the resident.

4. Any charge for this service is included in the facility's basic rate.

5. The facility is permitted to accept a resident's funds to hold, safeguard, and account for, only upon the written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee.

6. The facility is required to arrange for the management of the resident's personal funds if the resident becomes incapable of managing his/her personal funds and does not have a representative.

7. The facility must maintain a complete copy of its resident trust fund policies and procedures and must make them accessible and available for review.

C. Individual Records - The facility must maintain current, written, individual records of all financial transactions involving the resident's personal funds which the facility has been given for holding, safeguarding, and accounting. The facility must act as fiduciary of the resident's funds and account for these funds in an auditable manner. The facility must use Generally Accepted Accounting Principles (GAAP) when maintaining these records. GAAP means that the facility, for example, employs proper bookkeeping techniques by which it can determine, upon request, all deposits and withdrawals for each resident, how much interest these funds have earned for each resident, and the amount of individual resident funds.

D. Limitation on Charges to Resident Funds

1. Acceptable charges to resident funds include, but are not limited to, the following general categories and examples, if proper authorization and documentation, as specified in under the heading "Individual Records" of this section is provided. The facility must notify the resident and/or responsible party, in advance, that there will be a charge for non-Medicaid covered items and services, such as:

   a) Personal communication/entertainment items and services, like a telephone, television, radio, and computer,

   b) Personal comfort items, including tobacco, novelties, and candy,

   c) Items and services in excess of those included in the Medicaid per diem rate, such as grooming or cosmetic items which are requested by the resident. The resident must be furnished in advance with an itemized statement of charges for these items and services,

   d) Personal clothing,

   e) Personal reading material,

f) Gifts purchased on behalf of the resident,

g) Flowers and plants for the resident's room,

h) Entertainment and social events outside the scope of that provided by the facility and included in the Medicaid per diem rate,

i) Private sitters or aides,

j) Private room provided that a private room is not medically necessary, like isolation for infection control,

k) Specially prepared or alternative food requested instead of or in addition to the food generally prepared by the facility, and

l) Authorized cost-sharing in Medicaid-covered services, including Medicaid Income liability for room and board.

2. Unacceptable charges to resident funds include the following categories and examples:

a) Any charge not authorized and documented.

b) Nursing, dietary, activities, room/bed maintenance, and personal hygiene services.

c) Medically necessary items and services are reimbursed as part of the Medicaid per diem rate. However, any properly made charge for equipment or services, such as geriatric or geri-chairs, wheelchairs, support shoes, gurneys, and counseling services, must be supported by a written statement from the resident's physician that documents the item or service was not of medical necessity. Failure to maintain the physician's denial of medical necessity statement may result in the facility's reimbursement of charges to a resident's account.

d) Medical transportation. All transportation for nursing facility residents, whether emergency or non-emergency must be arranged by nursing facility staff. Transportation that does not qualify for benefits through the Ambulance Program must be arranged through a family member, if available. Transportation may also be arranged using nursing facility vehicles, or by utilizing outside resources. Costs for providing this level of service are to be reported by the nursing facility on their cost reports and are reimbursed through the facility per diem. The nursing facility may not bill the resident or family for any means of transportation. For cases requiring transportation other than by ambulance to and from dialysis, the nursing facility may make referrals to the Non-Emergency Transportation (NET) Program. The NET provider must, in these cases, submit claims to Medicaid for direct reimbursement. If a resident is transferred from a nursing facility to a hospital and remains hospitalized for longer than fifteen (15) days and is discharged from the nursing facility, transportation for these residents should be arranged by the hospital. If there has not

been a final discharge from the nursing facility and the resident had a hospital stay of less than fifteen (15) days, transportation back to the nursing facility must be arranged by the nursing facility staff.

e) Any item or service requiring a waiver of the resident's personal needs allowance, such as for repayment of a debt owed the facility. The personal needs allowance may be used by a nursing facility for nursing facility costs only upon the written authorization of the resident or the resident's responsible party and with the understanding by the resident that this action is voluntary and is not a requirement.

f) Loans or collateral for loans to anyone, including the facility and other residents in the trust fund. A resident's balance must be positive at all times, as a resident with a negative balance is in effect borrowing money from the other residents.

g) Transfers or gifts of money not authorized by the resident, such as when the resident's responsible party transfers funds without documentation that the funds were used for the benefit of the resident.

h) Any item or service as a condition of admission or continued stay.

E. Resident's Access to Financial Records and Quarterly Statements - The facility must provide each resident, responsible party, or legal representative of each resident, reasonable access to the resident's financial records. In addition, the facility must provide a written statement, at least quarterly, to each resident, responsible party, or legal representative. The quarterly statement must reflect any resident funds which the facility has deposited in an interest bearing or a non-interest bearing account, as well as any resident funds held by the facility in a petty cash account.

F. Comingling of Residents' Funds - The facility must keep any funds received from a resident for holding, safeguarding and accounting separate from the facility's funds and from the funds of any person other than another resident in that facility. The facility may not open any additional accounts within the trust fund account, such as donation accounts, miscellaneous accounts, or the like. Only funds of the facility's residents may be maintained as part of the resident trust fund account.

A. Deposit of Resident Funds into an Interest or Non-Interest Bearing Account

1. The facility must deposit any resident's personal funds in excess of fifty dollars ($50.00) in an interest bearing account(s) that is separate from any of the facility's operating accounts. The facility must credit all interest earned on such separate account(s) in one of the following ways, at the election of the facility:

a) Prorated to each resident's account on an actual interest-earned basis; or

b) Prorated to each resident's account on the basis of its end-of-quarter balance.

2. The facility must maintain a resident's personal funds that do not exceed fifty dollars ($50.00) in a non-interest bearing account, an interest-bearing account, or a petty cash fund. However, if the facility maintains a resident's personal funds of fifty dollars ($50.00) or less in a pooled account with all other residents' funds, interest is accumulated based on the total amount of funds in the trust fund account; therefore, all residents must be allocated interest proportionately in that instance.

3. The facility may neither limit nor restrict any resident with funds on deposit within the resident trust fund account to a maximum of fifty dollars ($50.00). A facility may not establish policy that conflicts with this absolute right of the residents for the facility to hold, safeguard, manage, and account for all residents' funds deposited with the facility.

H. Access to Funds

1. Funds held in the facility - The residents must have access to funds daily during normal business hours and for some reasonable time of at least two (2) hours on Saturdays and Sundays. The facility must, upon request or upon the resident's transfer or discharge, during normal business hours, return to the resident, the legal guardian or the representative payee all funds remaining that the facility has received for holding, safeguarding and accounting and that are maintained in a petty cash fund.

2. Funds held outside the facility - For a resident's personal funds that the facility has received and that are deposited in an account outside the facility, the facility, upon request, must, within five (5) business days, return to the resident, the legal guardian, or the representative payee, all or any part of those funds.

I. Accounting on Change of Ownership

1. Duties of new owner - Upon sale of the facility or other transfer of ownership, the facility must provide the new owner with a written accounting of all resident funds being transferred and obtain a written receipt for those funds from the new owner.

2. Duties to resident - The facility must give each resident or representative a written accounting of any personal funds held by the facility before any transfer of ownership occurs.

3. Rights of resident - In the event of a disagreement with the accounting provided by the facility, the resident retains all rights and remedies provided under state law.

4. Sponsor signatures for fiscal responsibility - A nursing facility cannot require a family member or other individual to sign a financial responsibility statement for a Medicaid resident. In instances where Medicaid beneficiaries have no family member or individual available for such signatures, it is clearly discriminatory for a Medicaid provider to refuse admission to the resident.

J. Accounting Upon Death or Discharge of Resident

1. The facility must, within thirty (30) days of a resident's death or discharge, convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate. If the deceased resident's estate has no executor or administrator, the facility must convey the resident's funds and provide a final accounting to the:

   a) Resident's next of kin,

   b) Resident's representative, or

   c) Clerk of the probate court of the county in which the resident died.

2. Disposition of Funds for Deceased Resident Who Dies Intestate Within a Long-Term Care Facility

   a) Any resident who dies intestate and leaves no known heirs and has no representative party shall have his final accounting of funds and conveyance of those funds sent to the Mississippi State Treasury Department within thirty (30) days of the resident's death. Such funds should be sent along with the report to the State Treasurer in the following manner.

   b) The report of such funds shall be on a form prescribed or approved by the State Treasurer and shall include the name of the deceased person and his/her last known address prior to entering the nursing facility; the name and last known address of each person who may possess an interest in such funds; and any other information which the State Treasurer prescribes by regulation as necessary.

   c) In the event a party with a claim to the deceased resident's funds comes to be known after funds have been conveyed to the State Treasurer, the party may file a claim with the State Treasurer. All reports of unclaimed funds filed by the facility prior to November 1st of each year will be included in a list published by the State Treasurer within one hundred twenty (120) days following November 1st. Claimants have ninety (90) days from the date of publishing to file for such funds. After the ninety (90) day filing limit, all unclaimed funds are placed in an account by the State Treasurer to be used for Medicaid purposes.

3. Disposition of Funds for Deceased Resident Who Dies Intestate in a State Institution - Section A above shall not be applicable for residents of any state institution. The funds of any resident in a state institution who dies intestate and without any known heirs may be deposited in the facility's operational account, after a period of one (1) year from the date of death.

K. Surety Bond

1. The facility must purchase a surety bond or otherwise provide assurance as to the security

of all personal funds of residents deposited with the facility. A surety bond is an agreement between the principal (the facility), the surety (the insurance company), and the obligee (the residents of the trust fund), wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, safeguards, manages and for which the facility accounts. The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring for any failure by the facility to hold, safeguard, manage, and account for the residents' funds; that is, losses occurring as a result of acts or errors of negligence, incompetence or dishonesty.

2. Unlike other types of insurance, the surety bond protects the obligee (the residents of the trust fund), not the principal, from loss. The surety bond differs from a fidelity bond, also called employee dishonesty insurance or a crime bond, which covers no acts or errors unless they involve dishonesty.

3. The surety bond is the commitment of the facility to meet the standard of conduct. The facility assumes the responsibility to compensate the obligee (the residents of the trust fund), for the amount of the loss up to the entire amount of the surety bond. Therefore, the surety bond coverage must be for an amount equal to or greater than the highest daily balance for all resident funds held on deposit. A copy of the surety bond and evidence of the payment of the premium for the appropriate bond coverage amount must be kept at the facility and available for inspection.

4. Reasonable alternatives to a surety bond must:

   a) Designate the obligee, (the resident, individually, or in aggregate), who can collect in case of a loss,

   b) Specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the residents' funds, and

   c) Be managed by a third party unrelated in any way to the facility or its management.

5. The facility cannot be named as an obligee. Self-insurance is not an acceptable alternative to a surety bond. Likewise, funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation (FDIC), or similar entity, are not acceptable alternatives.

6. If a corporation has a surety bond that covers all of its facilities, the corporation's surety bond must be sufficient to ensure that all of the residents in the corporation's facilities are covered against any losses due to acts or errors by the corporation, its agents, or any of its facilities. The intent of focus is to ensure that if a corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation's facilities would be protected.

L. Resident Incapable of Managing Funds

1. If a resident is incapable of managing personal funds and has no representative, the facility must refer the resident to the local office of the Social Security Administration (SSA) and request that a representative payee be appointed.

2. In the time period between notification to the appropriate agencies, institution of formal guardianship proceedings, and notification to the local SSA office and the actual appointment of a guardian or representative payee, the facility must serve as temporary representative payee for the resident.

3. In order to safeguard and maintain an accurate accounting of the resident's account, funds received on behalf of the resident must initially be deposited in the trust fund account before they can be disbursed for any expenses. A resident's monthly income source, like a Social Security check, cannot be commingled with facility funds prior to those funds being transferred to the trust fund account.

M. Notice of Resource Limits, Medicaid or SSI

1. The facility must notify each resident receiving medical assistance under Title XIX, Medicaid, when the amount in the resident's account reaches two hundred dollars ($200) less than the SSI resource limit and five hundred dollars ($500), less than the Medicaid resource limit, to remain eligible for Medicaid long term care benefits. The notice must include the fact that if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the applicable resource limits, the resident may lose eligibility for Medicaid or SSI.

2. The facility must issue written notification to the Medicaid regional office of any resident receiving medical assistance under Title XIX when the resident's account balance reaches the applicable resource limit.

N. Glossary and Explanation of Common Terms Used in the Performance of Resident Trust Fund Reviews

1. Basic Rate - Also referred to as the standard or per diem rate. This is the rate that Medicaid pays the facility per Medicaid resident per day, as established periodically from cost reports and assessment data. The basic rate is important in the discussion of resident funds in that items and services included in the rate cannot be charged to a resident; the resident must be informed, in writing at the time of admission, of the items and services provided by the facility, as well as the items and services not included in the basic rate, and the amount of such charges that may be charged to the resident.

2. Book Balance - The total balance of all resident trust funds and petty cash held according to the accounting ledger.

3. Census - The total number of residents in a facility.

4. Compliance - The Omnibus Budget Reconciliation Act of 1987, Paragraph 17, 399, Section 1919(6)(A) requires a facility to establish and maintain a system that fully and completely accounts for the resident's funds managed by the provider. A facility that does this is issued an opinion by the Division of Medicaid that "the facility generally complies with Section 1919(6)(A)." A facility may be found to be in compliance and still have minor errors in its resident fund system; however, for a facility that lacks an accounting system, lacks several parts of an accounting system, or has a sufficient number of exceptions that would indicate a breakdown of the system of accounting, an opinion may be issued that "the facility does not comply with Section 1919(6)(A)."

5. DOM - Division of Medicaid.

6. Fiduciary - A fiduciary has rights and powers normally belonging to another person that must be exercised with a high standard of care for the benefit of the beneficiary. Regarding resident funds, a party who is entrusted to conduct the financial affairs of another person is acting in a fiduciary or trust capacity and has responsibility to use due care and to act in the best interests of the party for whom he is acting in this capacity. A party acting in a fiduciary capacity is also responsible to give an accounting of all transactions made on behalf of the party for whom he is acting in this capacity.

7. Fiscal Agent - The agency, under contract with the Division of Medicaid, for the purpose of disbursing funds to providers of services under the Medicaid program. The fiscal agent collects eligibility and payment information from agencies administering Medicaid and processes the information for payment to providers.

8. GAAP - Generally Accepted Accounting Principles. GAAP for resident trust funds means that the facility employs proper bookkeeping techniques by which it can determine, upon request, all deposits and withdrawals for each resident, how much interest these funds have earned for each resident and the amount of each individual resident's fund balance. Proper bookkeeping techniques may, include a computer software package for the accounting of resident trust funds, an individual ledger card, ledger sheet or equivalent established for each resident on which only those transactions involving the resident's personal funds are recorded and maintained.

9. Intestate - Without a valid will at the time of death.

10. Legal Guardian - A legal guardian, or conservator, is a person or persons appointed by the court of jurisdiction to manage the resident's income and assets in the best interest of the resident. The court may require a court order prior to disbursements of the resident's funds, and/or a periodic accounting to the court to document income and disbursements. A legal guardian or conservator must supply documentation to the facility for disbursements from the resident fund, just as any other responsible party for any other resident.

11. Medicaid Income - The Medicaid income is the dollar amount shown on a resident's form DOM-317. It is the maximum liability that the resident owes to the facility each month

for room and board.

12. Medically Necessary Items and Services - Those items and services that are documented by the attending physician or medical personnel delegated by the attending physician as reasonable and necessary. If a resident's personal funds are expended for an item or service covered in the facility's basic rate, evidence must be in the resident's file to verify that the item or service is not medically necessary, and therefore justifiable as an expenditure of the resident's personal funds.

13. Obligee - The party to whom the facility is legally or morally bound, i.e. "the residents of the trust fund". The obligee is the beneficiary of funds collected in the event of the failure of the facility to hold, safeguard, manage, and account for the resident's funds.

14. Per Diem Rate - Refer to "Basic Rate."

15. Personal Needs Allowance (PNA) - The amount of funds a resident is allowed to keep after room and board liability, supplemental health insurance premiums, and allowable minimum monthly needs allowances are deducted from the resident's gross income.

16. Plan of Correction - An acceptable plan of correction must address each exception noted in the findings letter and include the following:

    a) Documentation that the exception has been corrected,

    b) The measures that have been put in place to ensure that the exception will not be repeated, and

    c) The measures that have been put in place to monitor the continued effectiveness of the changes.

17. Reconciliation - At all times, the total of the residents' funds held, as noted from the bank's current statement of the balance and any cash held at the facility, must equal the total of the resident's funds as noted from the facility's accounting ledger for all residents participating in the resident trust fund. Any difference between the two (2) totals must be accounted for by documented outstanding credits and debits, or documented reconciling items such as unposted current interest, unposted petty cash vouchers, or corrections.

18. Representative Payee - A resident may have someone designated to receive and manage their Social Security, Veterans Administration, Railroad Board, or other federal or state benefits. That party is the representative payee for the resident. A facility must be willing to be designated as a temporary representative payee if no responsible party is available to represent the resident.

19. Resident's Personal Funds - All of a resident's money on deposit with the facility, including all of the resident's funds, regardless of the source, that are placed in trust at the facility.

20. Resource Limit - The maximum amount of assets a resident may have in order to qualify for Medicaid services. For trust fund review purposes, there are two(2) resource limits to be considered, the Supplemental Security Income (SSI) resource limit and the Medicaid resource limit.

21. Responsible Party - For resident trust fund purposes, may be known as sponsor or residents representative. A resident may serve as his own responsible party. In other instances, the responsible party is the individual who signs appropriate documentation, commonly known as a Trust Fund Authorization form, to assist the resident in managing the personal funds of the resident that are maintained within the resident trust fund account. Any withdrawal of funds by a responsible party must be for the benefit of the resident, must be signed, and must be supported by appropriate documentation (e.g., receipts or invoice).

22. State Institution - These are facilities owned and operated by the State, such as: Mississippi State Hospital, Ellisville State School, East Mississippi State Hospital, North Mississippi Regional Center, Hudspeth Regional Center, South Mississippi Regional Center, University of Mississippi Medical Center, and the Boswell Regional Center. This listing is not intended to be all inclusive.

23. Testate - Having a valid will at the time of death.

24. Trial Balance - A listing of all residents participating in the resident trust fund and the balance of each resident's trust fund.

25. Written Authorization - Authorization to establish a resident trust fund for a resident must be in the form of a written statement signed by the resident or responsible party. In addition, authorization to perform a specific transaction of funds for the resident must be in writing and/or documented with a receipt of purchase.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483; 42 CFR 447.15; 42 CFR 483.10; Social Security Act 1919 (c)(16); 1919 (5)(A)(i); 1919 (6)

Rule 2.12: Nurse Aide Training

A. Nurse Aide Training and Testing Reimbursement

1. The Division of Medicaid uses the direct reimbursement method for nurse aide training and testing expenses incurred by nursing facilities.

2. Reasonable cost of training and competency testing of nurse aides in order to meet the requirements necessary for the nurse aide to be certified are to be billed directly to Medicaid

B. In-House Training Programs

1. The nursing facility will be directly reimbursed by Medicaid for covered services, equipment, and supplies. In order to receive Medicaid reimbursement, the training program must have approval from the Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification.

2. Services and supplies approved for payment will be subject to application of the nursing facility's percentage of Medicaid utilization. The Medicaid utilization percentages of every facility are redetermined annually and are applicable for one (1) state fiscal year. The percentages are taken from the most recent cost report at the time of redetermination. Nursing facilities and training centers are notified in writing of their Medicaid utilization percent. In cases where no cost report data is available, eighty (80) percent will be applied to approved billings until such time that the correct Medicaid utilization percent can be determined. Nurse aide training centers' Medicaid utilization percentage will be redetermined annually and will be calculated based on the weighted average of Medicaid utilization percentages of associated facilities weighted by bed size.

3. Only costs actually incurred by the facility will be considered for reimbursement. No reimbursements will be made for estimated cost.

4. In-house training programs refer to the training area set up within a nursing facility or training center. In-house training programs include training areas set up by a nursing facility in a remote location due to space restrictions. A training center is an area set up for nurse aide training which serves more than one (1) facility and is located in an area remote from any of the associated facilities.

C. Testing Fees are allowable for direct reimbursement for nurse aides who have been through an approved certification training program. Medicaid will reimburse for written or oral and clinical testing fees based on the fee schedule from the current testing services contracted by MSDH. Testing reimbursement will be subject to a nursing facility's Medicaid utilization percent just like training reimbursement. Testing must be billed by the employing facility of the nurse aide who was tested. This applies even to nurse aides trained in a training center. Training centers do not bill the nurse aide testing fees. Medicaid will reimburse the cost for a nurse aide to be tested up to three (3) times. If after three (3) attempts, a nurse aide fails to pass the tests, Medicaid requires the aide to complete another training program before any additional tests will be reimbursed. Testing fees must be billed with thirty (30) days of the test date. Pass/fail results must be included with the billing. Pass/fail results can include either the results received from the current testing service or the actual results given to the aides at the time of the tests.

D. Out of Facility Training

1. Facilities which do not have an approved nurse aide training and testing program and are not associated with an approved training center may acquire training for their employed aides at any approved non-facility-based Nurse Aide Training and Competency Evaluation Program (NATCEP). Medicaid has set a limit on reimbursable cost on

training and evaluating a nurse aide outside the facility.

2. The current limit is set at five hundred dollars ($500.00) for each nurse aide's training session and testing. Medicaid will apply the Medicaid utilization percent of the employing facility to the lesser of the cost incurred or the limit to determine the amount reimbursable. Under no circumstances will Medicaid reimburse a facility for off-site training and testing costs when it is determined that the off-site training and testing site is receiving reimbursement from Medicaid for the same training or testing session. Out of facility training should be billed using the billing form for nurse assistant training expenses. Pass/fail results should be submitted with the billing form if the aide was tested.

3. Facilities that do not have an approved nurse aide training program, which receive training for their employed nurse aides at an approved site that is a related party, are subject to reimbursement limits at cost. The training program must submit to Medicaid a record of the actual allowable costs incurred to run the training program for a month. Costs are determined allowable following the guidelines stated for approved training centers. Documentation must be submitted with the record of costs in accordance with other paragraphs of this section. The allowable reimbursement for each nurse aide trained for the related party nursing facility will be limited to cost and will be subject to the application of the Medicaid utilization percent.

4. The Medicaid utilization percent is determined by the total allowable monthly costs that will be divided by two (2) to recognize the time for two (2) training sessions of two (2) weeks each in each month. The monthly costs will be further divided by the maximum number of aides allowed in each training session. This calculation will result in the determination of the allowable tuition rate for a nurse aide employed by a related party nursing facility. The related party nursing facility will bill Medicaid the predetermined allowable tuition rate. Medicaid will then apply the facility's Medicaid utilization percent when approving the billing. The training program will be allowed to submit actual monthly costs as often as once per month. Submission of costs for subsequent months are only required when there is a permanent change. Facilities will have an option exercisable at the beginning of each state fiscal year and at the inception of the training program to report actual numbers of aides trained in total and for the related party nursing facility in each training session in order to prorate the monthly costs.

E. Reimbursement to an Individual Not Yet Employed at the Time of Training - Medicaid will reimburse the cost of an approved nurse aide training and competency evaluation program to an individual who is not employed, or who does not have an offer of employment, as a nurse aide on a pro rata basis under the following conditions:

1. The individual is employed or receives an offer of employment from a nursing facility not later than twelve (12) months after completing an approved program.

2. The individual incurred costs for the training and testing and can provide documentary evidence of them. Medicaid will not reimburse costs to an individual who received

training through a grant.

3. Medicaid will not approve costs in excess of the training and testing limits set for out-of-facility training. The Medicaid utilization percent(s) of the facility(s) which employs the nurse aide will be applied to the approved cost to determine the reimbursement amount.

4. Medicaid will reimburse one-half (1/2) of the settlement after six (6) months of full time employment by one (1) or more Mississippi nursing facilities. The remaining one-half (1/2) of the settlement will be reimbursed after the nurse aide has been employed full time for twelve (12) months by Mississippi nursing facilities.

5. The facility which employs the nurse aide must submit the bill for reimbursement to Medicaid on the billing form for Nurse Assistant Training Expenses.

F. Prohibition of Charges - No nurse aide who is employed by, or who has an offer of employment from, a facility on the date on which the aide begins training and testing program may be charged for any portion of the program.

G. Withdrawal of Program Approval - MSDH will notify Medicaid in writing when program approval is withdrawn. As a result, reimbursement from Medicaid will be stopped as of the date of withdrawal of program approval. As an exception, Medicaid will reimburse the allowable costs incurred to complete a training session which is in progress on the date of withdrawal of program approval. If it is determined by the MSDH that the equipment and supplies purchased for the nurse aide training program were never used for nurse aide training, Medicaid will require reimbursement from the facility for all costs incurred by Medicaid. Where possible used training equipment should be transferred to another approved training site. Any funds received from the sale of nurse aide training equipment, which was paid for by Medicaid must be refunded at the Medicaid utilization percent in effect at the time of original reimbursement.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483; OBRA 1987

Rule 2.13: Release of Information

A. Public access to records maintained by the Medicaid agency is mandated. The exceptions to public access are those records which are exempt as confidential or privileged.

B. Beneficiary-Specific Information will only be released by the Medicaid agency when the requirements of federal regulation are met.

C. Provider-Specific Information, including, but not limited to, cost reports, reimbursement rates, reimbursement amounts and reports not beneficiary-specific, will be available to the public when:

1. A written request for the information is made to the Executive Director of the Medicaid agency,

2. The information is available in existing agency files or reports, and

3. The requestor reimburses the Medicaid agency for the costs associated with the compilation of the requested material, as permitted by law.

D. Statistical Data that does not contain protected health information is available as requested. This type of information is generally available in the Medicaid agency annual report or other reports generated for agency reporting or administrative purposes. The requestor shall reimburse the Medicaid agency for the costs associated with the compilation of the requested material, as permitted by law.

Source: Miss. Code Ann. § 43-13-121; 25-61-1; 42 CFR 431.300 - 431.307; 45 CFR 160.164

Rule 2.14: Pharmacy

A. Beneficiaries in nursing facilities may obtain medications from pharmacies holding retail, closed door or institutional permits. Nursing facility (NF) residents may receive unlimited prescriptions per month if the medication orders, signed by the prescribing provider, are documented in the individual patient record and maintained at the nursing facility.

B. Beneficiaries maintain the ability to obtain Medicaid services from any institution, agency, pharmacy, person or organization that is qualified to furnish the services and willing to furnish them to that beneficiary. Participation in any package plan for medical care, such as those furnished by nursing facilities, must be strictly voluntary.

C. A resident of a long-term care facility is allowed freedom of choice of pharmacy providers for drugs covered by the Medicaid drug program. The freedom of choice is limited to pharmacies that meet labeling and packaging requirements established by the Mississippi State Board of Pharmacy.

D. Consequently, once a beneficiary chooses a particular provider or NF, he or she has clearly exercised freedom of choice with the respect to all items of medical care included within the scope of that nursing facility, including all services provided or arranged for by the NF which are reimbursed through the NF rates.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(23)

Rule 2.15: Ventilator Dependent Care

A. The Division of Medicaid defines ventilator dependent care (VDC) as mechanical ventilation for life support designed to replace and/or support normal ventilatory lung function.

B. Effective January 1, 2015, the Division of Medicaid provides an established reimbursement per diem rate in addition to the standard per diem rate to nursing facilities, excluding Nursing Facilities for the Severely Disabled (NF-SD), for residents requiring VDC services. On

January 1, 2015, the nursing facility will receive the following for a ventilator dependent resident:

1. A standard per diem, and

2. A ventilator per diem.

C. VDC provider enrollment requirements include:

1. The nursing facility must accept residents with pending Medicaid status.

2. Beneficiaries admitted under Medicare must receive approval from the Division of Medicaid prior to the nursing facility receiving reimbursement.

3. The nursing facility must file an Addendum to its current Provider Agreement and it must be approved by the Division of Medicaid.

   a) The Addendum must include required attestations regarding the nursing facility requirements consistent with Miss. Admin. Code Part 207, Rule 2.15. including, but not limited to:

      1) Number of beds designated to serve ventilator dependent residents,

      2) Required equipment,

      3) Staffing ratios for the VDC resident(s), and

      4) Documentation of a formal relationship between the nursing facility and a local hospital for the emergency care of all ventilator dependent residents.

   b) The Division of Medicaid reserves the right to approve Addendums at its discretion based on:

      1) Geographic coverage,

      2) Market saturation, and/or

      3) The ability of the nursing facility to demonstrate compliance with certification requirements.

   c) The approval of the Addendum is dependent upon:

      1) Successful completion of an Addendum and submission of required documents,

      2) Establishment of policies to support the operations of VDC services,

3) Successful completion of an on-site visit by Mississippi Department of Health, Health Facilities Licensure and Certification (HFLC), and

4) The nursing facility's completion of all other required documents applicable to providing VDC services as requested by HFLC or the Division of Medicaid.

d) The Division of Medicaid will close an Addendum for VDC services if the provider fails to submit any requested information or documentation within thirty (30) days of a request by the Division of Medicaid. Once closed, a provider is not eligible to re-apply for three (3) months.

D. The Division of Medicaid reserves the right to terminate a Nursing Facility Provider Agreement, including the Addendum, based on failure to comply with Administrative Code requirements and/or state licensure and federal requirements.

1. Upon receipt of a termination notice, the facility has ten (10) days to submit a transfer plan for each resident which fully addresses their medical, social, and safety support needs in anticipation of and throughout the transfer process.

2. Upon the Division of Medicaid's approval of the transfer plan, all transfers resulting from the termination of the agreement must be completed within thirty (30) days from the date of the termination notice.

3. Providers notified of termination may appeal this decision pursuant to Miss. Admin. Code, Title 23, Part 300.

4. The Division of Medicaid reserves the right to enforce an immediate transfer of ventilator dependent residents if the nursing facility's compliance failure is so egregious in nature that the resident(s) safety is threatened.

5. Once terminated, the provider may not reapply to provide VDC services for one (1) year from the date of termination.

E. Nursing facilities providing services to ventilator dependent residents must:

1. Meet all federal and state regulations governing nursing facilities.

2. Provide residents in need of VDC services with the following licensed staff which cannot be included as part of the HFLC nursing facility state minimum staffing requirements:

a) One (1) Registered Nurse (RN) assigned the primary responsibility for the VDC services and ventilator dependent residents twenty-four (24) hours a day seven (7) days a week in addition to:

1) One (1) RN for every ten (10) ventilator dependent residents (1:10),

2) One (1) RN and one (1) Licensed Practical Nurse (LPN) for every eleven (11) to fourteen (14) ventilator dependent residents, and

3) Two (2) RNs for every fifteen (15) to twenty (20) ventilator dependent residents.

b) One (1) in-house licensed respiratory therapist (RT) twenty-four (24) hours a day seven (7) days a week with a ratio of one (1) RT for every ten (10) ventilator dependent residents (1:10).

3. Must maintain separate staffing records for the nursing staff and respiratory staff responsible for the ventilator dependent residents.

4. Ensure physician visits are conducted in accordance with the federal and state regulations for nursing facilities.

5. Must provide adequate equipment and supplies for the provision of VDC services including, but not limited to,

   a) Primary ventilators,

   b) Back up ventilators,

   c) Emergency batteries,

   d) Oxygen tanks,

   e) Suction machines,

   f) Nebulizers,

   g) Manual resuscitator,

   h) Pulse oximetry monitoring equipment,

   i) Nutrient infusion pumps, and

   j) Any medically necessary durable medical equipment (DME) and supplies.

6. Must have an audible, redundant external alarm system located outside the resident's room to alert of ventilator failure.

7. Must have written policies and procedures for ventilator dependent residents including, but not limited to:

   a) Ventilator monitoring expectations,

b) Routine maintenance of ventilator equipment,

c) Specific staff training related to ventilator care and operation,

d) Staffing requirements,

e) Infection control program for:

1) Ventilator dependent residents, to include:

(a) Actions to investigate, control, and prevent infections,

(b) Isolation procedures,

(c) Standard precautions,

2) Maintenance and care requirements of equipment and disposal of supplies.

8. Place individuals admitted with any contagious diagnoses related to a respiratory illness in isolation according to the Centers for Disease Control (CDC) and requirements under 42 CFR § 483.65.

9. Provide staff education and in-service training to direct and indirect care staff.

a) Required training must be completed prior to the provision of care, including infection control procedures and addressing the needs of a ventilator dependent resident.

b) Required training must be conducted annually to all staff provided by a:

1) Licensed RT, or

2) A Board Certified Pulmonologist.

c) Additional training of nursing staff is required to be conducted by a full-time RN who has completed documented training in the care of ventilator dependent individuals by a Respiratory Therapist or a Board Certified Pulmonologist. This RN will be responsible for:

1) Quarterly and on-going training to all VDC nursing staff as evidenced by documentation.

2) Providing initial in-service training for ten (10) work days to all direct care and indirect care staff assuring they are competent to care for VDC residents.

10. Ensure the nursing facility's Emergency Plan includes:

a) Provisions for continuous operation of ventilator equipment during power outages and/or ventilator equipment failure, and

b) A revised Emergency Operations Plan approved by the MSDH Office of Emergency Planning and Response which includes the VDC services.

11. Execute a written agreement with a local acute care hospital:

a) Located within twenty (20) miles or thirty (30) minutes of an Emergency Department with the capability to treat emergencies for beneficiaries with ventilator dependency.

b) With provisions for twenty-four (24) hour access to VDC services.

c) Documenting a formal relationship between the nursing facility and a local acute care hospital that confirms the ability and willingness of the hospital to serve the acute care needs of residents requiring mechanical ventilation:

1) On an as-needed basis, and

2) In emergency situations when the entire VDC population of the unit/ventilator dependent residents must be temporarily transferred to the hospital.

3) The agreement should outline transfer logistics and financial responsibilities.

F. Residents in a nursing facility receiving VDC services must:

1. Have long term ventilator dependency greater than six (6) hours per day, for more than twenty-one (21) consecutive days prior to admission as a VDC resident.

2. Be dependent on mechanical ventilation via a tracheostomy for at least fifty percent (50%) of each day or continuous mechanical ventilation via a tracheostomy for at least six (6) hours each day while in need of VDC services except during the weaning process.

3. Require daily respiratory intervention, including, but not limited to, oxygen therapy, chest physiotherapy or deep suctioning.

4. Be medically stable and not require acute care services prior to the transfer to the nursing facility.

5. Be prior authorized by the Division of Medicaid or the Utilization Management/Quality Improvement Organization (UM/QIO) for admission and recertified as required by the Division of Medicaid or UM/QIO to determine if the resident's medical condition warrants VDC services.

a) The nursing facility must provide documentation of continued medical necessity and weaning attempts to the Division of Medicaid or UM/QIO.

b) The resident is considered appropriate for VDC services until the weaning process is completed.

G. The Division of Medicaid does not cover admissions as a VDC resident for those who only require CPAP or BiPAP.

H. The Division of Medicaid approves out-of-state nursing facility placements for ventilator dependent beneficiaries when all the following are met:

1. The nursing facility is a Mississippi Medicaid Provider,

2. All efforts for in-state placement are exhausted,

3. The transferring facility provides documentation of denial statements from Mississippi nursing facilities unable to care for the beneficiary or there are no nursing facilities beds available in Mississippi to treat VDC residents.

4. The needs of the ventilator dependent beneficiary cannot be met in the state of Mississippi.

5. The Division of Medicaid must prior authorize for medical necessity and approval must be obtained from the Executive Director,

6. The beneficiary is:

a) Mississippi Medicaid eligible.

b) Eligible for long-term care placement.

c) Ventilator dependent and meets all the following requirements:

1) The Division of Medicaid does not cover admission or recertification as a VDC resident for those who only require CPAP or BiPAP.

2) Medically stable and not require acute care services prior to the transfer to the nursing facility.

3) Has long-term ventilator dependency greater than six (6) hours per day, for more than twenty-one (21) consecutive days prior to admission as a VDC resident.

4) Requires daily respiratory intervention, including, but not limited to, oxygen therapy, chest physiotherapy or deep suctioning.

5) Be dependent on mechanical ventilation via a tracheostomy of at least fifty percent (50%) of each day or continuous mechanical ventilation via a

tracheostomy for at least six (6) hours each day while in need of VDC services except during the weaning process.

6) Be prior authorized by the Division of Medicaid for admission and recertified as required by the Division of Medicaid to determine if the resident's medical condition warrants VDC services.

(a) The nursing facility must provide documentation of continued medical necessity and weaning attempts to the Division of Medicaid.

(b) The resident is considered appropriate for VDC services until the weaning process is completed.

7. Completion of an admission assessment as required by federal and state regulations and/or the Division of Medicaid.

I. Beneficiaries admitted to an out-of-state nursing facility receiving reimbursement from Medicare must obtain approval from the Division of Medicaid prior to receiving Medicaid reimbursement.

J. The Division of Medicaid reimburses out-of-state nursing facilities utilizing Mississippi's Case Mix payment rate system.

1. The approved out-of-state facility must:

a) Provide an initial and quarterly Minimum Data Set (MDS) assessment for review,

b) Provide a desk audit to determine the category classification using the current calculation for reimbursement, and

c) Complete all required Omnibus Budget Reconciliation Act (OBRA) MDS assessments.

2. VDC reimbursement is discontinued to the nursing facility once the resident is successfully weaned from mechanical ventilation.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.

History: Revised to correspond with SPA 15-004 (eff. 01/01/2015) eff. 01/02/2015.

Rule 2.16: Therapy Services

A. All nursing facilities are required to provide rehabilitation services for residents. Requirements include physical, occupational and speech-language pathology therapies. Medicaid, consistent with third party liability rules, is obligated to cover these services.

B. Prior authorization/pre-certification of certain physical, occupation, and speech-language pathology services is required by the Division of Medicaid. Therapy providers must prior authorize services through the Utilization Management and Quality Improvement Organization (UM/QIO) for Medicaid. Failure to obtain prior authorization will result in denial of payment to billing providers.

C. The UM/QIO will determine medical necessity, the types of therapy services, and the number of visits/treatments reasonably necessary to treat the beneficiary's condition. A complete list of procedure codes that require prior authorization may be obtained through the UM/QIO. All procedures and criteria set forth by the UM/QIO are applicable and are approved by Medicaid.

D. Providers must also adhere to all Medicaid outpatient therapy rules.

E. Nursing Facility for the Severely Disabled - Miss. Admin. Code Part 207, Rule 2.16 is not applicable to a Nursing Facility for the Severely Disabled (NFSD). Therapy services for this provider type are inclusive in the per diem rate and cannot be billed separately.

F. Medicaid-Only Residents - Therapy services for Medicaid-only residents may be provided by state-licensed therapists who have a current Medicaid provider number. Nursing facilities may apply for a group therapy provider number for billing purposes.

G. Dually Eligible Residents - Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid dual eligibles. Therapists providing services to dually eligible beneficiaries must bill Medicare as the primary coverage. All therapy providers must meet state and federal requirements.

Source: Miss. Code Ann. § 43-13-121, SPA 15-004.

Rule 2.17: Feeding Assistant Program

A. Feeding Assistant Reimbursement

1. The Division of Medicaid uses the direct reimbursement method for feeding assistant training expenses incurred by nursing facilities. Reasonable costs of training of feeding assistants in order to meet the requirements necessary for the feeding assistant to be certified and are to be billed directly to Medicaid. The nursing facility will be directly reimbursed by Medicaid for covered services and items as defined on the agency website. In order to receive Medicaid reimbursement, the training program must have approval from the Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification.

2. Services and supplies approved for payment will be subject to application of the nursing facility's percentage of Medicaid utilization. The Medicaid utilization percentages of

every facility are redetermined annually and are applicable for one (1) state fiscal year. The percentages are taken from the most recent cost report at the time of redetermination. Nursing facilities and training centers are notified in writing of their Medicaid utilization percent. In cases where no cost report data is available, eighty (80) percent will be applied to approved billings until such time that the correct Medicaid utilization percent can be determined. Training centers' Medicaid utilization percentage will be redetermined annually and will be calculated based on the weighted average of Medicaid utilization percentages of associated facilities weighted by bed size.

3. The Division of Medicaid will reimburse the nursing facilities or related training centers for the minimum required services and supplies. A facility or training center will be reimbursed for no more than four (4) training sessions per year. No costs actually incurred by the facility or the training center will be considered for reimbursement, like for electricity, gas, or water. No reimbursements will be made for estimated cost. The cost of manuals approved for use by MSDH will be reimbursed.

4. Training programs refer to the training area set up within a nursing facility or training center. Training programs include, but are not limited to, training areas set up by a nursing facility in a remote location due to space restrictions and training centers where an area has been set up for training that serves more than one (1) facility and is located in an area remote from any of the associated facilities.

5. No reimbursement is available for training costs incurred by individuals or for tuition to outside entities.

A. Billing rules requirements for billing of training can be found on the agency website.

C. Withdrawal of Program Approval

1. The Mississippi State Department of Health (MSDH) will withdraw approval of a program if it is determined that any of the minimum requirements are not met by the program.

2. Upon withdrawal of approval, MSDH will notify the entity in writing and will explain the reason(s) for the withdrawal of the approval. Students who have started a program from which approval has been withdrawn must be allowed to complete the course.

3. MSDH will notify Medicaid in writing when program approval is withdrawn. As a result, reimbursement will be stopped as of the date of withdrawal of program approval. However, Medicaid will reimburse the allowable costs incurred to complete a training session which is in progress on the date of withdrawal of program approval.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §483.158; 42 CFR § 483.160

Rule 2.18: Individualized, Resident Specific Custom Manual and/or Custom Motorized/Power Wheelchairs Uniquely Constructed or Substantially Modified for a Specific Resident

A. The Division of Medicaid defines a wheelchair as a seating system that is designed to increase the mobility of residents who would otherwise be restricted by inability to ambulate or transfer from one place to another.

B. The Division of Medicaid defines an individualized, resident specific custom manual and/or custom motorized/power wheelchair as one that has been uniquely constructed or substantially modified for a specific resident referred to in this Rule as "custom manual wheelchair" and/or "custom motorized/power wheelchair".

C. The Division of Medicaid does not classify the following wheelchairs as custom manual and/or custom motorized/power wheelchairs:

   1. Standard manual wheelchairs,

   2. Standard manual wheelchairs with added accessories,

   3. Standard motorized/power wheelchairs, and/or

   4. Standard motorized/power wheelchairs with added accessories.

D. The Division of Medicaid covers custom manual and/or custom motorized/power wheelchairs and accessories for rental up to the purchase price or purchase when:

   1. Medically necessary with comprehensive documentation that a standard wheelchair cannot meet the resident's needs and the resident requires the custom manual and/or custom motorized/power wheelchair for six (6) months or longer,

   2. Ordered by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist,

   3. Not primarily used as a restraint, and

   4. Prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO).

E. The Division of Medicaid requires the following documentation for a custom manual and/or custom motorized/power wheelchair.

   1. A face-to-face evaluation by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist who is prescribing the custom manual and/or custom motorized/power wheelchair which includes, but is not limited to:

      a) The reason for the evaluation visit was a mobility examination.

b) If the resident currently possesses a custom manual and/or custom motorized/power wheelchair not previously purchased by the Medicaid program.

c) A certificate of medical necessity with comprehensive documentation that describes the medical reason(s) why a custom manual and/or custom motorized/power wheelchair is medically necessary such that no other type of wheelchair can meet the needs of the resident including, but not limited to:

1) The diagnosis/co-morbidities and conditions relating to the need for a custom manual and/or custom motorized/power wheelchair.

2) Description and history of limitation/functional deficits.

3) Description of physical and cognitive abilities to utilize equipment.

4) History of previous interventions/past use of mobility devices.

5) Description of existing equipment, age of equipment, and specifically why it is not meeting the resident's needs.

6) Explanation as to why a less costly mobility device is unable to meet the resident's needs.

7) Description of the resident's ability to safely tolerate/utilize the prescribed custom manual and/or custom motorized/power wheelchair.

8) The type of custom wheelchair and each individual attachment and/or accessory required by the resident.

2. An initial evaluation by a physical therapist (PT) or occupational therapist (OT), not employed by the Durable Medical Equipment (DME) provider or the manufacturer, within three (3) months of the date of the written prescription to determine the individualized needs of the resident which includes whether the resident currently possesses a custom manual and/or custom motorized/power wheelchair, not previously purchased by the Medicaid program.

3. An agreement by both the prescribing physician and the PT or OT performing the initial evaluation that the individualized equipment being ordered is appropriate to meet the needs of the resident.

4. A subsequent evaluation after the delivery of the custom manual and/or custom motorized/power wheelchair by a PT or OT, not employed by the DME provider or the manufacturer, to determine if the custom manual and/or custom motorized/power wheelchair is appropriate for the resident's needs. The DME provider cannot bill the Division of Medicaid until the PT/OT documentation verifies on the subsequent

evaluation that the custom manual and/or custom motorized/power wheelchair is appropriate for the resident's needs.

5. The PT/OT initial and subsequent evaluations must include the appropriate seating accommodation for the resident's height and weight, specifically addressing anticipated growth and weight gain or loss.

F. The Division of Medicaid covers a custom motorized/power wheelchair only when a custom manual wheelchair cannot meet the needs of the resident and the resident must:

1. Be bed/chair confined with documented severe abnormal upper extremity dysfunction or weakness,

2. Expect to have physical improvements or the reduction of the possibility of further physical deterioration from the use of a custom motorized/power wheelchair,

3. Be for the necessary treatment of a medical condition,

4. Have a poor prognosis for being able to self-propel a functional distance,

5. Not exceed the weight capacity of the custom motorized/power wheelchair prescribed,

6. Have sufficient eye and/or hand perceptual capabilities to operate the custom motorized/power wheelchair safely,

7. Have sufficient cognitive skills to understand directions, such as left, right, front, and back, and be able to maneuver the motorized/power wheelchair in these directions independently,

8. Be independently able to move away from potentially dangerous or harmful situations when seated in the custom motorized/power wheelchair,

9. Demonstrate the ability to start, stop, and guide the custom motorized/power wheelchair within a reasonably confined area,

10. Be in an environment conducive to the use of the custom motorized/power wheelchair.

a) The environment must have sufficient floor surfaces and sufficient door, hallway, and room dimensions for the custom motorized/power wheelchair to turn and enter and exit, as well as necessary ramps to enter and exit the nursing facility.

b) The environmental evaluation must be documented and signed by the resident/caregiver and DME provider for the custom motorized/power wheelchair.

G. The Division of Medicaid covers a customized electronic interphase device, specialty and/or alternative controls if the resident is unable to manage a custom motorized/power wheelchair

without the assistance of said device. The Division of Medicaid requires documentation of an extensive evaluation of each customized feature required for physical status and specification of the medical benefit of each customized feature.

1. For a joystick, the resident must demonstrate safe operation of the custom motorized/power wheelchair with an extremity, such as the hand or foot, using a joystick hand or foot operated device. The resident can manipulate the joystick with fingers, hand, arm, or foot.

2. For a chin control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the chin control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their chin and safely operate the chair in all circumstances.

3. For a head control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the head control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their head freely with control of their head and can safely operate the chair in all circumstances.

4. For an extremity control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the extremity control device. The resident must have a medical condition which prevents or limits fine motor skills during the use of their extremities but is able to move their hands/arms/legs to safely operate the chair in all circumstances.

5. For a sip and puff feature, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the sip and puff control. The resident cannot move their body at all and cannot operate any other driver except this one.

H. Custom manual and custom motorized/power wheelchairs are limited to one (1) per resident every five (5) years based on medical necessity. Reimbursement:

1. Is made for only one (1) custom manual and custom motorized/power wheelchair at a time.

2. Includes all labor charges involved in the assembly of the wheelchair and all covered additions, accessories and modifications.

3. Includes support services such as emergency services, delivery, setup, education and ongoing assistance with use of the wheelchair.

4. Is made only after the PT or OT subsequent evaluation is completed.

I. The DME providers must ensure the prescribed custom manual and/or custom motorized/power wheelchair and accessories are adequate to meet the resident's needs, must

ensure the proper height and width, and must provide an automatic or special locking mechanism for residents unable to apply manual brakes.

J. The DME provider providing custom motorized/power wheelchairs to residents must:

1. Have at least one (1) employee with Assistive Technology Professional (ATP) certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) who specializes in wheelchairs and who must be registered with the National Registry of Rehab Technology Suppliers (NRRTS).

   a) The NRRTS and RESNA certified personnel must have direct, in-person, face-to-face interaction and involvement in the custom motorized/power wheelchair selection for the resident.

   b) RESNA certifications must be updated every two (2) years.

   c) NRRTS certifications must be updated annually.

   d) If the certifications are found not to be current, the prior authorization request for the motorized/power wheelchair will be denied.

2. Provide a lifetime warranty on the powered mobility base frame against defects in material and workmanship for the lifetime of the resident.

3. Provide a two (2) year warranty of the major components, beginning on the date of delivery to the resident.

   a) The main electronic controller, motors, gear boxes and remote joystick must have a two (2) year warranty from the date of delivery.

   b) Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects or if the surface does not remain intact due to normal wear.

4. If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the DME provider is responsible for any repairs, replacement or maintenance that may be required within the two (2) years.

K. DME providers providing custom motorized/power wheelchairs, customized electronic interphase devices, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, with a technician available during normal business hours, between eight (8:00) a.m. and five (5:00) p.m. Monday through Friday. Each technician must keep on file records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.

L. The Division of Medicaid covers repairs, including labor and delivery, of a custom manual and/or custom motorized/power wheelchair owned by the resident not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.

1. The nursing facility is responsible for the repairs, including labor and delivery, of custom manual and/or custom motorized/power wheelchairs delivered to the resident prior to January 2, 2015.

2. Major repairs and/or replacement of parts require prior authorization from the UM/QIO and must include an estimated cost of the necessary repairs, including labor, and documentation from the practitioner that there is a continued need for the custom manual and/or custom motorized/power wheelchair.

3. An explanation of time involved for repairs and/or replacement of parts must be submitted to the UM/QIO.

4. Manufacturer time guides must be followed for repairs and/or replacement of parts.

5. The Division of Medicaid defines repair time as point of service and does not include travel time to point of service.

6. No payment is made for repairs or replacement if it is determined that intentional abuse, or misuse, of the wheelchair or components has occurred, which includes damage incurred due to inappropriate covered transportation for the prescribed custom manual and/or custom motorized/power wheelchair.

7. Reimbursement will be made for up to one (1) month for a rental of a wheelchair while the resident's wheelchair is being repaired.

8. The Division of Medicaid does not cover the repair of a rented custom manual and/or custom motorized/power wheelchair.

Source: Social Security Act § 1834; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: New eff. 01/02/2015.

Part 207 Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Rule 3.1: General

A. The Division of Medicaid may not execute a provider agreement with a facility for services unless the State survey agency or the Centers for Medicare and Medicaid Services (CMS) has certified the facility as having met all of the participation requirements. The Mississippi State Department of Health, Division of Health Facilities Licensure and Certification pursuant to federal law and regulation, certifies facilities for participation in the Medicaid program.

B. Medicaid payments may not be made to any ICF/MR prior to the date of certification and execution of a valid Medicaid provider agreement.

C. If the Division of Medicaid has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement, with a certified facility. A provider agreement is not valid, even though certified by the State survey agency, if the facility fails to meet civil rights requirements.

Source: Sections 1919 (a), (b), (c), and (d) of the Act; 42 CFR § 447.15; 42 CFR. § 431.10; Miss. Code Ann. § 43-13-107; § 43-13-121; § 43-13-103; 42 CFR § 442.12; § 483.1; § 442.10; Miss. Code Ann. § 43-11-1; 42 CFR § 442.12; 45 CFR Parts 80, 84 and 90.

Rule 3.2: Provider Enrollment/Provider Agreement

A. The duration of an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Medicaid provider agreement is for the same period of time as an ICF/IID's certification or recertification for participation by the Mississippi State Department of Health (MSDH).

B. The certification or recertification for an ICF/IID remains in effect until it is determined that the ICF/IID is no longer in compliance with the Conditions of Participation as determined by MSDH and/or the Centers for Medicare and Medicaid Services(CMS).

1. ICF/IIDs must be surveyed by MSDH licensure and certification:

   a) No later than fifteen (15) months after the last day of the previous survey to determine compliance with the Conditions of Participation, and

   b) At a state-wide average interval of twelve (12) months or less which is computed at the end of each federal fiscal year by comparing the last day of the most recent survey for each participating facility to the last day of each facility's previous survey.

2. ICF/IIDs in compliance with the Conditions of Participation with standard level deficiencies, defined as when there is noncompliance with any single requirement or several requirements within a particular standard that are not of such character as to substantially limit a facility's capacity to furnish adequate care, or which would not jeopardize or adversely affect the health or safety of beneficiaries if the deficient practice recurred, may be conditionally certified with the understanding that certification will continue if either of the following applies:

   a) All deficiencies have been satisfactorily corrected, or

   b) The ICF/IID has made substantial progress in correcting the deficiencies and has a new plan of correction that is acceptable.

C. The Division of Medicaid may deny payment for new admissions to an ICF/IID that no longer meets the applicable Conditions of Participation as determined by MSDH and/or CMS.

1. The Division of Medicaid will:

   a) Provide the facility up to sixty (60) days to come into compliance with the Conditions of Participation, and

   b) Notify the facility of the intent to deny payment for new admissions and an opportunity for an informal hearing.

2. The Division of Medicaid will provide an informal hearing upon written request which includes:

   a) The opportunity to present to a Division of Medicaid official not involved in making the initial determination, evidence or documentation, in writing or in person, to refute the decision that the facility is out of compliance with the Conditions of Participation, and

   b) A written decision stating the facts and legal basis governing the resolution of the dispute.

3. If the decision of the informal hearing is to deny payment for new admissions the Division of Medicaid will inform the facility and the public at least fifteen (15) days before the effective date of the sanction with a notice that includes the:

   a) Effective date of the denial of payments, and

   b) Reasons for the denial of payments.

D. The denial of payments for new admissions will continue for eleven (11) months after the month it was imposed unless, before the end of that period:

1. The ICF/IID has come into compliance or is making a good faith effort to achieve compliance with the Conditions of Participation and the deficiencies do not present an immediate jeopardy to residents' safety and health, or

2. The non-compliance is such that it presents an immediate jeopardy to residents' safety and health and it is necessary to terminate the facility's provider agreement.

E. The Division of Medicaid must terminate an ICF/IID's provider agreement if an ICF/IID has been unable to achieve compliance with the Conditions of Participation during the period that payments for new admissions have been denied with the termination effective the day following the last day of the denial of payments.

F. When a provider agreement is terminated, the Division of Medicaid may continue to make payments for up to thirty (30) days to provide time for an orderly transfer of residents, whose primary source of payment is Medicaid, as specified in federal law. The ICF/IID must notify every resident, whose primary source of payment is Medicaid, and/or guardian or legal representative in writing within forty-eight (48) hours of receipt by the facility of the termination letter.

G. An ICF/IID may request an evidentiary hearing in writing within sixty (60) days of the receipt of the notice of a denial of payments or notice of termination or nonrenewal of its provider agreement.

1. The evidentiary hearing must be completed either before the effective date of the adverse action or within one hundred twenty (120) days after said date, and

2. If the hearing is made available only after the effective date of the action, the Division of Medicaid will, before that date, offer the ICF/IID an informal reconsideration that meets the following requirements:

a) Written notice to the facility of the denial, termination or nonrenewal and the findings upon which it was based,

b) A reasonable opportunity for the facility to refute those findings in writing, and

c) A written affirmation or reversal of the denial, termination, or nonrenewal.

Source: 42 CFR §§ 431.108, 431.153, 431.154, 442.15, 442.109, 442.110, 442.117, 442.118, 442.119; Miss. Code Ann. § 43-13-121.

History: Revised eff. 12/01/2015.

Rule 3.3: Admission Review

A. The Department of Mental Health is the agency responsible for conducting reviews for admission to an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

B. Under federal regulations, the Mississippi Department of Health, Division of Health Facilities Licensure and Certification, is responsible for the following review activities:

1. Certification and recertification of need for inpatient care,

2. Individual program plan, and

3. Utilization review plan.

C. An ICF/MR Pre-Admission Team Report and Request for Medicaid Certification for ICF/MR Care must be completed no more than thirty (30) days prior to the admission of the

beneficiary to an ICF/MR and submitted with a copy of the current physical examination, medical and social history, and the preliminary evaluation.

D. A physician must certify for each applicant or beneficiary that ICF/MR services are or were needed at the time of admission. Re-Certification must be made at least every twelve (12) months after certification.

E. The Interdisciplinary team must prepare for each client, within thirty (30) days after admission, an individual program plan that states the specific objective necessary to meet the beneficiary's needs. At least annually, the comprehensive functional assessment of each beneficiary must be reviewed by the interdisciplinary team for relevancy and must be updated and revised as needed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 456.360; 42 CFR § 456.380; 42 CFR § 456.400; 42 CFR § 456.350 - 456.381; 42 CFR; 42 CFR § 456.431; 42 CFR § 456.370

Rule 3.4: Per Diem

A. The Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) must provide for all items and services required to meet the needs of a resident according to the comprehensive functional assessment and the individual program plan.

B. Items and services covered by Medicare or any other third party must be billed to Medicare or the other third party and are considered non-allowable on the cost report. Applicable crossover claims must also be filed with the Division of Medicaid.

C. The following items and services are included in the Medicaid per diem rates and cannot be billed separately to the Division of Medicaid or charged to a resident:

1. Room/bed maintenance services.

2. Nursing services.

3. Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services.

4. Dietary services, including nutritional supplements.

5. Activity services.

6. Medically-related social services.

7. Routine personal hygiene items and services.

8. Laundry services including the residents' personal laundry.

9. Over-the-counter (OTC) drugs.

10. Legend drugs not covered by the Medicaid program, Medicare, private, Veteran's Administration (VA) or any other payor source.

11. Medical supplies including, but not limited to, those listed below. The Division of Medicaid defines medical supplies as medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a resident to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease and appropriate for use in the ICF/IID. [Refer to Miss. Admin. Code Part 207, Rule 3.4.D. for medical supplies which must be billed outside the per diem rate.]

    a) Enteral supplies,

    b) Diabetic supplies,

    c) Diapers and blue pads, and

    d) Oxygen administration supplies.

12. Durable medical equipment (DME), except for DME listed in Miss. Admin. Code Part 207, Rule 3.4.D. The Division of Medicaid defines DME as an item that (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) is generally not useful to a resident in the absence of illness, injury or congenital defect, and (4) is appropriate for use in the ICF/IID. [Refer to Miss. Admin. Code Part 207, Rule 3.4.D. for DME which must be billed outside the per diem rate.]

13. Routine personal hygiene items and services as required to meet the needs of the residents including, but not limited to:

    a) Hair hygiene supplies,

    b) Comb and brush,

    c) Bath soap,

    d) Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection,

    e) Razor and shaving cream,

    f) Toothbrush and toothpaste,

    g) Denture adhesive and denture cleaner,

h) Dental floss,

i) Moisturizing lotion,

j) Tissues, cotton balls, and cotton swabs,

k) Deodorant,

l) Incontinence care and supplies,

m) Sanitary napkins and related supplies,

n) Towels and washcloths,

o) Hair and nail hygiene services, including shampoos, trims and simple haircuts as part of routine grooming care, and

p) Bathing.

14. Private room coverage as medically necessary.

a) The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room if medically necessary and ordered by a physician. The Medicaid reimbursement for a medically necessary private room is considered payment in full for the private room. The resident, the resident's family or the Division of Medicaid cannot be charged for the difference between a private and semi-private room if medically necessary.

b) The resident may be charged the difference between the private room rate and the semi-private room rate when it is the choice of the resident or family if the provider informs the resident in writing of the amount of the charge at the time of admission or when the resident becomes eligible for Medicaid.

D. The following items and services are not included in the Medicaid per diem rates, are considered non-allowable costs on the ICF/IID's cost report and must be billed directly to the Division of Medicaid by a separate provider with a separate provider number from that of the ICF/IID:

1. Laboratory services,

2. X-ray services,

3. Drugs covered by the Medicaid drug program,

4. Ostomy supplies,

5. Continuous Positive Airway Pressure (CPAP) Devices effective January 2, 2015,

6. Bi-level Positive Airway Pressure (BiPAP) Devices effective January 2, 2015, and/or

7. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident when prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or a designated entity effective January 2, 2015. [Refer to Miss. Admin. Code Part 207, Rule 3.10 for definition and coverage criteria]

E. All ICF/IID's must prominently display the below information in the ICF/IID, and provide to applicants for admission and residents the below information in both oral and written form:

1. How to apply for and use Medicare and Medicaid benefits, and

2. How to receive refunds for previous payments covered by such benefits.

F. The ICF/IID must:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the ICF/IID or when the resident becomes eligible for Medicaid of:

   a) The items and services that are included in the ICF/IID services under the State Plan and for which the resident may not be charged, and

   b) Those other items and services that the ICF/IID offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in Miss. Admin. Code Part 207, Rule 3.4.F.1.

3. Inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

4. Notify the resident and the resident's guardian or legal representative of a transfer or discharge in an easily understood written notice.

   a) The notice of transfer or discharge must be given at least thirty (30) calendar days prior to the transfer or discharge unless:

      1) The safety or health of the individuals in the facility would be endangered,

      2) The resident no longer requires the level of care provided by the facility,

3) An immediate transfer or discharge is required by the resident's urgent medical needs, or

4) The resident has not resided in the facility for thirty (30) calendar days.

b) The notice must include the following information:

1) The reason for the transfer or discharge,

2) The effective date of the transfer or discharge,

3) The location to which the resident is being transferred or discharged,

4) A statement that the resident has the right to appeal the action to the appropriate state authorities,

5) The name, address and telephone number of the State long-term care ombudsman,

6) For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals, and

7) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.

5. Maintain physician documentation in the medical record of transfers or discharges and the reasons for the transfer or discharge.

6. Provide sufficient preparation and orientation to residents to ensure safe and orderly transfers or discharges.

G. The ICF/IID may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for items and services, consistent with the notice stated in Miss. Admin. Code Part 207, Rule 3.4.F.

1. The ICF/IID's non-Medicaid per diem rate may be set above the Medicaid per diem rate, but the items and services included in the non-Medicaid rate must be identical to the items and services included in the Medicaid per diem rate.

2. Items and services available in the ICF/IID not covered under Title XVIII or the ICF/IID's Medicaid per diem rate must be available and priced identically for all residents in the facility.

H. An ICF/IID cannot require a deposit before admitting a card-carrying Medicaid beneficiary.

I. Refer to Miss. Admin. Code Part 224, Rule 1.4 for coverage of immunizations.

Source: 42 C.F.R. § 483.12; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Removed Miss. Admin. Code Part 207, Rule 3.4.D.5 (retroactively eff. 01/02/2015) eff. 11/01/2016; Added Miss. Admin. Code Part 207, Rule 3.4.F.4.-6., eff. 04/01/2016. Revised eff. 01/02/2015.

Rule 3.5: Reimbursement

A. Participating Mississippi facilities must prepare and submit a Medicaid cost report for reimbursement of long term care facilities.

   1. All cost reports are due by the end of the fifth (5th) calendar month following the reporting period.

   2. Failure to file a cost report by the due date or the extended due date will result in a penalty of fifty dollars ($50.00) per day and may result in the termination of the provider agreement.

B. The Division of Medicaid uses a prospective method of reimbursement.

   1. The rates are determined from cost report data.

   2. Standard rates are determined annually with an effective date of January first (1st).

   3. In no case may the reimbursement rate for services provided exceed an individual facility's customary charges to the general public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.

   4. Prospective rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

   5. Prospective rates may be adjusted by the Division of Medicaid based on revisions to allowable costs or to correct errors.

      a) These revisions may result from amended cost reports, field visit reviews, or other corrections.

      b) Facilities are notified in writing of amounts due to or from the Division of Medicaid as a result of these adjustments.

      c) There is no time limit for requesting settlement of these amounts. This is applicable to claims for dates of service since July 1, 1993.

C. The Division of Medicaid conducts periodic field level cost report financial reviews of

selected long term care facilities, including nursing facilities, intermediate care facilities for the mentally retarded, and psychiatric residential treatment facilities, to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. Adjustments will be made as necessary to the reviewed cost reports based on the results of the reviews.

D. Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program to keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

1. Providers must maintain adequate documentation including, but not limited to, financial records and statistical data, for proper determination of costs payable under the Medicaid program.

   a) The cost report must be based on the documentation maintained by the facility.

   b) All non-governmental facilities must file cost reports based on the accrual method of accounting.

   c) Governmental facilities have the option to use the cash basis of accounting for reporting.

2. Documentation of financial and statistical data should be maintained in a consistent manner from one period to another and must be current, accurate and in sufficient detail to support costs contained in the cost report.

3. Providers must make available to the Division of Medicaid all documentation that substantiates the information included in the facility cost report for the purpose of determining compliance.

   d) These records must be made available as requested by the Division of Medicaid.

   e) All documentation which substantiates the information included in the cost report, including any documentation relating to home office and/or management company costs must be made available to Division of Medicaid reviewers as requested by the Division.

Source: Miss. Code Ann. § 43-13-121, 42 CFR § 447 Subparts B & C, Miss. Code Ann. § 43-13-117

Rule 3.6: Temporary Leave Payment

A. A temporary absence of a resident from an ICF/MR will not interrupt the monthly payments to the facility.

   1. The Division of Medicaid defines the period of leave by counting the day the resident left the facility as the first day of leave. The Division of Medicaid defines an absence from the facility for eight (8) to twenty-four (24) hours a leave day.

   2. The facility must reserve the resident's bed in anticipation of the resident's return.

      a) The bed may not be filled with another resident during the covered period of leave.

      b) Leave days may not be billed if the facility refuses to readmit the resident under their resident return policy.

   3. A refund of payment will be demanded for all leave days taken in excess of the allowable or authorized number of days.

B. The Division of Medicaid pays for the day of admission to a facility.

C. The day of discharge is not paid by the Division of Medicaid unless it is the same day as the date of admission. Facilities cannot bill the resident or responsible party for the day of discharge.

D. Each facility is required to maintain leave records and indicate periods of hospitalization and therapeutic leave days on billing documents.

E. Before the resident departs on therapeutic or in-patient leave, the facility must provide written information to the resident and/or family member or legal representative explaining leave policies.

   1. This information must define the period of time during which the resident will be permitted to return and resume residence in the facility.

   2. The notice must also state that, if the resident's absence exceeds Medicaid's bed-hold limit, the resident will be readmitted to the facility upon the first availability of a semi-private bed if the resident still requires the services provided by the facility.

F. Residents in an ICF/MR may have absences for home/therapeutic leave from the ICF/MR other than for in-patient hospital leave. Home/therapeutic leave also includes dialysis and other outpatient treatments. Specific requirements applicable to home/therapeutic leave are as follows:

   1. The Division of Medicaid's coverage of home/therapeutic leave days per fiscal year, July 1 to June 30, for ICF/MR facilities is eighty-four (84) days, in addition to Christmas Day, the day before Christmas, the day after Christmas, Thanksgiving Day, the day before Thanksgiving and the day after Thanksgiving.

2. All home/therapeutic leave days must be approved by the attending physician.

3. Fifteen (15) days home/therapeutic leave are allowed each absence. A resident must be discharged from the facility for Medicaid billing if he/she remains on home/therapeutic leave for more than fifteen (15) days.

4. A leave of absence for home/therapeutic leave is broken if the resident returns to the facility for twenty-four (24) hours or longer.

G. The Division of Medicaid allows fifteen (15) days of hospital leave for each hospital stay for ICF/MR residents.

1. There is no maximum number of hospital leave days each year.

2. Hospital leave applies to acute care hospital stays in a licensed hospital, including geri-psychiatric units.

3. The hospital leave rules apply as follows:

a) A resident must be discharged from the facility for Medicaid billing if he/she remains in the hospital for more than fifteen (15) days.

b) When the resident is readmitted to the facility after a hospital stay, readmission certification on a new Medicaid Certification for ICF/MR Care is not necessary if the resident has been continuously institutionalized. A leave of absence for hospitalization is broken only if the resident returns to the facility for twenty-four (24) hours or longer.

c) Facilities may not refuse to readmit a resident from in-patient hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires ICF/MR services.

d) Facilities which bill Medicaid for fifteen (15) days of in-patient hospital leave, discharge the resident, and subsequently refuse to readmit the resident under their resident return policy when a bed is available must repay Medicaid for the fifteen (15) days of hospital leave and are subject to additional remedies for failure to comply with the requirements relating to residents' rights.

e) In-patient hospital leave will not be paid for days in which the resident is placed in a Medicare skilled nursing facility (SNF) or a swing bed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §447.40, Miss. Code Ann. § 43-13-117

Rule 3.7: Resident Funds

A. The facility must, upon written authorization by the resident, accept responsibility for holding, safeguarding and accounting for the resident's personal funds.

   1. The facility may make arrangements with a federally or state insured banking institution to provide these services, but the responsibility for the quality and accuracy of compliance with the requirements of this section remains with the facility.

   2. The facility may not charge the resident for these services, but must include any charges in the facility's basic daily rate.

B. Resident fund accounts are reviewed to ensure the facility's compliance and to assist facilities in developing acceptable systems of accounting for resident funds. Penalties may be assessed on any licensed ICF/MR that fails to maintain an auditable system of accounting for residents' funds or has had repeated instances of noncompliance with federal regulations.

C. The facility must provide each resident and responsible party with a written statement at the time of admission that states the following:

   1. All services provided by the facility, distinguished between the services included in the facility's basic rate and those services not included in the facility's basic rate. The statement must include both the services that may be charged to the resident's personal funds and the amount of such charges.

   2. There is no obligation for the resident to deposit funds with the facility.

   3. The resident has the right to select how personal funds will be handled. The following alternatives must be included:

      a) The resident's right to receive, retain, and manage his/her personal funds or have this done by a legal guardian, if any,

      b) The resident's right to apply to the Social Security Administration to have a representative payee designated for purposes of federal or state benefits to which he/she may be entitled,

      c) The resident's right to designate, in writing, another person to act for the purpose of managing his or her personal funds except when Rule.7, C.2 of this section applies, and

      d) The resident's right to require the facility to hold, safeguard and account for such personal funds under a system established and maintained by the facility requested by the resident.

   4. Any charge for this service is included in the facility's basic rate.

   5. The facility is permitted to accept a resident's funds to hold, safeguard and account for,

only upon written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee.

6. The facility is required to arrange for the management of the resident's personal funds if the resident becomes incapable of managing his/her personal funds and does not have a representative.

7. The facility must maintain a complete copy of its resident trust fund policies and procedures and must make them accessible and available for review.

D. The facility must maintain current, written, individual records of all financial transactions involving the resident's personal funds which have been given for holding, safeguarding, and accounting.

1. The facility must act as fiduciary of the resident's funds and account for these funds in an auditable manner.

2. The facility must use Generally Accepted Accounting Principles (GAAP) when maintaining these records. The Division of Medicaid requires the facility to employ proper bookkeeping techniques by which it can determine upon request all deposits and withdrawals for each resident, how much interest these funds have earned for each resident, and the amount of individual resident funds.

E. Acceptable charges to resident funds include, but are not limited to, the following general categories and examples, if proper authorization and documentation as specified under the heading "Individual Records" of this section, is provided. The facility must notify the resident in advance that there will be a charge for non-Medicaid covered items and services, such as:

1. Personal communication/entertainment items and services, including telephone, television, radio, and computer.

2. Personal comfort items, including tobacco, novelties, and candy.

3. Items and services in excess of those included in the Medicaid per diem rate, such as grooming or cosmetic items which are requested by the resident. The resident must be furnished in advance with an itemized statement of charges for these items and services.

4. Personal clothing.

5. Personal reading material.

6. Gifts purchased on behalf of the resident.

7. Flowers and plants for the resident's room.

8. Entertainment and social events outside the scope of that provided by the facility and included in the Medicaid per diem rate.

9. Private sitters or aides.

10. Private room, provided a private room is not medically necessary, including isolation for infection control.

11. Specially prepared or alternative food requested instead of, or in addition to, the food generally prepared by the facility.

12. Authorized cost-sharing in Medicaid-covered services, including Medicaid Income liability for room and board.

F. Unacceptable charges to resident funds include:

1. Any charge not authorized and documented.

2. Nursing, dietary, activities, room/bed maintenance, and personal hygiene services.

3. Medically necessary items and services reimbursed as part of the Medicaid per diem rate.

a) Any properly made charge for equipment or services, such as geriatric or geri-chairs, wheelchairs, support shoes, gurneys, and counseling services must be supported by a written statement from the resident's physician that documents the item or service was not of medical necessity.

b) Failure to maintain the physician's denial of medical necessity statement may result in the facility's reimbursement of charges to a resident's account.

4. Medical transportation.

a) All transportation for ICF/MR residents, whether emergency or non-emergency, must be arranged by ICF/MR staff.

b) Transportation that does not qualify for benefits through the Ambulance Program must be arranged through a family member, if available. Refer to Part 201, Chapter 1.

c) Transportation may also be arranged using ICF/MR vehicles or by utilizing outside resources. Costs for providing this level of service are to be reported by the ICF/MR on their cost reports and are reimbursed through the facility per diem. The ICF/MR may not bill the resident or family for any means of transportation. For cases requiring transportation other than by ambulance to and from dialysis, the ICF/MR may make referrals to the Non-Emergency Transportation (NET) Program. The NET provider must, in these cases, submit claims to the Division of Medicaid for direct reimbursement. Refer to Part 201, Chapter 2.

d) If a resident is transferred from an ICF/MR to a hospital and remains hospitalized for longer than fifteen (15) days and is discharged from the ICF/MR, transportation for these residents should be arranged by the hospital. If there has not been a final discharge from the ICF/MR and the resident had a hospital stay of less than fifteen (15) days, transportation back to the ICF/MR must be arranged by the ICF/MR staff.

5. Any item or service requiring a waiver of the resident's personal needs allowance, such as for repayment of a debt owed the facility. The personal needs allowance may be used by an ICF/MR for ICF/MR costs only upon the written authorization of the resident or the resident's responsible party and with the understanding by the resident that this action is voluntary and is not a requirement.

6. Loans or collateral for loans to anyone, including the facility, and other residents in the trust fund. A resident's balance must be positive at all times, as a resident with a negative balance is in effect borrowing money from the other residents.

7. Transfers or gifts of money not authorized by the resident including when the resident's responsible party transfers funds without documentation that the funds were used for the benefit of the resident.

8. Any item or service as a condition of admission or continued stay.

G. The facility must provide each resident, or a legal representative of the resident, reasonable access to his/her own financial records.

1. The facility must provide a written statement, at least quarterly, to each resident, responsible party, or legal representative.

2. The quarterly statement must reflect any resident funds which the facility has deposited in an interest bearing or a non-interest bearing account, as well as any resident funds held by the facility in a petty cash account.

H. The facility must keep any funds received from a resident for holding, safeguarding and accounting separate from the facility’s funds and from the funds of any person other than another resident in that facility.

1. The facility may not open any additional accounts within the trust fund account, including donation accounts or miscellaneous accounts.

2. Only funds of the facility’s residents may be maintained as part of the resident trust fund account.

I. The facility must deposit any resident’s personal funds in excess of fifty ($50.00) dollars into an interest-bearing account(s) separate from any of the facility’s operating accounts.

1. The facility must credit all interest earned on such separate account(s) in one of the following ways, at the election of the facility:

   a) Prorated to each resident's account on an actual interest-earned basis; or

   b) Prorated to each resident's account on the basis of its end-of-quarter balance.

2. The facility must maintain a resident's personal funds that do not exceed fifty dollars ($50.00) in a non-interest bearing account, an interest bearing account or a petty cash fund. However, if the facility maintains a resident's personal funds of fifty dollars ($50.00) or less in a pooled account with all other resident's funds, and interest is accumulated based on the total amount of funds in the trust fund account, all residents must be allocated interest proportionately. The facility must neither limit nor restrict any resident with funds on deposit within the resident trust fund account to a maximum of fifty dollars ($50.00). A facility must not establish policy that conflicts with the absolute right of residents for the facility to hold, safeguard, manage, and account for all residents' funds deposited with the facility.

J. The residents must have access to funds daily during normal business hours and for some reasonable time of at least two (2) hours on Saturday and Sunday. The facility must, upon request or upon the resident's transfer or discharge, during normal business hours, return to the resident, the legal guardian or the representative payee all funds remaining that the facility has received for holding, safeguarding, and accounting in a petty cash fund.

K. For a resident's personal funds that the facility has received and are deposited in an account outside the facility, the facility, upon request, must within five (5) business days return to the resident, the legal guardian, or the representative payee, any or all of those funds.

L. Upon sale of the facility or other transfer of ownership, the facility must provide the new owner with a written account, prepared by a Certified Public Accountant in accordance with the American Institute of Certified Public Accountants' Generally Accepted Accounting Principles, of all resident funds being transferred and obtain a written receipt for those funds from the new owner.

   1. The facility must give each resident or representative a written accounting of any personal funds held by the facility before any transfer of ownership occurs.

   2. In the event of a disagreement with the accounting provided by the facility, the resident retains all rights and remedies provided under state law.

   3. An ICF/MR cannot require a family member or other individual to sign a financial responsibility statement for a Medicaid resident. In instances where a Medicaid beneficiary has no family member or individual available for such signatures, it is clearly discriminatory for a Medicaid provider to refuse admission to the resident.

M. The facility must, within thirty (30) days of a resident's death or discharge, convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.

1. There is no minimum dollar amount that would relieve the facility of this fiduciary responsibility.

2. If the deceased or discharged resident's estate has no executor or administrator, the facility must convey the resident's funds and provide a final accounting to the:

   a) Resident's next of kin,

   b) Resident's representative; or

   c) Clerk of the probate court of the county in which the resident died**.**

3. The Disposition of funds for deceased residents who die intestate within a long term care facility is as follows:

   d) Any beneficiary who dies in the State of Mississippi and leaves no known heirs must have his final accounting of funds and conveyance of those funds sent to the Mississippi State Treasury Department within thirty (30) days of the resident's death. Such funds should be sent along with the report to the State Treasurer in the following manner:

      1) The report of such funds shall be verified, shall be on a form prescribed or approved by the State Treasurer and shall include:

         i) The name of the deceased person and his/her last known address prior to entering the ICF/MR,

         ii) The name and last known address of each person who may possess an interest in such funds, and

         iii) Any other information which the State Treasurer prescribes by regulation as necessary.

      2) In the event a party with a claim to the deceased residents' funds comes to be known after funds have been conveyed to the State Treasurer, the party may file a claim with the State Treasurer.

         i) All reports of unclaimed funds filed by the facility prior to November first (1st) of each year will be included in a list published by the State Treasurer within one hundred twenty-one (120) days following November first (1st).

         ii) Claimants have ninety (90) days from the date of publishing to file for such

funds.

iii) After the ninety (90) day filing limit, all unclaimed funds are placed in an account by the State Treasurer to be used for Medicaid purposes.

4. Disposition of funds for deceased residents who die intestate in a state institution is as follows:

   e) Part 207, Chapter 3, Rule 3.7. M. 3, shall not be applicable for residents of any state institution.

   f) The funds of any resident in a state institution who dies intestate and without known heirs may be deposited in the facility's operational account, after a period of one (1) year from the date of death.

N. The facility must purchase a surety bond or otherwise provide assurance as to all personal funds of residents deposited with the facility.

1. The Division of Medicaid defines a surety bond as an agreement between the principal, the or facility, the surety, the insurance company, and the oblige, or the residents of the trust fund, wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, safeguards, manages and for which the facility accounts. The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring for any failure by the facility to hold, safeguard, manage, and account for the residents' funds, that is, losses occurring as a result of acts or errors of negligence, incompetence or dishonesty.

2. Unlike other types of insurance, the surety bond protects the obligee, or the residents of the trust fund, not the principal, from loss. The surety bond differs from a fidelity bond, sometimes called employee dishonesty insurance or a crime bond, which covers no acts or errors unless they involve dishonesty.

3. The surety bond is the commitment of the facility to meet the standard of conduct.

   a) The facility assumes the responsibility to compensate the obligee, or the residents of the trust fund, for the amount of the loss up to the entire amount of the surety bond.

   b) The surety bond coverage must be for an amount equal to or greater than the highest daily balance for all resident funds held on deposit.

   c) A copy of the surety bond and evidence of the payment of the premium for the appropriate bond coverage amount must be kept at the facility and available for inspection.

4. Any reasonable alternative to a surety bond must:

a) Designate the obligee, or the residents, individually or in aggregate, who can collect in case of a loss,

b) Specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the residents' funds, and

c) Be managed by a third party unrelated in any way to the facility or its management.

5. The facility cannot be named as an obligee.

a) Self-insurance is not an acceptable alternative to a surety bond. Funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation (FDIC), or similar entity, are not acceptable alternatives.

b) If a corporation has a surety bond that covers all of its facilities, the corporation surety bond must be sufficient to ensure that all of the corporation's facilities are covered against any losses due to acts or errors by the corporation, its agents, or any of its facilities. The intent is to ensure that if a corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation's facilities would be protected.

O. If a resident is incapable of managing personal funds and has no representative, the facility must refer the patient to the local office of the Social Security Administration (SSA) and request that a representative payee be appointed.

1. In the time period between notification to the appropriate agencies, institution of formal guardianship proceedings, and notification to the local SSA and the actual appointment of a guardian or representative payee, the facility must serve as temporary representative payee for the resident.

2. In order to safeguard and maintain an accurate accounting of the resident's account, funds received on behalf of the resident must initially be deposited in the trust fund account before they can be disbursed for any expenses. A resident's monthly income source cannot be commingled with facility funds prior to those funds being transferred to the trust account.

P. The facility must maintain a current, written record for each resident that includes written receipt for all personal possessions deposited with the facility by the resident. The property record must be available to the resident.

Q. The facility must notify each resident receiving medical assistance under Title XIX, Medicaid, when the amount in the resident's account reaches two hundred dollars ($200.00) less than the SSI resource limit and five hundred dollars ($500.00) less than the Medicaid resource limit to remain eligible for Medicaid long term care benefits.

1. The notice must include the fact that if the amount in the account, in addition to the value of the resident's other non-exempt resources, reaches the applicable resource limits; the resident may lose eligibility for such medical assistance or SSI.

2. The facility must issue written notification to the Medicaid Regional Office of any resident receiving medical assistance under Title XIX when the resident's account balance reaches the applicable resource limit.

R. The Division of Medicaid defines:

1. The basic rate as the standard or per diem rate Medicaid pays the facility per Medicaid resident per day, as established periodically from cost reports and assessment data. The basic rate is important in the discussion of resident funds in that items and services included in the rate cannot be charged to a resident; the resident must be informed, in writing at the time of admission, of the items and services provided by the facility as well as the items and services not included in the basic rate; and the amount of such charges that may be charged to the resident.

2. The book balance as the total balance of all resident trust funds and petty cash held according to the accounting ledger.

3. Census as the total number of residents in a facility.

4. Compliance of The Omnibus Budget Reconciliation Act of 1987, Paragraph 17, 399, Section 1919(6)(A) as requiring a facility to establish and maintain a system that fully and completely accounts for the resident's funds managed by the provider. A facility that does this and follows the policies and procedures and this manual is issued an opinion by the Division of Medicaid that "the facility generally complies with Section 1919(6)(A)." A facility may be found to be in compliance and still have minor errors in its resident fund system; however, for a facility that lacks an accounting system, lacks several parts of an accounting system, or has a sufficient number of exceptions that would indicate a breakdown of the system of accounting, an opinion may be issued that "the facility does not comply with Section 1919(6)(A)."

5. Exception as any item or area selected for review that does not meet the regulatory standards.

6. Fiduciary as having rights and powers normally belonging to another person that must be exercised with a high standard of care for the benefit of the beneficiary. Regarding resident funds, a party who is entrusted to conduct the financial affairs of another person is acting in a fiduciary or trust capacity and has responsibility to use due care and to act in the best interests of the party for whom he is acting in this capacity. A party acting in a fiduciary capacity is also responsible to give an accounting of all transactions made on behalf of the party for whom he is acting.

7. Finding and exception are used interchangeable for resident trust fund review purposes.

8. Fiscal Agent as the agency under contract with the Division of Medicaid for the purpose of disbursing funds to providers of services under the Medicaid program. The fiscal agent collects eligibility and payment information from agencies administering Medicaid and processes the information for payment to providers.

9. Generally Accepted Accounting Principles (GAAP), for resident trust funds, as the facility's proper bookkeeping techniques by which it can determine, upon request, all deposits and withdrawals for each resident, how much interest these funds have earned for each resident and the amount of each individual resident's fund balance.

10. Intestate as without a valid will at the time of death.

11. Legal guardian, or conservator, as a person(s) by the court of jurisdiction to manage the resident's income and assets in the best interest of the resident. The court may require a court order prior to disbursements of the resident's funds, and/or a periodic accounting to the court to document income and disbursements. A legal guardian or conservator must supply documentation to the facility for disbursements from the resident fund, just as any other responsible party for any other resident.

12. Medicaid income as the maximum liability that the resident owes to the facility each month for room and board.

13. Medically necessary items and services as those items and services that are documented by the attending physician or medical personnel delegated by the attending physician as reasonable and necessary. If a resident's personal funds are expended for an item or service covered in the facility's basic rate, evidence must be in the resident's file to verify that the item or service is not medically necessary and therefore justifiable as an expenditure of the resident's personal funds.

14. Obligee as the residents of the trust fund, the party to whom the facility is legally or morally bound. The obligee is the beneficiary of funds, collected in the event of the failure of the facility to hold, safeguard, manage, and account for the residents' funds.

15. Per Diem Rate - Refer to Rule 3.7.R.1.

16. Personal needs allowance (PNA) as the amount of funds a resident is allowed to keep after room and board liability, supplemental health insurance premiums, and allowable minimum monthly needs allowances are deducted from the resident's gross income.

17. Plan of Correction as an acceptable plan of correction that must address each exception noted in the findings letter and include the following:

    a) Documentation that the exception has been corrected;

    b) Measures that have been put in place to ensure that the exception will not be repeated;

c) Measures that have been put in place to monitor the continued effectiveness of the changes.

18. Reconciliation as at all times, the total of the residents' funds held, as noted from the bank's current statement of the balance and any cash held at the facility, must equal the total of the resident's funds as noted from the facility's accounting ledger for all residents participating in the resident trust fund. Any difference between the two (2) totals must be accounted for by documented outstanding credits and debits or documented reconciling items such as unposted current interest, unposted petty cash vouchers, or corrections.

19. Representative payee as someone designated by the resident to receive and manage their Social Security, Veterans Administration, Railroad Board, or other federal or state benefits. That party is the representative payee for the resident. A facility must be willing to be designated as a temporary representative payee if no responsible party is available to represent the resident.

20. Resident's personal funds as all of a resident's money on deposit with the facility, including all of the resident's funds, regardless of the source, that are placed in trust at the facility.

21. Resource limit as the maximum amount of assets a resident may have in order to qualify for Medicaid services. For trust fund review purposes, there are two resource limits to be considered, the Supplemental Security Income (SSI) resource limit and the Medicaid resource limit.

22. Responsible party for resident trust fund purposes, as a sponsor or resident's representative. A resident may serve as his own responsible party. In other instances, the responsible party is the individual who signs appropriate documentation, commonly known as a Trust Fund Authorization, to assist the resident in managing his/her personal funds maintained within the resident trust fund account. Any withdrawal of funds by a responsible party must be for the benefit of the resident, must be signed, and must be supported by appropriate documentation such as a receipt or invoice.

23. State institutions as facilities owned and operated by the State, such as: Mississippi State Hospital, Ellisville State School, East Mississippi State Hospital, North Mississippi Regional Center, Hudspeth Regional Center, South Mississippi Regional Center, University of Mississippi Medical Center, and the Boswell Regional Center. This listing is not intended to be all inclusive.

24. Testate as having a valid will at the time of death.

25. Trial balance as a listing of all residents participating in the resident trust fund and the balance of each resident's trust fund.

26. Written authorization as authorization to establish a resident trust fund for a resident must

be in the form of a written statement signed by the resident or responsible party. In addition, authorization to perform a specific funds transaction for the resident must be in writing and/or documented with a receipt of purchase.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483; Section 1-7 (C); 1919 (5) (a) (ii) of the Social Security Act; 42 CFR 447.15; 42 CFR 431.53; OBRA (1987), paragraph 17, 399, Section 1919(6)(A)

Rule 3.8: Utilization Review

The Mississippi State Department of Health Division of Licensure and Certification is the State Agency designated to conduct reviews in ICF/MR facilities, as required by the Division of Medicaid. The regulatory requirements for review include:

A. Review of Need for Admission,

B. Certification/Recertification of Need for Care,

C. Plan of Care, and

D. Utilization Review.

Source: Miss. Code Ann. § 43-13-121; § 43-11-1; § 43-11-13; 42 CFR, Part 456 and 483, Subpart I, 42 CFR 456.271; 456.371; 456.372; 42 CFR 456.360; 42 CFR 456.380; 42 CFR 456.650

Rule 3.9: Release of Information

A. Public access to records maintained by the Division of Medicaid is mandated. The exception to public access is those records which are exempt as confidential or privileged.

B. Beneficiary-specific information will only be released by the Division of Medicaid when the requirements of federal regulations are met.

C. Provider-specific information, including, but not limited to, cost reports, reimbursement rates, reimbursement amounts and reports not beneficiary-specific, will be available to the public when:

    1. A written request for the information is made to the Executive Director of the Division of Medicaid,

    2. The information is available in existing agency files and reports, and

    3. The requestor reimburses the Division of Medicaid for the costs associated with the compilation of the requested material, as permitted by law.

D. Statistical data that does not contain protected health information are available as requested. This type of information is generally available in the Division of Medicaid's annual report or other reports generated for agency reporting or administrative purposes. The requestor shall reimburse the Division of Medicaid for the costs associated with the compilation of the requested material, as permitted by law.

Source: Miss. Code Ann. § 43-13-121; Section 25-61-1 et.seq. of the Mississippi Code of 1972, as amended; 42 CFR 431.300 – 307; 45 CFR 160,164

Rule 3.10: Individualized, Resident Specific Custom Manual and/or Custom Motorized/Power Wheelchairs Uniquely Constructed or Substantially Modified for a Specific Resident

A. The Division of Medicaid defines a wheelchair as a seating system that is designed to increase the mobility of residents who would otherwise be restricted by inability to ambulate or transfer from one place to another.

B. The Division of Medicaid defines an individualized, resident specific custom manual and/or custom motorized/power wheelchair as one that has been uniquely constructed or substantially modified for a specific resident referred to in this Rule as "custom manual wheelchair" and/or "custom motorized/power wheelchair.

C. The Division of Medicaid does not classify the following wheelchairs as custom manual and/or custom motorized/power wheelchairs:

1. Standard manual wheelchairs,

2. Standard manual wheelchairs with added accessories,

3. Standard motorized/power wheelchairs, and/or

4. Standard motorized/power wheelchairs with added accessories.

D. The Division of Medicaid covers custom manual and/or custom motorized/power wheelchairs and accessories for rental up to the purchase price or purchase when:

1. Medically necessary with comprehensive documentation that a standard wheelchair cannot meet the resident's needs and the resident requires the custom manual and/or custom motorized/power wheelchair for six (6) months or longer,

2. Ordered by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist,

3. Not primarily used as a restraint, and

4. Prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO).

E. The Division of Medicaid requires the following documentation for a custom manual and/or custom motorized/power wheelchair.

1. A face-to-face evaluation by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist who is prescribing the custom manual and/or custom motorized/power wheelchair which includes, but is not limited to:

   a) The reason for the evaluation visit is a mobility examination,

   b) If the resident currently possesses a custom manual and/or custom motorized/power wheelchair not previously purchased by the Medicaid program.

   c) A certificate of medical necessity with comprehensive documentation that describes the medical reason(s) why a custom manual and/or custom motorized/power wheelchair is medically necessary such that no other type of wheelchair can meet the needs of the resident including, but not limited to:

      1) The diagnosis/co-morbidities and conditions relating to the need for a custom manual and/or custom motorized/power wheelchair.

      2) Description and history of limitation/functional deficits.

      3) Description of physical and cognitive abilities to utilize equipment.

      4) History of previous interventions/past use of mobility devices.

      5) Description of existing equipment, age of equipment and specifically why it is not meeting the resident's needs.

      6) Explanation as to why a less costly mobility device is unable to meet the resident's needs.

      7) Description of the resident's ability to safely tolerate/utilize the prescribed custom manual and/or custom motorized/power wheelchair.

      8) The type of custom wheelchair and each individual attachment and/or accessory required by the resident.

2. An initial evaluation by a physical therapist (PT) or occupational therapist (OT), not employed by the Durable Medical Equipment (DME) provider or the manufacturer, within three (3) months of the date of the written prescription to determine the individualized needs of the resident which includes whether the resident currently possesses a custom manual and/or custom motorized/power wheelchair not previously purchased by the Division of Medicaid at the time of the initial evaluation.

3. An agreement by both the prescribing physician and the PT or OT performing the initial evaluation that the individualized equipment being ordered is appropriate to meet the needs of the resident.

4. A subsequent evaluation after the delivery of the custom manual and/or custom motorized/power wheelchair by a PT or OT, not employed by the DME provider or the manufacturer, to determine if the custom manual and/or custom motorized/power wheelchair is appropriate for the resident's needs.

5. The PT/OT initial and subsequent evaluations must include the appropriate seating accommodation for the resident's height and weight, specifically addressing anticipated growth and weight gain or loss.

F. The Division of Medicaid covers a custom motorized/power wheelchair only when a custom manual wheelchair cannot meet the needs of the resident. The resident must meet the following criteria:

1. Be bed/chair confined with documented severe abnormal upper extremity dysfunction or weakness,

2. Expect to have physical improvements or the reduction of the possibility of further physical deterioration from the use of a custom motorized/power wheelchair,

3. Be for the necessary treatment of a medical condition,

4. Have a poor prognosis for being able to self-propel a functional distance,

5. Not exceed the weight capacity of the custom motorized/power wheelchair prescribed,

6. Have sufficient eye and/or hand perceptual capabilities to operate the custom motorized/power wheelchair safely,

7. Have sufficient cognitive skills to understand directions, such as left, right, front, and back, and be able to maneuver the motorized/power wheelchair in these directions independently,

8. Be independently able to move away from potentially dangerous or harmful situations when seated in the custom motorized/power wheelchair,

9. Demonstrate the ability to start, stop, and guide the custom motorized/power wheelchair within a reasonably confined area,

10. Be in an environment conducive to the use of the custom motorized/power wheelchair.

a) The environment must have sufficient floor surfaces and sufficient door, hallway, and room dimensions for the custom motorized/power wheelchair to turn and enter and exit, as well as necessary ramps to enter and exit the ICF/IID.

b) The environmental evaluation must be documented and signed by the resident/caregiver and DME provider for the custom motorized/power wheelchair.

G. The Division of Medicaid covers a customized electronic interphase device, specialty and/or alternative controls if the resident is unable to manage a custom motorized/power wheelchair without the assistance of said device. The Division of Medicaid requires documentation of an extensive evaluation of each customized feature required for physical status and specification of the medical benefit of each customized feature.

1. For a joystick, the resident must demonstrate safe operation of the custom motorized/power wheelchair with an extremity, such as the hand or foot, using a joystick hand or foot operated device. The resident can manipulate the joystick with fingers, hand, arm, or foot.

2. For a chin control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the chin control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their chin and safely operate the chair in all circumstances.

3. For a head control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the head control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their head freely with control of their head and can safely operate the chair in all circumstances.

4. For an extremity control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the extremity control device. The resident must have a medical condition which prevents or limits fine motor skills during the use of their extremities but is able to move their hands/arms/legs to safely operate the chair in all circumstances.

5. For a sip and puff feature, the resident must demonstrate safe operation of the custom motorized wheelchair with manipulation of the sip and puff control. The resident cannot move their body at all and cannot operate any other driver except this one.

H. Custom manual and custom motorized/power wheelchairs are limited to one (1) per resident every five (5) years based on medical necessity. Reimbursement:

1. Is made for only one (1) custom manual and/or custom motorized/power wheelchair at a time.

2. Includes all labor charges involved in the assembly of the wheelchair and all covered additions, accessories and modifications.

3. Includes support services such as emergency services, delivery, setup, education and ongoing assistance with use of the wheelchair.

4. Is made only after the PT or OT subsequent evaluation is completed.

I. The DME providers must ensure the prescribed custom manual and/or custom motorized/power wheelchair and accessories are adequate to meet the resident's needs, must ensure the proper height and width, and must provide an automatic or special locking mechanism for residents unable to apply manual brakes.

J. The DME provider providing custom motorized/power wheelchairs to residents must:

1. Have at least one (1) employee with Assistive Technology Professional (ATP) certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) who specializes in wheelchairs and who must be registered with the National Registry of Rehab Technology Suppliers (NRRTS).

   a) The NRRTS and RESNA certified personnel must have direct, in-person, face-to-face interaction and involvement in the custom motorized/power wheelchair selection for the resident.

   b) RESNA certifications must be updated every two (2) years.

   c) NRRTS certifications must be updated annually.

   d) If the certifications are found not to be current, the prior authorization request for the motorized/power wheelchair will be denied.

2. Provide a lifetime warranty on the powered mobility base frame against defects in material and workmanship for the lifetime of the resident.

3. Provide a two (2) year warranty of the major components, beginning on the date of delivery to the resident.

   a) The main electronic controller, motors, gear boxes and remote joystick must have a two (2) year warranty from the date of delivery.

   b) Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects or if the surface does not remain intact due to normal wear.

4. If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the DME provider is responsible for any repairs, replacement or maintenance that may be required within the two (2) years.

K. DME providers providing custom motorized/power wheelchairs, customized electronic interphase devices, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, with a technician available during normal business hours, between eight (8:00) a.m. and five (5:00) p.m. Monday through Friday. Each technician must keep on file records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.

L. The Division of Medicaid covers repairs, including labor and delivery, of a custom manual and/or custom motorized/power wheelchair owned by the resident not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.

1. The ICF/IID is responsible for the repairs, including labor and delivery, of custom manual and/or custom motorized/power wheelchairs delivered to the resident prior to January 2, 2015.

2. Major repairs and/or replacement of parts require prior authorization from the UM/QIO and must include an estimated cost of the necessary repairs, including labor, and documentation from the practitioner that there is a continued need for the custom manual and/or custom motorized/power wheelchair.

3. An explanation of time involved for repairs and/or replacement of parts must be submitted to the UM/QIO.

4. Manufacturer time guides must be followed for repairs and/or replacement of parts.

5. The Division of Medicaid defines repair time as point of service and does not include travel time to point of service.

6. No payment is made for repairs or replacement if it is determined that intentional abuse, or misuse, of the wheelchair or components has occurred. This includes damage incurred due to inappropriate covered transportation for the prescribed custom manual and/or custom motorized/power wheelchair.

7. Reimbursement will be made for up to one (1) month for rental of a wheelchair while the resident's wheelchair is being repaired.

8. The Division of Medicaid does not cover the repair of a rented custom manual and/or custom motorized/power wheelchair.

Source: Social Security Act § 1834; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: New eff. 01/02/2015.

Part 207 Chapter 4: Psychiatric Residential Treatment Facility

Rule 4.1: General

A. The purpose of these regulations is to set forth the minimum requirements for providers who provide described mental health services to Medicaid beneficiaries in a Psychiatric Residential Treatment Facility (PRTF).

B. The regulations have been prepared for the information and guidance of providers of services participating in the Mississippi Medicaid Program.

C. Inpatient psychiatric services for beneficiaries under age twenty-one (21) must be provided before the beneficiary reaches age twenty-one (21) or, if the beneficiary was receiving the services immediately before he/she reached age twenty-one (21), before the earlier of the following: the date he/she no longer requires the services or the date he/she reaches age twenty-two (22).

D. The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible.

E. PRTF providers must adhere to applicable state and federal regulations related to their license.

F. The facility must have a signed transfer agreement with one or more general hospitals to provide needed diagnostic and medical services to residents.

G. The facility must have arrangements with community physicians to provide specialized medical care to residents when needed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.151 (a)(2)(ii), (c)(1)(2), 441.152 (a)(3); OBRA section 4755; 42 CFR 441, Subpart D; 42 CFR 483.52

Rule 4.2 Provider Enrollment

Enrollment into the Medicaid program requires each provider to comply with the requirements outlined Part 200, Chapter 4, Rule 4.8, in addition to the following provider type specific requirements:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

B. Board of Director's (Commissioner's) Resolution form, letter of signature authority, or copy of minutes indicating signature authority.

C. Written confirmation from the IRS confirming your tax identification number and legal business name.

D. CLIA certificate and completed certification form.

E. Joint Commission on Accreditation of Health Care Organization (JCAHO) or Council on Accreditation (COA) accreditation.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129; 42 CFR 441, Subpart D; 42 CFR 441.151

Rule 4.3: Staffing

The Division of Medicaid requires Psychiatric Residential Treatment Facilities (PRTF) have the following staff:

A. The governing body of the PRTF must appoint an administrator to be responsible for the overall management of the facility. The administrator must have appropriate academic credentials and administrative experience in child/adolescent psychiatric treatment. The administrator must be responsible for the fiscal and administrative support of the facility's clinical program.

B. The facility must appoint a medical director to be responsible for coordinating medical services and directing resident treatment. The medical director must be a board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry.

C. The facility must appoint a full-time clinical director to be responsible for coordinating clinical services and implementing patient treatment. The clinical director must be one of the following:

    1. A board-certified child/adolescent psychiatrist,

    2. A psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry,

    3. A licensed psychologist who is experienced in child/adolescent mental health treatment,

    4. A psychiatric mental health nurse practitioner (PMHNP) who is experienced in child/adolescent mental health treatment, or

    5. A licensed certified social worker who is experienced in child/adolescent mental health treatment.

D. A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry may serve as both medical director and clinical director provided that he/she is a full-time employee.

E. The facility must employ sufficient full-time professional staff to provide clinical assessments, therapeutic interventions, ongoing program evaluations, and adequate resident supervision twenty-four (24) hours a day. At least fifty percent (50%) of the professional staff hours must be provided by full-time employees. Professional staff must be appropriately licensed and trained/experienced in providing mental health treatment. These staff members will include, but not be limited to, the following:

1. A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry,

2. A licensed psychologist,

3. A registered nurse,

4. A licensed certified social worker,

5. A certified teacher, and

6. A recreation specialist.

F. The PRTF must have access, through full/part-time or contract employment, the services of each of the following:

1. A licensed occupational therapist or credentialed creative arts therapist,

2. A rehabilitation counselor, and

3. A licensed speech-language pathologist.

G. The PRTF must provide an adequate staff-to-resident ratio on all shifts to provide for resident and staff safety.

H. The PRTF must notify the Division of Medicaid of changes in the Administrator, Medical Director or Clinical Director. Division of Medicaid must receive the notification in writing within seventy-two (72) hours of the effective change.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441. Subpart D; 42 CFR 441.151 (a)(2)

Rule 4.4: Admission

The Division of Medicaid covers PRTF services when a child does not require emergency or acute psychiatric care but does require supervision and treatment on a twenty-four (24) hour basis.

A. A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry with admitting privileges

must approve each admission.

B. The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible.

C. The need for PRTF admission must be supported by documentation that:

1. The child has a diagnosable psychiatric disorder.

2. The child can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.

3. The child's psychiatric symptoms are severe enough to warrant residential treatment under the direction of a psychiatrist.

4. The referring psychiatrist or psychologist advises that residential treatment is needed.

5. At least one (1) of the following:

a) The child has failed to respond to less restrictive treatment in the last three (3) months.

b) Adequate less restrictive options are not available in the child's community.

c) The child is currently in an acute care facility whose professional staff advise that residential treatment is needed.

6. The admission has been certified by the UM/QIO as medically and psychologically necessary.

D. The facility must provide the parent/guardian with contact information for the Disability Rights Mississippi, including the phone number and mailing address, and document in the record.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.152 (a)(3); 456.180(b)(1); 441.152 (a)(2); 441.152 (a)(1); 483.356 (c); 483.366 (a); 483.356 (d)

Rule 4.5: Non-Covered Services

Division of Medicaid does not cover:

A. Admissions on the weekends. The Division of Medicaid defines weekend admissions as admission after 5:00 p.m. on a Friday. Covered days will not begin until the following Monday.

B. Non-covered days of stay.

C. Any days of stay not certified by the UM/QIO.

Source: Miss. Code Ann. § 43-13-121

Rule 4.6: Reimbursement

A. Participating Mississippi facilities must prepare and submit a Medicaid cost report for reimbursement of long term care facilities.

   1. All cost reports are due by the end of the fifth (5th) calendar month following the reporting period.

   2. Failure to file a cost report by the due date or the extended due date will result in a penalty of fifty dollars ($50.00) per day and may result in the termination of the provider agreement.

B. The Division of Medicaid uses a prospective method of reimbursement.

   1. The rates are determined from cost report data.

   2. Standard rates are determined annually with an effective date of January first (1st).

   3. In no case may the reimbursement rate for services provided exceed an individual facility's customary charges to the general public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.

   4. Prospective rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

   5. Prospective rates may be adjusted by the Division of Medicaid based on revisions to allowable costs or to correct errors.

      a) These revisions may result from amended cost reports, field visit reviews, or other corrections.

      b) Facilities are notified in writing of amounts due to or from the Division of Medicaid as a result of these adjustments.

      c) There is no time limit for requesting settlement of these amounts. This is applicable to claims for dates of service since July 1, 1993.

C. The Division of Medicaid conducts periodic field level cost report financial reviews of selected long term care facilities, including nursing facilities, intermediate care facilities for

the mentally retarded, and psychiatric residential treatment facilities, to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. Adjustments will be made as necessary to the reviewed cost reports based on the results of the reviews.

D. Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program to keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

1. Providers must maintain adequate documentation including, but not limited to, financial records and statistical data, for proper determination of costs payable under the Medicaid program.

   a) The cost report must be based on the documentation maintained by the facility.

   b) All non-governmental facilities must file cost reports based on the accrual method of accounting.

   c) Governmental facilities have the option to use the cash basis of accounting for reporting.

2. Documentation of financial and statistical data should be maintained in a consistent manner from one period to another and must be current, accurate and in sufficient detail to support costs contained in the cost report.

3. Providers must make available to the Division of Medicaid all documentation that substantiates the information included in the facility cost report for the purpose of determining compliance.

   a) These records must be made available as requested by the Division of Medicaid.

   b) All documentation which substantiates the information included in the cost report, including any documentation relating to home office and/or management company costs must be made available to Division of Medicaid reviewers as requested by the Division.

E. Services and charges include the following:

1. The facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for the provision of services under the State Medicaid Plan.

2. While the facility may set their basic per diem charge for non-Medicaid residents at any

level, the services covered by that charge must be identical to the services provided to Medicaid residents and covered by the Medicaid per diem rate.

3. Any items and services available in the facility that are not covered under Title XVIII or the facility's basic per diem rate or charge must be available and priced identically for all residents in the facility.

F. Medicaid allows payment for the date of admission to the PRTF. Medicaid does not cover the date of discharge from the facility. A Medicaid-eligible beneficiary cannot be charged for the date of discharge. If a beneficiary is discharged on the date of admission, the day is covered as the date of admission.

G. Private room coverage by Medicaid is as follows:

1. The overall average cost per day determined from the cost report includes the cost of private rooms.

2. The average cost per day is used to compute PRTF reimbursement rates. Therefore, the cost of a private room is included in the reimbursement rate and no extra charge can be made to the beneficiary, his/her family or the Medicaid program.

3. Medicaid reimbursement is considered as payment in full for the beneficiary.

H. The following rules apply to hospital leave:

1. A fifteen (15) day length of stay is allowed in a non-psychiatric unit of a hospital. The facility must reserve the hospitalized resident's bed in anticipation of his/her return. The bed cannot be filled with another resident during the covered period of hospital leave.

2. A resident must be discharged from the facility if he/she remains in the hospital for over fifteen (15) days. A leave of absence for hospitalization is broken if the resident returns to the facility for twenty-four (24) hours.

3. Facilities cannot refuse to readmit a resident from hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires PRTF services.

I. If a resident elopes from the facility and remains absent for twenty-four (24) hours or longer, he/she must be discharged from the facility. If further treatment at the same facility is desired after the end of the twenty-four (24) hours, the child/adolescent must go through a readmission process.

J. The following rules apply to therapeutic leave:

1. An absence from the facility for eight (8) hours or more within one calendar day constitutes a leave day.

2. Medicaid coverage of therapeutic leave days per fiscal year, July 1 – June 30, is eighteen (18) days for a PRTF.

3. Each therapeutic leave day taken each month must be reported on the billing mechanism.

4. The attending physician must approve all therapeutic leave days. Documentation must include goals to be achieved during the leave, the duration of leave, who participated in the leave, and the outcome of the leave.

K. Payment during therapeutic leave from the facility is as follows:

1. A temporary absence of a resident from a PRTF does not interrupt the monthly payments to the facility under the provisions as outlined in Part 207, Chapter 4 Rule 4.6 J.

2. Each facility is required to maintain leave records and indicate periods of therapeutic leave days.

3. Before a resident departs on therapeutic leave, the facility must provide each resident and family member or legal representative written information explaining leave policies. The information must define the period of time the resident is permitted to return and resume residence in the facility.

4. A refund of payment will be demanded for all leave days taken in excess of the allowable or authorized number of days.

Source: Miss. Code Ann. § 43-13-121, 42 CFR § 447 Subparts B & C, Miss. Code Ann. § 43-13-117, 42 CFR § 447.15

Rule 4.7: Active Treatment

The use of the term "treatment' refers to the active treatment of the resident. The Division of Medicaid defines active treatment as a process comprising of the following:

A. Multi-disciplinary diagnostic assessment,

B. Interdisciplinary treatment planning,

C. Therapeutic intervention,

D. Treatment evaluation/revision, and

E. Discharge/aftercare planning.

Source: Miss. Code Ann. § 43-13-121; 142 CFR 441.154

Rule 4.8: Assessment and Evaluation

A. The diagnostic evaluation must document the need for the PRTF level of care.

B. Diagnostic evaluations must be completed within the first fourteen (14) days of admission. The assessment process must include, but is not limited to, the following:

   1. A psychiatric evaluation.

   2. A psychological evaluation signed by a licensed psychologist, which must have been completed in the sixty (60) days prior to admission. If no psychological evaluation has been conducted within the last twelve (12) months, one must be completed within fourteen (14) days following PRTF admission.

   3. A medical history and examination.

   4. A psychosocial assessment, which includes a psychological profile, a developmental profile, a behavioral assessment, and an assessment of the potential resources of the resident's family.

   5. A Child and Adolescent Needs and Strengths (CANS-MH) assessment.

   6. An educational evaluation.

   7. A nursing assessment.

   8. A nutritional assessment, if indicated.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.155(b)(1), 441.156(b)(2)

Rule 4.9: Treatment Planning

A. Treatment planning is defined by the Division of Medicaid as a collaborative venture which the members of various disciplines jointly develop a comprehensive, individualized plan for the treatment of each resident.

   1. The treatment plan charts a course designed to help the resident move to a less restrictive level of care as quickly as possible.

   2. An initial treatment plan must be in effect within seventy-two (72) hours after the resident's admission to the facility.

   3. The interdisciplinary treatment team must meet to discuss, approve and implement a more comprehensive treatment plan within fourteen (14) days after the resident's admission, once at the conclusion of the first (1st) month of stay, and once a month thereafter.

4. The treatment plan document must contain evidence of the resident's and his/her parent/guardian's active participation in the treatment planning/review/revision process.

B. The treatment team should include as many staff as possible who are involved in the treatment of the resident.

1. At a minimum, the team must include, either:

a) A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry, or

b) A Psychiatric Mental Health Nurse Practitioner (PMHNP) and a physician licensed to practice medicine or osteopathy, or

c) A licensed psychologist and a physician licensed to practice medicine or osteopathy.

2. The team must also include one (1) of the following:

a) A licensed certified social worker who has a minimum of one (1) years' experience in treating children with serious emotional disturbances (SED), or

b) A registered nurse who has a minimum of one (1) years' experience in treating individuals with SED.

C. The treatment plan delineates all aspects of the resident's treatment and includes, at a minimum:

1. A multi-axial diagnosis.

2. An assessment of the resident's immediate therapeutic needs.

3. An assessment of the resident's long-range therapeutic needs.

4. An assessment of the resident's personal strengths and liabilities.

5. Identification of the clinical problems that are to be the focus of treatment.

6. Measurable and realistic treatment goals for each identified problem.

7. Observable, measurable treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement.

8. Specific treatment modalities and/or strategies that will be employed to reach each objective.

a) Special procedures must not be included in the treatment plan unless justified by current or historical evidence of aggressive behavior which, cannot be controlled by less restrictive interventions.

b) If special procedures become necessary, the treatment plan must be amended or modified within one (1) working day of the first incident to reflect the use of the least restrictive necessary measures.

9. The clinician identified as responsible for each aspect of treatment.

10. Identification of goals, objectives and treatment strategies for the family as well as the resident, and identification of the clinician responsible for family treatment. If a geographically distant therapist will be utilized, this must be specified in the treatment plan.

11. An individualized discharge plan that includes:

a) Discharge criteria, indicating specific goals to be met,

b) An estimated discharge target date, and

c) No later than seven (7) days prior to discharge, the discharge plan must also include an aftercare plan that addresses coordination of family, school/vocational and community resources to provide the greatest possible continuity of care for the resident.

D. The treatment team must meet to staff each resident and review/revise his/her treatment plan as often as necessary to provide optimum treatment. The treatment review team must assess the resident's progress in treatment by:

1. Noting treatment successes, discussing which objectives and/or goals have been achieved and when, and explaining treatment failures.

2. Making changes in the treatment plan, as needed.

3. Re-assessing the child's need for continued residential care, as opposed to less restrictive treatment.

4. Noting the child's measurable progress towards discharge, reviewing/revising the discharge criteria and/or target date as needed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.154(a)(b); 441.155(b)(2); 441.155(c)(1)(2); 441.156(b)(1)(3)(4)(5); 441.156(c)(1)(2); 144.156(d)(1)(2).

Rule 4.10: Therapeutic Interventions

A. Psychotherapy is defined as the intentional, face to face interaction between a mental health professional and a client, either an individual, family, or group, in which a therapeutic relationship is established to help resolve symptoms of the resident's mental and/or emotional disturbance.

B. Individual therapy is defined as psychotherapy that takes place between a mental health therapist and a resident. Individual Therapy must be provided a minimum of one (1) hour each week unless its contraindication is documented in the treatment plan. Individual Therapy must be provided by master's level mental health therapists.

C. Family therapy is defined as psychotherapy that takes place between a mental health therapist and a resident's family members or guardians, with or without the presence of the resident. If a resident is in the custody of the Department of Human Services (DHS), family therapy may also include others, including DHS representatives and foster family members, acting in loco parentis. Family Therapy must be at least twice a month, unless its contraindication is documented in the treatment plan.

1. Each resident's family, guardian, or person acting in loco parentis must participate in the family therapy sessions.

2. If the resident's family is more than a two (2) hour drive from the PRTF, one (1) face-to-face family therapy session and one (1) therapeutic conference call is acceptable.

3. Family Therapy must be therapeutic in nature to include discussing the resident's functioning, treatment progress, goals and objectives.

4. Social visits or phone calls are not considered family therapy.

5. Family Therapy must be provided by master's level mental health therapists.

6. Residents who are in the custody of the Department of Human Services (DHS) must complete one (1) face-to-face family therapy session with the social worker in the county of the PRTF, unless the social worker in the home county is available, and complete the second (2nd) family therapy session via telephone with the social worker in the home county.

7. A geographically distant therapist may provide family therapy when there are family issues that must be resolved or ameliorated before face-to-face sessions that include the resident can be productive and therapeutic.

   a) Distance alone is not justification for prescribing off-site therapy.

   b) When off-site therapy is appropriate, the treatment plan must identify the off-site therapist, indicate the goals for such therapy, and specify how information will be exchanged between the PRTF and the off-site therapist.

c) Collaboration between therapists is the responsibility of the PRTF and must be documented in the clinical record.

D. Group therapy is defined as psychotherapy that takes place between a mental health therapist and at least two (2), but not more than eight (8) residents at the same time.

1. Possibilities for groups include, but are not limited to, those which focus on relaxation training, anger management and/or conflict resolution, social skills training, and self-esteem enhancement.

2. Each resident must participate in a minimum of three (3) hours of group therapy, provided in at least three (3) sessions, each week unless contraindication is documented in the treatment plan.

3. The length, frequency and timing of sessions in which services are delivered must be determined by what is developmentally appropriate for each resident.

4. Group therapy must be provided by master's level mental health therapists although larger groups up to twelve (12) participants can be co-led by a person with a lesser level of training.

E. Psychotherapy notes must be documented for each therapy session and include the following essential elements:

1. The date and time in and time out of the session,

2. The type of therapy, either individual, family or group,

3. The person(s) participating in the session,

4. The length of the session,

5. Clinical observations about the resident including their demeanor, mood, affect, mental alertness, thought processes or risks,

6. The content of the session,

7. Therapeutic interventions attempted and the resident's response to the intervention(s),

8. The resident's response to any significant others who may be present in the session,

9. The outcome of the session,

10. A statement summarizing the resident's degree of progress toward the treatment goals,

11. Reference at least monthly to the resident's progress in relation to the discharge criteria

and the estimated discharge date,

12. The signature and printed name, if needed for clarity, of the therapist, and

13. Monthly summaries are not acceptable in lieu of psychotherapy session notes.

F. Milieu therapy is defined as residential psychiatric treatment that occurs in the total environment of the closed setting, also referred to as the "therapeutic community." Milieu therapy must be provided twenty-four (24) hours a day by all PRTF staff.

1. Emphasis is placed on clear, healthy, respectful communication between resident/resident, staff/staff, and staff/resident, and on shared problem-solving and decision-making.

2. The entire environment, not just the limited time spent with an identified therapist, is considered vital to the treatment process. The physical environment of the facility must reflect a warm, child-friendly atmosphere with treatment-oriented information including, but not limited to, motivational/educational posters, schedules of activities, requirements for level systems and rules for unit, written in positive terms and age appropriate language. Materials must be posted in a manner that is highly visible and easily accessible to residents.

3. Milieu notes must be documented daily and:

   a) Present a clear picture of the resident's participation and interactions in the therapeutic community.

   b) Describe the resident's actions, staff interventions, and the resident's response to those interventions.

   c) Are usually completed by direct care staff.

   d) If a checklist is used, it must be accompanied by at least a brief narrative.

   e) Must be behaviorally focused.

   f) Behavior and events should be described rather than labeled.

   g) Must reflect a pattern of clear, respectful communication between staff and resident, with emphasis on the resident's involvement and collaboration in his/her own treatment.

4. The community meeting is a required element of milieu therapy. This is a time when all residents and most, if not all, professional and direct care staff meet together to discuss and solve problems that arise in community living, make community decisions, set goals, resolve conflicts and discuss ideas that may enhance treatment.

5. Documentation that community meetings are held at least daily and are attended by all residents and most, if not all, professional and direct care staff.

6. Documentation that the focus of community meetings is good communication and collaboration among residents and staff to solve problems, make community decisions, and introduce/discuss ideas/suggestions that will enhance treatment.

7. Documentation that residents are knowledgeable about their treatment and actively participate in goal-setting and treatment evaluation.

8. Community meeting notes must be clearly identifiable.

9. Each resident's participation must be documented, or his/her absence justified, in a minimum of one (1) community meeting per day.

10. Notes must reflect that the community meetings are therapeutic in nature and address treatment issues including, but not limited to:

    a) Problem identification,

    b) Goal-setting,

    c) Problem-solving,

    d) Conflict resolution,

    e) Behavioral observations/evaluation,

    f) Problems in community living.

11. The nature of each resident's participation must be described.

12. If a checklist is used, it must be accompanied by at least a brief narrative.

G. Therapeutic Pass/Therapeutic Leave is defined as those times when a resident is permitted time "away" from the PRTF to practice skills learned in treatment or to work on significant relationships in a setting that is less structured and controlled.

1. Therapeutic Pass refers to "away" time of less than eight (8) hours.

    a) If a resident leaves the facility on a therapeutic pass accompanied by PRTF staff, no documentation is required.

    b) If a resident leaves the facility on a therapeutic pass with anyone other than staff, including relatives or representatives of DHS, therapeutic goals for the pass must be

identified and documented. At the conclusion of the pass, documentation must indicate whether or not the therapeutic goals were met.

2. Therapeutic Leave refers to "away" time of eight (8) hours or more in the same calendar day. A single day of therapeutic leave is determined by the resident's absence from the facility for eight (8) hours or more between the hours of 12:01 a.m. and 11:59 p.m. on any given day.

   a) Therapeutic Leave is not allowed during the fourteen (14) day assessment period following admission.

   b) The attending physician or PMHNP must approve all therapeutic leave days.

3. Documentation at the time a resident leaves the facility must include:

   a) The date/time of check-out,

   b) The required time of return,

   c) The name(s) of the person(s) with whom the leave will be spent,

   d) The resident's physical/emotional condition at the time of departure including vital signs,

   e) The types and amounts of medication being provided and instructions in lay terms for taking them,

   f) Therapeutic goals for the leave, as related to the goals established in the treatment plan,

   g) The name and signature of the person with whom the resident is leaving, and

   h) The signature of the staff person checking the resident out.

4. Documentation at the time of the resident's return must include:

   a) The date and time of check-in,

   b) The resident's physical/emotional condition at the time of return including vital signs and notation of any physical injury or complaint,

   c) Whether or not any contraband was found,

   d) The types and amounts of medication being returned, if any, and explanation of any missed doses,

e) An explanation of any early or late return from leave,

f) A brief report on the outcome of the leave by the parent or guardian,

g) The name and signature of the person returning the resident's to the facility,

h) The signature of the staff person checking resident in, and

i) An assessment of the outcome of the leave must be conducted by the resident's therapist within seventy-two (72) hours of the resident's return from leave.

H. Creative arts therapies is defined as those therapies, including art, movement/dance, music and poetry, which a qualified professional uses the creative process and the resident's response to the created product to help the resident resolve emotional conflicts, increase self-awareness, develop social skills, manage behavior, solve problems, reduce anxiety, improve reality orientation, and/or increase self-esteem.

I. Occupational therapy is defined as the use of purposeful activity, designed and guided by a qualified professional, to help the resident achieve functional outcomes that promote the highest possible level of independence.

J. Recreation therapy is defined as a process that utilizes recreation services for purposive intervention in physical, emotional and/or social behavior to bring about a desired change in that behavior and to promote the growth and development of the resident.

K. Speech-Language Pathology is defined as remedial assistance with speech and/or language problems provided by a licensed speech-language pathologist.

L. When other therapies such as art therapy, recreational therapy, occupational therapy, dance/movement therapy, music therapy, speech/language therapy, are employed, their use must be documented in the clinical record in much the same manner as psychotherapy including date, length, type of session, together with a summary of the session's content, process, outcome and the therapist's name/signature.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 441.155(b)(1)(4)(5)

Rule 4.11: Medical Treatment Requirements

Each unit must identify an appropriate place/procedure for responding to resident's physical/medical complaints.

Source: Miss. Code Ann. § 43-13-121

Rule 4.12: Special Procedures

A. The Division of Medicaid defines special procedures as seclusion and restraint and must be used as an immediate response only in emergency safety situations when needed to help a resident regain control of his/her behavior. At all times, the least restrictive effective intervention must be used. The potential therapeutic effects of prevention of self and other injury and reinforcement of behavioral boundaries must be weighed against the counter-therapeutic effects.

1. Seclusion is defined as the involuntary confinement of a resident in an area from which she/he is physically prevented from leaving. It is used to ensure the physical safety of the resident or others and to prevent the destruction of property or serious disruption of the milieu.

2. Restraint is defined as the restriction of a resident's freedom of movement or normal access to his/her body through physical, mechanical or pharmacological means, in order from the least to the most restrictive method. It is used to ensure the resident's physical safety.

   a) Personal restraint is defined as the restraint of a resident through human physical action using a standard technique or method designed and approved for such use. It is used to prevent a resident from causing harm to self or others or to prevent destruction of property.

   b) Mechanical restraint is defined as the restraint of a resident through the use of any mechanical device, material or equipment attached or adjacent to the resident's body that s/he cannot easily remove.

   c) Pharmacological restraint is defined as the use of a medication, which is not a standard part of the resident's treatment regimen, to control or alter the resident's mood or behavior or to restrict freedom of movement. Pharmacological restraint is used to insure the safety of the resident or others through a period of extreme agitation when less restrictive measures have not been effective. Standing PRN orders for pharmacological restraints are prohibited.

B. Seclusion or restraint must only be used in situations where less restrictive interventions have been determined to be ineffective. Any use of seclusion or restraint must be:

1. In accordance with appropriate techniques,

2. Applied by staff trained and approved to use such techniques,

3. Implemented in the least restrictive manner possible,

4. In a room that is safe and sanitary, with adequate lighting, ventilation and temperature control, and

5. Evaluated on a continual basis and ended at the earliest possible time based on the

assessment and evaluation of the resident's condition.

C. Seclusion or restraint cannot be used as a method of coercion, discipline or retaliation as compensation for lack of staff presence or competency, for the convenience of staff in controlling a resident's behavior, or as a substitute for individualized treatment.

1. Restraint and seclusion must not be used simultaneously.

2. Any personal or mechanical restraint of a resident in a face-down position is prohibited.

3. Any personal or mechanical restraint of a resident in a spread-eagle position with legs and arms apart is prohibited.

4. Standing, or "as needed" (PRN), orders for seclusion or restraint are prohibited.

D. The following actions are required for any form of special procedure with the exceptions as noted below:

1. Only a physician or a PMHNP may order the seclusion or personal/mechanical restraint of a resident.

2. If seclusion or personal/mechanical restraint is initiated without orders from a physician or PMHNP, a verbal or telephone order must be obtained from the physician or PMHNP by an RN or LPN no later than one (1) hour after the start of the procedure. If the physician's or PMHNP's order cannot be obtained within the one (1) hour, the procedure must be discontinued.

3. Pharmacological restraint may be initiated only by medical staff acting on a physician's or PMHNP's orders. At the time of the order, the physician or PMHNP must identify a specific time when the procedure is expected to end and/or the expected duration of the medication's effects, at which time the resident's condition must be assessed and the incident must be processed with the resident.

4. The physician's or PMHNP's order for seclusion or personal/mechanical restraint must be for a time period not to exceed one (1) hour for residents younger than nine (9) years of age, or two (2) hours for residents nine (9) to twenty one (21) years of age.

   a) The original order may be renewed, if clinically justified, in accordance with these limits for up to a total of twenty four (24) hours.

   b) After the renewal limits of the original order are reached, a physician or PMHNP must see and assess the resident before issuing a new order.

5. The staff person responsible for terminating seclusion must be physically present in or immediately outside the seclusion room throughout the duration of the procedure.

6. The staff person responsible for terminating a mechanical restraint must be physically present throughout the duration of the procedure.

7. Within one (1) hour of the initiation of the emergency safety intervention, a physician, PMHNP or RN must conduct a face-to-face assessment of the physical and psychological well-being of the resident.

8. Even if the emergency safety intervention is terminated in less than one (1) hour, the face-to-face assessment must be conducted within an hour of its initiation.

9. The health and comfort of the resident must be assessed every fifteen (15) minutes by direct observation, and staff must record their findings at the time of observation.

10. Vital signs must be taken every hour unless contraindicated and documented in the resident's record.

11. There must be clear criteria for ending the special procedure and the resident must be made aware of them when the procedure is initiated and at follow-up intervals as appropriate.

12. A physician, PMHNP, or RN must evaluate the resident's well-being immediately after the seclusion or restraint is terminated.

13. At an appropriate time, but no later than twenty-four (24) hours following the conclusion of the special procedure, the resident must be given the opportunity to discuss with all staff involved in the procedure the antecedents, emotional triggers, and consequences of his/her behavior and any learning that occurred as a result of the intervention.

E. All staff who have direct resident contact must have ongoing education, training, and demonstration of knowledge of the proper and safe use of seclusion/ restraint and alternative techniques/methods for handling the behavior, symptoms, and situations that traditionally have been treated through seclusion and restraint. Training in the application of physical restraint must be a professionally recognized method, which does not involve restraining a resident in a face-down or spread-eagle position with legs and arms apart.

F. If a facility provides for the use of seclusion/restraint, it must inform the prospective resident and the parent/guardian at the time of admission of the circumstances under which these special procedures are employed. The facility must provide the parent/guardian with a copy of its policy regarding seclusion/restraint and obtain a signed acknowledgment from the parent/guardian documenting that the policy was explained and a copy given to them. This acknowledgment must be filed in the resident's record. In the event that a resident requires either seclusion or restraint, the PRTF must notify the parent/guardian as soon as possible, but no later than twenty-four (24) hours after the initiation of the procedure.

G. Documentation of each incident of seclusion or restraint must be part of the resident's permanent record.

1. Documentation of each incident of seclusion or restraint, including personal, mechanical and pharmacological restraint, must include, but not be limited to, the following information:

   a) The date and time the procedure started and ended,

   b) The name of the physician or PMHNP who authorized it, the name(s) of staff who initiated the procedure, were involved in applying or monitoring it, and/or were responsible for terminating it,

   c) Whether or not the resident returned from therapeutic leave within the preceding twenty-four (24) hours,

   d) The reason the procedure was used,

   e) Which less restrictive options were attempted, and how they failed,

   f) Criteria for ending the procedure,

   g) The results of the face-to-face assessment conducted by a physician, PMHNP or RN within one (1) hour after initiation of the procedure including:

      (1) The resident's physical and psychological status,

      (2) The resident's behavior,

      (3) The appropriateness of the intervention measures, and

      (4) Any complications resulting from the intervention.

   h) The resident's condition at the time of each fifteen (15) minute reassessment and at the end of the procedure,

   i) The signature of the person documenting the incident,

   j) A record of both staff/resident and staff only debriefing sessions, which must take place within twenty-four (24) hours of the use of seclusion/restraint, and must include the names of staff present for or excused from the debriefing and any changes to the resident's treatment plan that resulted from the debriefings, and

   k) Notification of the resident's parents/guardians within twenty-four (24) hours of the initiation of each incident, including the date and time of notification and the name of the staff person providing the notification.

2. A separate log documenting all episodes of seclusion/restraint in the PRTF must be

maintained. A multi-disciplinary team, including at least nursing personnel, physician or PMHNP, therapist, and quality management personnel, must review incidents of seclusion/restraint monthly. These meetings must be documented.

3. Information regarding the number of times seclusion or restraint have been employed by a facility must be included each month as part of the facility's census report to the UM/QIO.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 483.364(b)(1)(2); 483.356(a)(1)(2)(3)(4); 483.366(a); 483.356(a)(3)(ii); 483.358(d)(e)(f); 483.364(a); 483.362(a)(c); 483.370(a)(b).

Rule 4.13: Medication

A. Documents pertaining to medication must be accurate and readily located. When medication is a prescribed intervention for a problem identified in the resident's treatment plan, it must be noted as such in the treatment plan. Medication changes must be made during treatment planning meetings whenever possible. When circumstances preclude this, the changes must be reviewed for all team members' update at the next available staffing opportunity.

B. When medications are prescribed or changed, a member of the professional staff must review, with each resident's parent/guardian, the following:

   1. The name/class of medication,

   2. The method of administration,

   3. The symptoms targeted,

   4. Possible side effects of the medication,

   5. Possible long-term effects of the medication,

   6. Treatment alternatives, and

   7. Likely outcomes of using/not using the medication.

C. When a face-to-face encounter cannot be held with a parent/guardian prior to starting a medication regimen, the "informed consent" conference must be held by telephone, with the parent's/guardian's responses noted and dated.

   1. Two (2) PRTF staff must witness the form after talking with the parent/guardian.

   2. The informed consent must be signed by the parent/guardian within thirty (30) days after the telephone consent.

D. Documentation must substantiate that medications have been accurately administered in accordance with the physician's or PMHNP's orders. Any variances must be justified in the

record by medical staff.

E. An instrument for monitoring medication side effects must be identified and routinely administered to each resident who is prescribed psychoactive medication upon admission, at least every sixty (60) days during his/her stay and again at discharge.

F. Medication adjustment is defined as the use of a resident's routine medication in a non-routine way to help the resident through a period of heightened stress or agitation. Medication adjustment is not considered to be a special procedure. Medication adjustments must not be sedating, must be administered orally, and must be taken voluntarily by the resident. Standing PRN orders for medication adjustments are acceptable.

Source: Miss. Code Ann. § 43-13-121.

Rule 4.14: Discharge Aftercare

A. No later than seven (7) days prior to the resident's projected discharge date, the treatment team must develop a provisional aftercare plan for the resident. The plan's content must include, but not be limited to:

   1. The planned discharge date,

   2. The date of the resident's admission and discharge,

   3. The name of the person/agency expected to assume care and custody of the resident,

   4. The physical location/address where the resident is expected to reside,

   5. A list of the resident's psychiatric diagnoses,

   6. Behavior management recommendations for parents and any other suggestions which might contribute towards the resident's successful participation in family life,

   7. Educational summary and practical recommendations/suggestions for teachers which might contribute towards the resident's success at school, and

   8. Treatment recommendations or observations/comments for follow-up mental health clinicians which may increase the likelihood of success in therapeutic aftercare.

B. At the time of the resident's discharge the facility must:

   1. Amend the provisional aftercare plan to include:

      a) The dates of the resident's admission and discharge,

      b) The name of the person/agency expected to assume care and custody of the resident,

c) The physical location/address where the resident is expected to reside,

d) A list of the resident's psychiatric diagnoses,

e) Detailed information about the resident's medications the names, strengths and dosage instruction in lay terms for all medications prescribed for the resident, as well as any special instructions such as lab work requirements,

f) Behavior management and other pertinent recommendations for parents/caregivers,

g) Names, addresses and telephone numbers of the agencies/persons who will provide follow -up mental health services, the date and time of initial aftercare appointments, and treatment recommendations for the providers of those services,

h) Place where the resident will be attending school, a summary of the resident's educational progress while at the PRTF, his/her current educational standing, and recommendations for the resident's teachers,

i) Other recommended resources, if applicable, including recreational, rehabilitative, or other special programs believed to offer benefit to the resident,

j) The parent/guardian's signed acknowledgment that she/he was provided:

1) A copy of the resident's aftercare plan,

2) A minimum of a seven (7) day supply of the resident's medications, and

3) Prescriptions for a thirty (30) day supply of the resident's medications.

2. Provide the parent/guardian with:

a) A written copy of the final aftercare plan.

b) A supply of all current medications prescribed for the resident, equal to the amount already stocked for that resident by the PRTF but not less than a seven (7) day supply or more than a thirty (30) day supply.

c) Prescriptions for a thirty (30) day supply of all medications prescribed for the resident.

3. Seek the parent's/guardian's consent to release copies of the resident's educational summary and recommendations to the resident's school. If this consent is obtained, the educational information must be mailed to the resident's school within one working day following the resident's discharge. The school must not be sent the resident's complete aftercare plan, but only the part pertaining to education.

4. Seek the parent's/guardian's consent to release copies of the resident's aftercare plan and discharge summary to the providers of follow-up mental health services. If this consent is obtained, the aftercare plan and discharge summary must be mailed to mental health aftercare within two (2) weeks following the resident's discharge.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441, Subpart D

Rule 4.15: Reporting Requirement

A. The PRTF must keep the Division of Medicaid informed of serious occurrences involving residents of the PRTF.

   1. The death of any resident or a serious incident involving any resident, regardless of whether or not those involved were Medicaid beneficiaries, must be reported to the Division of Medicaid.

      a) The death of any resident must be reported to the Division of Medicaid as soon as possible, but no later than close of business the same day.

      b) Serious incidents must be reported by fax to the Division of Medicaid by close of the next business day.

   2. The Division of Medicaid defines serious incidents as:

      a) Serious injury of a resident, defined as any significant impairment of the physical condition of the resident as determined by qualified medical personnel.

         1) This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

         2) All serious injuries that require medical intervention are to be reported.

      b) Suicide attempt by a resident.

      c) Elopement of a resident.

      d) Allegations of sexual contact between residents.

      e) Allegations of maltreatment, like abuse and/or neglect of a resident.

      f) Any injury of a resident sustained in the course of a seclusion or restraint.

   3. Each report must include:

a) The name of the resident, if she/he is a Medicaid beneficiary,

b) A description of the occurrence, and

c) The name, street address, and telephone number of the facility.

B. Serious incidents must also be reported to the appropriate agencies or entities according to applicable state and federal regulations. These include, but are not limited to:

1. Department of Human Services (DHS).

2. Mississippi State Department of Health, Bureau of Health Facilities Licensure and Certification (MSDH).

3. Disability Rights Mississippi (DRM) formerly known as the State Protection and Advocacy office.

4. Regional Office of the Center for Medicare and Medicaid Services (CMS)

5. Medicaid Fraud Control Unit, Attorney General (MFCU)

6. Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid.

Source: Miss. Code Ann. § 43-13-121; 43-21-353; 42 CFR 483.374

Rule 4.16: Maintenance of Records

Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; 43-21-353

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 208
Home and Community Based Services (HCBS), Long Term Care

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Title 23: Division of Medicaid

Part 208: Home and Community Based Services (HCBS) Long Term Care

Part 208 Chapter 1: HCBS Elderly and Disabled Waiver

Rule 1.1: General

A. The Division of Medicaid covers certain home and community-based services as an alternate to institutionalization in a nursing facility through its Elderly and Disabled Waiver (E & D).

   1. Persons enrolled in the E & D Waiver must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.

   2. The Division of Medicaid does not cover E & D waiver services to persons in congregate living facilities, institutional settings, on the grounds of or adjacent to institutions, or in any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

B. The E & D Waiver is administered and operated by the Division of Medicaid.

Source: 42 C.F.R. § 441.301; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017.

Rule 1.2: Eligibility

A. Eligibility requirements for the Elderly & Disabled (E&D) Waiver Program include the following:

   1. Persons must be twenty-one (21) years of age or older.

   2. Persons must require nursing facility level of care as determined by a standardized comprehensive preadmission screening tool.

   3. A person's nursing facility level of care must be certified by a physician and recertified every twelve (12) months at a minimum.

   4. Persons must be in one of the following Categories of Eligibility (COE):

      a) Supplemental Security Income (SSI), or

      b) An aged, blind or disabled individual who meets all factors of institutional eligibility. If income exceeds the current institutional limit, the individual must pay the Division of Medicaid the portion of their income that is due under the terms of an Income Trust in order to qualify.

B. Persons enrolled in the E & D Waiver cannot reside in a nursing facility or licensed or unlicensed personal care home and are prohibited from receiving additional Medicaid services through another waiver program.

C. Persons enrolled in the E & D Waiver who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice. Persons may receive non-duplicative waiver services in coordination with hospice services.

Source: 42 USC § 1396n; 42 CFR §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised eff. 08/01/2016; Revised eff. 06/01/2016; Revised eff. 01/01/2013.

Rule 1.3: Provider Enrollment

A. Providers of long term care/home and community based waiver services, excluding the intellectual disabilities/developmental disabilities waiver, must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

2. Copy of current licensure card or permit, if applicable,

3. Verification of a social security number using a social security card, driver's license with a social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9, and

4. Written confirmation from the IRS confirming the provider's tax identification number and legal name.

B. To become a HCBS Elderly & Disabled Waiver Provider, the prospective provider must:

1. Be approved by Division of Medicaid after submitting a completed proposal package.

2. Enter into a provider agreement with the Division of Medicaid.

3. Establish a Mississippi based physical address/office prior to enrollment and maintain the physical address/office until the provider agreement is terminated.

4. Depending on the provider type, successfully pass a facility inspection by the Division of Medicaid staff/inspector.

5. Conduct a criminal background check on all employees prior to employment and maintain the record in the employee personnel file.

6. Not employ individuals nor personally have been convicted of or pleaded guilty or nolo contendere to a felony of possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense listed in Section 45-33-23(f) of the Mississippi Codes, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

7. Not apply for a Division of Medicaid provider number for the purpose of providing care to friends/family members.

C. Provider Qualifications:

1. All providers of E&D waiver services must ensure that all employees who have direct participant contact receive an annual physical examination, including a TB skin test.

2. Providers of Adult Day Care, Personal Care Services, and In-Home Respite must satisfy the applicable qualifications to render services.

3. Qualifications for Adult Day Care Services:

   a) Adult day care services must be provided by an established, qualified facility/agency.

   b) Each adult day care service must meet the following requirements:

      1) The facility must be compliant with applicable state and local building restrictions as well as all zoning, fire, and health codes/ordinances.

      2) The facility must meet the requirements of the American Disabilities Act of 1990.

      3) The facility must have a sufficient number of employees with the necessary skills to provide essential administrative and direct care functions to meet the needs of the waiver participants.

      4) The facility must meet the physical and social needs of each waiver participant and maintain compliance with state and federal guidelines regarding services provided.

      5) The facility must have a governing body with full legal authority and judiciary responsibility for the overall operation of the program in accordance with applicable state and federal requirements.

      6) The facility must have an advisory committee representative of the community

and participant population.

7) The facility must have a written plan of operation that is reviewed, approved, and revised as needed by the governing board.

8) The facility must have a qualified administrator, either a chief executive officer or president, responsible for the development, coordination, supervision, fiscal management, and evaluation of services provided through the adult day care services program. The administrator must have a master's degree and one (1) year supervisory experience, either full-time or an equivalent, in a social or health service setting; or a bachelor's degree and three (3) years supervisory experience, either full-time or an equivalent, in a social or health service setting; or comparable technical and human service training with demonstrated competence and experience as a manager in a health or human service setting.

9) The facility must have a program director, either center manager, site manager, or center coordinator, responsible for the organization, implementation, and coordination of the daily operation of the adult day care services program in accordance with the participant's needs and any mandatory requirements. The program director must have a bachelor's degree in health, social services, or a related field and one (1) year supervisory experience, either full-time or an equivalent, or comparable technical and human services training with demonstrated competence and experience as a manage in a health or human services setting. The program director must be under the direction of the administrator.

10) The facility must have a qualified social service staff person. The staff person must be a licensed social worker (LSW) and have a master's degree in social work and at least one (1) year of professional work experience, either full-time or an equivalent, in a human services setting; or a bachelor's degree in social work and two (2) years of professional work experience, either full-time or an equivalent in a human services setting; or a bachelor's degree in a health or social services related field and two (2) years' experience, either full-time or an equivalent, in a human services field. Social Workers must comply with all licensure requirements set by the Mississippi State Board of Examiners for Social Workers and Marriage & Family Therapists. In lieu of a licensed social worker, the functions must be carried out by other health service professionals such as certified rehabilitation counselors, licensed gerontologists, licensed professional counselors, or licensed/certified mental health workers.

11) The facility must have a registered nurse (RN) on staff if the facility provides nursing services. The RN must have a valid state license and a minimum of one (1) year applicable experience, either full-time or the equivalent. The RN must adhere to the scope of practice pursuant to the Nursing Practice Law and the rules and regulations of the Mississippi Board of Nursing.

12) The facility must have an activities coordinator. The activities coordinator must have a bachelor's degree and at least one (1) year of experience, either full-time or an equivalent, in developing and conducting activities for the type population to be served or an associate's degree in a related field and at least two (2) years of appropriate experience, either full-time or equivalent.

13) The facility must have a program assistant. The program assistant must have a high school diploma or the equivalent and at least one (1) year experience, either full-time or an equivalent, in working with adults in a health care or social service setting. The program assistant must receive training in working with older adults and conducting activities for the population served.

14) If the facility prepares food on site, there must be a food service director. The food service director must be a registered dietician (RD), dietetic technician registered (DTR), RD eligible, DTR eligible, or a four (4) year graduate of a baccalaureate program in nutrition/dietetics/food service. In addition, the food service director must have a minimum of one (1) year experience, either full-time or an equivalent, in working with adults in a health care or social service setting. If the food is not prepared on site, the facility must contract with a reputable food service provider/caterer.

15) The facility must have a secretary/bookkeeper. The secretary/bookkeeper must, at a minimum, have a high school diploma or equivalent and the skills and training to carry out the responsibilities of the position.

16) The facility must have a driver. The driver must have a valid state driver's license, a safe driving record, and training in first aid and cardiopulmonary resuscitation (CPR). The driver must maintain compliance with all state requirements for licensure/certification. The driver must be trained in basic transfer techniques and safe ambulation.

17) The facility must record volunteer hours and activities if the facility utilizes volunteers. Volunteers must be individuals or groups who desire to work with adult day service participants. Volunteers must successfully complete an orientation/training program. The responsibilities of volunteers must be mutually determined by the volunteers and staff and performed under the supervision of facility staff members. Duties must either supplement staff in established activities or provide additional services for which the volunteer has special talent/training. The facility must not use volunteers in place of required staff and can use volunteers only on a periodic/temporary basis.

4. Qualifications for Personal Care Service:

a) The agency must be established and in business for a minimum of one (1) year.

b) The provider must provide written documentation to the Division of Medicaid stating

how the required standards are to be met.

c) There must be a Medicaid provider agreement in which the provider agrees to the Home and Community-Based Waiver requirements.

d) There must be a duly constituted authority and a governing structure for assuring responsibility and for requiring accountability for performance.

e) There must be responsible fiscal management.

f) There must be responsible personnel management including:

    1) Appropriate process used in the recruitment, selection, retention, and termination of personal care attendants, and;

    2) Written personnel policies, and job descriptions.

g) There must be a roster of qualified personal care attendants for scheduled service.

h) There must be written criteria for service provision, including procedures for dealing with emergency service requests.

i) Each Personal Care Service provider must have qualified personal care attendants and qualified personal care service supervisors.

    1) The personal care attendant must meet the following requirements:

        i) Must be a high school graduate, have a GED or must demonstrate the ability to read the written personal care services assignment and write adequately to complete required forms and reports of visits.

        ii) Must successfully complete and pass the 40-hour personal care services curriculum training course and the standardized examination designated by DOM prior to rendering services unless otherwise excluded.

        iii) Must demonstrate the ability to work well with aged and disabled individuals who have limited functioning capacity. Must exhibit basic qualities of compassion and maturity and be able to respond to waiver participants and situations in a responsible manner.

        iv) Must be at least eighteen (18) years of age;

        v) Must possess a valid Mississippi driver's license, and have access to reliable transportation;

        vi) Must be able to function independently without constant observation and

supervision;

vii) Must be physically able to perform the job tasks required and assurance that communicable diseases of major public health concern are not present, as verified by a physician;

viii) Must have interest in, and empathy for, people who are ill, elderly, or disabled;

ix) Must have communication and interpersonal skills with the ability to deal effectively, assertively, and cooperatively with a variety of people;

x) Must maintain current and active first aid and CPR certification;

xi) Must be able to carry out and follow verbal and written instructions;

xii) Must have no physical/mental impairments to prevent lifting, transferring, or providing any other assistance to the waiver participant.

2) The personal care service supervisor must have at least two (2) years of supervisory experience in programs dealing with elderly and disabled individuals and meet one of the following requirements:

i) A Bachelor's Degree in Social Work, Home Economics, or a related profession with one year of direct experience working with aged and disabled clients,

ii) A Licensed Registered Nurse or Licensed Practical Nurse, with one (1) year of direct experience working with aged and disabled clients, or

iii) A High School Diploma and four years of direct experience working with aged and disabled clients.

5. In-Home Respite Qualifications

a) Must be established and in business for a minimum of one (1) year.

b) All providers of in-home respite services must submit written policies and procedures, hiring practices, and general business plan detailing the delivery of services prior to entering into a provider agreement.

c) Each in-home respite agency must have qualified in-home respite providers and supervisors.

1) In-home respite provider supervisor must meet the following requirements:

i) Bachelor's degree in social work or related profession,

ii) At least one (1) year experience, either full-time or an equivalent, working with aged and disabled clients, and

iii) Two (2) years supervisory experience, either full-time or an equivalent, or

iv) Licensure as a RN or LPN,

v) One (1) year experience, either full-time or an equivalent, working directly with aged and disabled individuals, and

vi) Two (2) years supervisory experience, either full-time or an equivalent, or

vii) A high school diploma,

viii) Four (4) years' experience, either full-time or an equivalent, working directly with aged and disabled individuals, and

ix) Two (2) years supervisory experience, either full-time or an equivalent.

2) In-home respite providers must meet the following requirements:

i) Eighteen (18) years of age or older.

ii) High school diploma/GED, and at least for (4) years, either full-time or an equivalent, experience as a direct care provider to the aged or disabled.

iii) Certification in CPR and first aid.

iv) Valid Mississippi driver's license and access to reliable transportation.

v) Ability to function independently without constant supervision/observation.

vi) Physical ability to perform tasks required.

vii) Ability to recognize signs of abuse, neglect, and/or exploitation; ability to follow procedures required in the Vulnerable Adult Act.

viii) Knowledge of how to prevent burns, falls, and fires and knowledge of emergency numbers for contacting emergency personnel if required.

ix) Absence of communicable diseases as verified by a physician.

x) Interest in, and empathy for, individuals who are ill, elderly, and/or disabled.

xi) Emotional maturity and ability to respond to individuals and situations in a responsible manner.

xii) Effective communication and interpersonal skills with the ability to deal effectively, assertively and cooperatively with a variety of people.

xiii) Absence of any criminal convictions related to violent crime and/or crime substantially related to the dependent population.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E; 42 CFR 440.180

History: Revised – 06/01/2013, 01/01/2013

Rule 1.4: Freedom of Choice

A. Persons enrolled in a Medicaid Waiver have the right to freedom of choice of Medicaid providers for Medicaid covered services. [Refer to Miss. Admin. Code Part 200, Rule 3.6]

B. Each person found eligible for the Elderly and Disabled (E & D) waiver must be given free choice of all qualified providers.

C. The person and/or guardian or legal representative must be informed of setting options based on the person's needs and preferences, including non-disability specific settings. The setting options must be selected by the person and identified and documented in the plan of services and supports (PSS).

Source: 42 U.S.C. § 1396a; 42 C.F.R. § 431.51; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017; Revised – 01/01/2013.

Rule 1.5: Quality Management

A. Waiver providers must meet applicable service specifications as referenced in the waiver document approved by the Centers for Medicare and Medicaid Services.

B. Providers must report:

1. Changes in contact information, staffing, and licensure within ten (10) calendar days to the Division of Medicaid HCBS staff.

2. Critical incidences of abuse, neglect, and exploitation within twenty (24) hours of the occurrence or knowledge of the occurrence to DOM HCBS staff and other applicable agencies as required by law.

C. Only the Division of Medicaid can initiate, in writing, any interpretation or exception to Medicaid rules or regulations.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.302

History: Revised – 01/01/2013

Rule 1.6: Covered Services

A. Providers must meet all provider specifications as outlined in the Centers for Medicare and Medicaid Services (CMS) approved waiver to provide the following services through the Elderly and Disabled (E & D) Waiver:

1. Case Management (CM)

a. Case management services are provided through the Mississippi Planning and Development Districts/Area Agencies on Aging (PDD/AAA). Each PDD/AAA providing case management services must be approved by the Division of Medicaid and must enter into a provider agreement.

b. Case management services are rendered by two (2) member teams which are composed of the following:

1) A Registered Nurse (RN) - The registered nurse must maintain an active and current unencumbered license to practice in the state of Mississippi or a privilege to_practice in Mississippi with a compact license, with a minimum of two (2) years of nursing experience with aged and/or disabled persons. If the RN has less than two years' experience, they must receive at least ninety (90) days of orientation regarding direction of waiver services under the supervision of an established waiver case manager that has two (2) years of waiver experience.

2) A Licensed Social Worker (LSW)- The LSW must have a current and active social work license with a bachelor's degree in social work or other health related field and two (2) years of experience in direct care services for the aged and/or disabled clients. If the LSW has less than two (2) years` experience, they must receive at least ninety (90) days of orientation regarding direction of waiver services under the supervision of an established waiver case manager that has two (2) years of waiver experience.

c. Each team must have an assigned case management supervisor. The case management supervisor must not carry an active caseload of clients.

d. The case management team, consisting of the RN and the LSW, must conduct face to face visits together using the long-term services and support assessment instrument at the time of admission and recertification. At a minimum thereafter, the RN must visit the person on a quarterly basis. The RN must be available at all times for consultation. The case managers must coordinate services that best meet the waiver person’s needs. Case management services may be provided at the Adult Day Care

Facility at a maximum of one (1) visit per quarter. This visit cannot be the initial assessment, recertification assessment or quarterly visit for the RN.

2. Adult Day Care Services

   a. Adult Day Care will include comprehensive program services which provide a variety of health, social and related supportive services in a protective setting during daytime and early evening hours. This community-based service must meet the needs of aged and disabled persons through an individualized Plan of Services and Supports (PSS) that includes the following:

      1) Personal care and supervision,

      2) Provide choices of food and drinks to persons at any time during the day to meet their nutritional needs in addition to the following:

         (a) A mid-morning snack,

         (b) A noon meal, and

         (c) An afternoon snack.

      3) Provision of limited health care,

      4) Transportation to and from the site, with cost being included in the rate paid to providers, and

      5) Social, health, and recreational activities.

   b. Adult Day Care activities must be included in the PSS, must be related to specific, verifiable, and achievable long and short-term goals/objectives, and must be monitored by the person's assigned case manager.

   c. To receive Medicaid reimbursement the person must receive a minimum of four (4) hours, but less than twenty-four (24) hours, of services per day. Providers cannot bill for time spent transporting the person to and from the facility.

   d. Adult Day Care settings must be physically accessible to the person and must:

      1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including engagement in community life, to the same degree of access as individuals not receiving Medicaid HCBS.

      2) Be selected by the person from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the person's needs and preferences.

3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

4) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

5) Facilitate individual choice regarding services and supports, and who provides them.

e. Adult Day Care settings do not include the following:

1) A nursing facility,

2) An institution for mental diseases,

3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),

4) A hospital, or

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:

(a) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

(b) Located in a building on the grounds of or immediately adjacent to a public institution, or

(c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

3. Personal Care Services

a. Personal Care Services (PCS) include non-medical support services provided in the home of eligible persons by trained personal care attendants to assist the waiver person in meeting daily living needs and ensure optimal functioning at home and/or in the community.

b. Personal care services include assistance to functionally impaired persons allowing them to remain in their home by providing assistance with activities of daily living, instrumental activities of daily living, and assistance in participating in community activities.

c. It must be medically necessary for a personal care attendant to accompany persons during transportation provided by a Medicaid Non-Emergency Transportation (NET) provider.

d. Services must be provided in accordance with a waiver person's PSS.

e. Eligible persons are approved for personal care services based upon assessed needs with the person's involvement. Services will not be approved without sufficient documentation to substantiate the request. The frequency cannot duplicate hours rendered for respite care and/or home health aide services. Any increase in the number of hours indicated on the PSS must be prior approved by the Division of Medicaid. Decreases in the number of hours do not require the Division of Medicaid's approval but notification of the decreases must be submitted.

f. Personal care attendant responsibilities:

1) Assist with personal care:

(a) Mouth and denture care,

(b) Shaving,

(c) Finger and toe nail care (no cutting),

(d) Grooming hair to include shampooing, combing, and oiling,

(e) Bathing or bed bath-shower or tub (partial or complete),

(f) Assist with dressing,

(g) Assist with toileting including bed pan, commode/chair, or urinal (emptying and cleaning),

(h) Remind waiver person to take medication,

(i) Assist with eating,

(j) Transferring or changing the waiver person's body position, and

(k) Assist with ambulation.

2) Perform housekeeping tasks:

(a) Assure that rooms are clean and orderly, including sweeping, mopping and dusting,

(b) Prepare shopping lists,

(c) Purchase and store groceries,

(d) Prepare and serve meals,

(e) Launder and iron clothes,

(f) Run errands,

(g) Clean and operate equipment in the home such as the vacuum cleaner, stove, refrigerator, washer, dryer, and small appliances,

(h) Change linen and make the bed, and

(i) Clean the kitchen, including washing dishes, pots, and pans.

3) Report to the personal care services supervisor, PCS director, or the individual designated to supervise the personal care services program.

g. Personal care attendant supervisor responsibilities:

1) The personal care attendant supervisor is responsible for providing the following:

(a) Supervise no more than twenty (20) full-time personal care attendants,

(b) Make home visits with personal care attendants to observe and evaluate job performance, maintain supervisory reports, and submit monthly activity sheets,

(c) Review and approve PCS duties on the approved service plans,

(d) Receive and process requests for services,

(e) Be accessible to personal care attendants for emergencies, case reviews, conferences, and problem solving,

(f) Evaluate the work, skills, and job performance of the personal care attendant,

(g) Interpret agency policies and procedures relating to the personal care services program,

(h) Prepare, submit, or maintain appropriate records and reports,

(i) Plan, coordinate, and record ongoing in-service training for the personal care attendants, and

(j) Perform supervised visits in the person's home and unsupervised visits which may be performed in the person's home or by phone, alternating on a biweekly basis to assure services and care are provided according to the PSS.

2) The personal care services supervisor is directly responsible to the PCS agency's Director and is responsible for the regular, routine, activities of the personal care services program in the absence of the Director.

4. Institutional or In-Home Respite Services

a. Respite Care provides non-medical care and supervision/assistance to persons unable to care for themselves in the absence of the person's primary full-time, live-in caregiver(s) on a short-term basis.

b. Services must be rendered only to provide assistance to the caregiver(s) during a crisis situation and/or scheduled relief to the primary caregiver(s) to prevent, delay or avoid premature institutionalization of the person.

c. Institutional Respite Services

1) Institutional respite must only be provided in Title XIX hospitals, nursing facilities, and licensed swing bed facilities.

2) Providers must meet all certification and licensure requirements applicable to the type of respite service provided, and must obtain a separate provider number, specifically for this service.

3) Eligible persons may receive no more than thirty (30) calendar days of institutional respite care per fiscal year.

d. In-Home Respite Services

1) In-Home Respite services shall be provided on a short-term basis to persons unable to care for themselves and furnished in the absence of the person's primary full-time, live-in caregiver/caregivers.

2) Criteria for in-home respite services include all of the following:

(a) Person must be home-bound due to physical or mental impairments, and

(b) Person must require twenty-four (24) hour assistance by the caregiver, meaning that the person cannot be left alone and unattended for any period of time.

3) In-Home Respite services are limited to no more than sixty (60) hours per month

to any person. In-Home Respite services in excess of sixteen (16) continuous hours must be prior approved by the case management team.

5. Home Delivered Meals

   a. Requirements for Home Delivered Meals include:

      1) Persons must be unable to leave home without assistance, unable to prepare their own meals, and/or have no responsible caregiver in the home.

      2) All eligible persons must receive a minimum of one (1) meal per day, five (5) days per week. If there is no responsible caregiver to prepare meals, the person will qualify to receive a maximum of one (1) meal per day, seven (7) days per week.

   b. Home Delivered Meal~~s~~ services must not be provided by individual providers.

6. Extended Home Health Services

   a. Persons may receive twenty-five (25) home health visits each fiscal year through the Medicaid State Plan. Through the Elderly and Disabled Waiver, people may receive additional home health visits after the initial twenty-five (25) have been exhausted, but only with prior approval from the Division of Medicaid. Home Health Services include skilled nursing, physical therapy, speech therapy and home health aide.

   b. Home Health Agencies must follow all rules and regulations set forth in Part 215. The word "waiver" does not apply to anything other than Home Health visits with prior approval from the Division of Medicaid. Waiver persons are subject to home health co-payment requirements through the twenty-fifth (25th) visit. Starting with the twenty-sixth (26th) home health visit, within the state fiscal year, the Waiver person is exempt from home health co-payment requirements.

   c. Providers must be certified to participate as a home health agency under Title XVIII, Medicare, of the Social Security Act; furnish the Division of Medicaid with a copy of its certification and/or recertification; meet all applicable state and federal laws and regulations; provide the Division of Medicaid with a copy of its certificate of need approval when applicable; and execute a participation agreement with the Division of Medicaid.

   d. The personal care attendant and home health aide must not be in the person's home at the same time and must not perform the same duties. Exceptions to this rule must be based on medical justification and thoroughly documented.

7. Transition Assistance

   a. Transition Assistance is a one (1) time initial expense required for setting up a

household. The expenses must be included in the approved PSS. Transition Assistance Services are capped at eight hundred dollars ($800.00) one (1) time initial expense per lifetime.

b. To be eligible for Transition Assistance Services the person must meet all of the following criteria:

   1) Person must be a nursing facility resident whose nursing facility services are paid for by the Division of Medicaid,

   2) Person must have no other source to fund or attain the necessary items/support,

   3) Person must be moving from a nursing facility where these items/services were provided, and

   4) Person must be moving to a residence where these items/services are not normally furnished.

c. Transition Assistance Services include the following:

   1) Security deposits required to obtain a lease on an apartment or home,

   2) Essential furnishings such as bed, table, chairs, window blinds, eating utensils, and food preparation items. Items such as televisions, cable TV access or VCR/DVD/Blue Ray players are not considered furnishings,

   3) Moving expenses,

   4) Fees/deposits for utilities or service access such as telephone, electricity, and the like, and

   5) Health and safety assurances such as pest eradication, allergen control, or one (1) time cleaning, prior to occupancy.

d. All Transition Assistance Services are essential to:

   1) Ensuring that the person is able to transition from the current nursing facility, and

   2) Removing an identified barrier or risk to the success of the transition to a more independent living situation.

e. Transition Assistance is not available for persons whose stay in a nursing facility is ninety (90) days or less.

B. Persons who choose to reside in a licensed/unlicensed Personal Care Home are not eligible to receive Elderly & Disabled (E & D) Waiver services.

Source: 42 C.F.R. §§ 431.53, 440.170, 440.180, 441.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2017; Revised – 01/01/2013.

Rule 1.7: Prior Approval/Physician Certification

A. Prior approval must be obtained from the Division of Medicaid before a participant can receive services through the Home and Community-Based Waiver Program. To obtain approval, the waiver provider must complete and submit current Division of Medicaid approved forms as follows:

   1. Pre-Admission Screening (PAS),

   2. Web Plan of Care,

   3. Stand Alone Plan of Care,

   4. Admitted and Discharged Form,

   5. Completed Informed Choice form,

   6. Section X/Certification Page Signed and dated by the Physician, and

   7. Electronic Summary.

B. The Section X/Certification Page must be submitted to the Division of Medicaid within thirty (30) days of the physician's signature date or the date received by the case manager if not dated by the physician.

C. An eligible participant must be locked into only one (1) program at a time. Any request to add or increase skilled services listed on the approved plan of care must receive prior approval.

D. All requests for increases in service must be submitted to the Division of Medicaid for approval and must include documentation to substantiate the need for the increase. DOM must also receive notification of any decreases in services but approval is not required.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.301(b)(1)

History: Revised – 01/01/2013

Rule 1.8: Documentation/Record Maintenance

A. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect

requirements set forth in the waiver.

B. In addition, waiver providers must submit copies of all service logs and documentation of visits for each waiver participant served, to the individual's case manager no later than the fifteenth (15th) of the following month in which the service was rendered. Refer to Maintenance of Records Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

History: Revised – 01/01/2013

Rule 1.9: Participant Cost Sharing

Participants enrolled in wavier programs are exempt from co-pay for waiver services. Refer to Part 200, Chapter 3, Rule 3.7.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 447.50 – 447.59; Social Security Act 1902(a)(14)

History: Revised – 01/01/2013

Rule 1.10: Reimbursement

A. Requests for reimbursement for waiver services must be withheld until the first (1st) day of the month following the month in which services were rendered.

B. Extended Home Health services will be paid in accordance with the Home Health reimbursement rules.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(15)

Rule 1.11: Due Process Protection

A. The Case Manager must provide written notice to the participant when any of the following occur:

    1. Services are reduced,

    2. Services are denied, or

    3. Services are terminated.

B. The recourse/appeal procedure notice, E&D Waiver or Notice of Action, must contain the following information:

    1. The dates, type, and amount of services requested,

2. A statement of the action to be taken,

3. A statement of the reason for the action,

4. A specific regulation citation which supports the action,

5. A complete statement of the participant/authorized representative's right to request a fair hearing,

6. The number of days and date by which the fair hearing must be requested,

7. The participant's right to represent himself or herself, or use legal counsel, a relative, friend, or other spokesperson, and

8. The circumstances under which services may be continued if a hearing is requested.

C. Whenever the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the participant must be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction or termination of services or within ten (10) calendar days of the decision to deny additional services.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.307; 42 CFR 431.210; 42 CFR 431 Subpart E

History: Revised – 01/01/2013

Rule 1.12: Hearings and Appeals

A. Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed. If the participant/legal representative chooses to appeal, all appeals must be in writing and submitted to the Division of Medicaid within thirty (30) days from the date of the notice of the change in status.

B. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to immediate or perceived danger, racial discrimination or sexual harassment of the service providers. The case manager will maintain responsibility for ensuring that the participant receives all services that were in place prior to the notice of change.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 431 Subpart E; 42 CFR 441.308

History: Revised - 01/01/2013

Rule 1.13: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

1. Allow the person to lead the process where possible with the person's guardian and/or legal representative having a participatory role, as needed and as defined by the person and any applicable laws.

2. Include people chosen by the person.

3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

4. Be timely and occur at times and locations of convenience to the person.

5. Reflect cultural considerations of the person and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

6. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process.

8. Offer informed choices to the person regarding the services and supports they receive and from whom.

9. Include a method for the person to request updates to the PSS as needed.

10. Record the alternative HCBSs that were considered by the person.

B. The PSS must reflect the services and supports that are important for the person to meet the needs identified through an assessment of functional need, as well as what is important to the person with regard to preferences for the delivery of such services and supports and the level of need of the individual and must:

1. Reflect that the setting in which the person resides is:

    a) Chosen by the person,

    b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

        (1) Seek employment and work in competitive integrated settings,

        (2) Engage in community life,

        (3) Control personal resources, and

        (4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

8. Identify the individual and/or entity responsible for monitoring the PSS.

9. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

10. Be distributed to the individual and other people involved in the plan.

11. Include those services, the purpose or control of which the individual elects to self-direct.

12. Prevent the provision of unnecessary or inappropriate services and supports.

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

1. A description of the individual's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports.

2. The outcomes identified by the individual and how progress toward achieving those outcomes will be measured.

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Providers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

Source: 42 C.F.R. § 441.301; Miss. Code Ann. § 43-13-117.

History: New rule eff. 01/01/2017.

Part 208 Chapter 2: Home and Community-Based Services (HCBS) Independent Living Waiver

Rule 2.1: General

A. The Division of Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in a nursing facility through its Independent Living (IL) Waiver.

1. Waiver participants must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.

2. The Division of Medicaid does not cover IL waiver services to persons in congregate living facilities, institutional settings, on the grounds of or adjacent to institutions, or any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

B. The IL Waiver is administered by the Division of Medicaid and jointly operated by the Division of Medicaid and Mississippi Department of Rehabilitative Services (MDRS).

C. The Division of Medicaid maintains responsibility for the administration of the waiver and formulates policies, rules, and regulations. Under the direction of the Division of Medicaid, the fiscal agent is responsible for processing claims, issuing payments to providers, and notifications regarding billing. MDRS is responsible for operational functions and maintaining a current Medicaid provider number.

D. The average cost for a waiver applicant/participant must not be above the average estimated cost for nursing facility level of care approved by the Centers for Medicaid and Medicare Services (CMS) for the current waiver year. The State may refuse entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the facility and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State.

Source: 42 U.S.C. § 1396n; 42 C.F.R. § 440.180; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2017; Revised 01/01/2013.

Rule 2.2: Eligibility

A. Eligibility is limited to individuals age sixteen (16) or older who:

1. Exhibit severe orthopedic and/or neurological impairments that render the individual dependent on others, assistive devices, other types of assistance, or a combination of the three (3) to accomplish the activities of daily living.

2. Are able to express ideas and wants either verbally or nonverbally with caregivers, personal care attendants (PCAs), counselors, case managers or others involved in their care.

3. Are certified as medically stable by their physician. The Division of Medicaid defines medical stability as the absence of all of the following:

   a) An active, life-threatening condition requiring systematic therapeutic measures,

b) Intravenous drip to control or support blood pressure, and

c) Intracranial pressure or arterial monitoring.

B. Clinical eligibility for waiver services is determined through a comprehensive Pre-Admission Screening (PAS) tool that includes, but is not limited to, the following areas: activities of daily living, instrumental activities of daily living, sensory deficits, cognitive deficits, client behaviors, medical conditions, and medical services.

C. Pre-admission screening data, entered into a scoring algorithm generating a numerical score, is compared to a set numerical threshold and determines clinical eligibility.

D. Individuals must qualify for full Medicaid benefits in one (1) of the following Categories of Eligibility (COE):

1. Supplemental Security Income (SSI),

2. Parents and Other Caretaker Relatives Program,

3. Disabled Child Living at Home,

4. Children under age nineteen (19) who meet the applicable income requirements,

5. Disabled Adult Child,

6. Protected Foster Care Adolescents,

7. Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,

8. IV-E Foster Children and Adoption Assistance Children,

9. An aged, blind or disabled individual who meets all factors of institutional eligibility. If income exceeds the current institutional limit, the individual must pay the Division of Medicaid the portion of their income that is due under the terms of an Income Trust in order to qualify, or

10. Working Disabled.

E. Persons enrolled in the Independent Living Waiver who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice. Persons may receive non-duplicative waiver services in coordination with hospice services.

Source: 42 USC § 1396n; 42 CFR §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised eff. 08/01/2016; Added Miss. Admin. Code Part 208, Rule 2.2.E. eff. 06/01/2016; Revised eff. 01/01/2013.

Rule 2.3: Covered Services

The Division of Medicaid covers the following Independent Living Waiver services:

A. Case Management services are mandatory services provided by a Registered Nurse and a Rehabilitation Counselor and include the following activities:

   1. Must initiate and oversee the process of assessment and reassessment of the participant's level of care and review the plan of care to ensure services specified on the plan of care are appropriate and reflective of the participant's individual needs, preferences, and goals.

   2. Must assist waiver applicant/participants in gaining access to needed waiver and other State plan services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services to which access is gained.

   3. Are responsible for ongoing monitoring of the provision of services included in the participant's plan of care.

   4. Must conduct quarterly face-to-face reviews to determine the appropriateness and adequacy of the services and to ensure that the services furnished are consistent with the nature and severity of the participant's disability and make monthly phone contact with the participant to ensure that services remain in place without issue and to identify any problems or changes that are required. More frequent visits are expected in the event of alleged abuse, neglect or exploitation of waiver participants.

   5. Are responsible for ensuring that all personal care attendants for the waiver meet basic competencies that include both academic requirements (i.e. infection control, principles of safety, disability awareness, etc.) and functional requirements (i.e. bathing, transferring, skin care, dressing, bowel and bladder programs).

B. Case Management must be provided by Registered Nurses (RN) and Rehabilitation Counselors who must meet the following qualifications:

   1. The Registered Nurse must:

      a) Have a current and active unencumbered Registered Nurse license to practice in the state of Mississippi or be working in Mississippi on a privilege with a valid compact RN license; and

      b) Have at least one (1) year of experience with the aged and/or individuals with disabilities; and

      c) Not have a history of a criminal offense which precludes him/her from working with

the vulnerable population; and

d) Not appear on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General (OIG) exclusion list.

2. The Rehabilitation Counselor must:

a) Possess at a minimum a Bachelor's degree in Rehabilitation Counseling or other related field; and

b) Have one (1) year of experience working with individuals with disabilities; and

c) Be free of a history of a criminal offense which would preclude him/her from working with a vulnerable population; and

d) Not appear on the Nurse Aide Abuse Registry or the Office of the Inspector General's (OIG) exclusion list.

3. Mississippi Department of Rehabilitation Services (MDRS) is responsible for validating qualifications of the Registered Nurse and Rehabilitation Counselor. MDRS must subscribe with the Mississippi Board of Nursing to receive immediate electronic notification of adverse or disciplinary action taken occurring against nurse employees.

4. MDRS must verify provider qualifications upon hire and at least annually.

C. Personal Care Attendant (PCA) services are non-medical, hands-on care of both a supportive and health related nature. Personal care services are provided to meet daily living needs to ensure adequate support for optimal functioning at home or in the community, but only in non-institutional settings.

1. PCA services must be provided in accordance with the approved plan of care, cannot be purely diversional in nature, and must include:

a) Assistance with eating, bathing, dressing, personal hygiene, and other activities of daily living.

b) Food shopping and assistance with preparation of meals, but not the cost of the meals.

c) Housekeeping chores essential to the health of the beneficiary, when specified in the approved plan of care.

d) Support for community participation by accompanying and assisting the participant as necessary to access community resources; participate in community activities; including appointments, shopping, and community recreation/leisure resources, and socialization opportunities, but does not include the price of the activities themselves.

2. A personal care attendant must be chosen by the participant as someone with whom they are comfortable providing their personal care or chosen from a list of available, eligible/qualified personal care attendants. All personal care attendants must meet basic competencies that include both educational and functional requirements. MDRS Rehabilitation Counselors and Registered Nurses must certify and document that the PCA meets the requirements.

3. A personal care provider must have completed training/instruction that covers the purpose, functions, and tasks associated with the personal care attendant program. The educational program must be personalized with participation of the participant to ensure his/her specific needs are met. The cost of training/instruction of personal care attendants cannot be provided under the waiver. The individual must demonstrate competency to perform each activity of daily living task to the participant and Rehabilitation Counselor/Registered Nurse prior to rendering any waivered services. In addition to the technical skills required, the personal care provider must demonstrate the ability to comprehend and comply with basic written and verbal instructions at a level determined by the participant and Rehabilitation Counselor/Registered Nurse to be adequate in fulfilling the responsibilities of personal care. The training, to be conducted by the participant/caregiver and the Rehabilitation Counselor/Registered Nurse, or an agency permitted by law to train nurse aides, must include:

   a) The purpose and philosophy of self-directed services by the disabled,

   b) Disability awareness,

   c) Employee-employer relationships and the need for respect for the participant's privacy and property.

   d) Basic elements of body functions,

   e) Infection control procedures,

   f) Maintaining a clean and safe environment,

   g) Appropriate and safe techniques in personal hygiene and grooming to include bed, sponge, tub, or shower bath, hair care, nail and skin care, oral hygiene, dressing, bladder and bowel routine, transfers, and equipment use and maintenance.

   h) Meal preparation and menus that provide a balanced, nutritional diet.

4. The individual who has satisfactorily completed a nurse aide training program for a hospital, nursing facility, or home health agency or who was continuously employed for twelve (12) months during the last three (3) years as a nurse aide, orderly, nursing assistant or an equivalent position by one of the above medical facilities shall be deemed to meet the classroom training requirements. Competency certification for these personal care providers by the participant and Rehabilitation Counselor/Registered Nurse is

required. A personal care attendant that has satisfactorily provided personal care attendant service for four (4) weeks prior to coverage under the waiver program, with such service certified by and verified by the participant and the Counselor/Registered Nurse, shall be deemed to meet the training requirement.

5. Personal care services can be furnished by family members provided they are not the spouse or the parent or step-parent of a minor child. Only qualified family members not legally responsible for the waiver participant can be employed as the personal care attendant. Family members must meet provider standards and be certified competent to perform the required tasks by the participant and the Rehabilitation Counselor/Registered Nurse. There must be adequate justification for the family member to function as the attendant such as lack of other qualified attendants in the remote area.

6. Minimum requirements include:

   a) Must be at least 18 years of age;

   b) Must be a high school graduate, have a GED or demonstrates the ability to read and write to complete required forms and reports of visits;

   c) Must be able to follow verbal and written instructions;

   d) Must have no physical/mental impairment to prevent lifting, transferring or providing any other assistance to participant;

   e) Must be certified as meeting the training and competence requirement by the participant and the Rehabilitation Counselor/Registered Nurse;

   f) Must be able to communicate effectively and carry out directions;

   g) Must not have been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors which include, but are not limited to, possession or sale of drugs, murder, manslaughter, armed robbery, rape, sexual battery, any sex offense, child abuse, arson, grand larceny, burglary, gratification of lust, aggravated assault, or felonious abuse and/or battery of a vulnerable adult, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

   h) Must receive training in the areas of the Vulnerable Person's Act, care giver boundaries and dealing with difficult patients upon hire and annually thereafter.

7. MDRS must verify the competency for all personal care attendant as needed.

8. If the participant has not located or chosen a personal care attendant within six months after admission to the waiver, or after being without a personal care attendant for six (6) consecutive months, the participant is reevaluated for the need for waiver services to determine if the waiver can meet the needs of this participant.

9. MDRS is authorized to fingerprint and perform criminal background investigations on personal care attendants for employment decisions and/or actions and service provision to consumers of the department's services. MDRS must verify that any potential personal care attendant is not on the Mississippi Nurse Aide Abuse Registry or the OIG exclusion list.

10. If a waiver participant chooses the Participant Directed Care Service option for managing personal care attendants, the Financial Management Service provider is responsible for obtaining the criminal background check. The FMS provider must verify that the personal care attendants employed by the waiver participant are not on the Mississippi Nurse Aide Abuse Registry or the OIG exclusion list.

D. Specialized Medical Equipment and Supplies include devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

1. The need for use of such items must be documented in the assessment/case file and approved on the plan of care.

2. Items reimbursed with waiver funds are in addition to specialized medical equipment and supplies furnished under Medicaid State Plan. Items not of direct medical or remedial benefit to the participant are excluded.

3. Specialized medical equipment and supplies must meet the applicable standards of manufacture, design and installation. MDRS must certify and document that providers meet the criteria/standards in the waiver document.

4. Requests for specialized medical equipment and supplies must be evaluated by the MDRS counselor or the Division of Medicaid to determine if an Assistive Technology (AT) evaluation and recommendation is needed. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the plan of care and the request for specialized medical equipment and/or supplies for approval.

5. Medicaid waiver funds are utilized as the payor of last resort.

E. Transition Assistance Services are provided to a Mississippi Medicaid eligible nursing facility (NF) resident to assist in transitioning from the nursing facility into the Independent Living Waiver program.

1. Transition Assistance services include the following:

a) Security deposits required to obtain a lease on an apartment or home.

b) Essential furnishings required to occupy and use a community domicile. Televisions

or cable TV access are not essential furnishings.

c) Moving expenses.

d) Fees/deposits for utilities and service access for a telephone.

e) Health and safety assurances including, but not limited to, pest eradication, allergen control, or one-time cleaning prior to occupancy.

2. Transition Assistance is a one (1) time initial expense required for setting up a household and is capped at eight hundred dollars ($800.00) per lifetime. These expenses must be included in the approved plan of care.

3. To be eligible for Transition Assistance, the beneficiary must meet all of the following criteria:

   a) Be currently residing in a nursing facility whose services are paid for by the Division of Medicaid;

   b) Have no other source to fund or obtain the necessary items/supports;

   c) Be moving from a nursing facility where these items/services were provided;

   d) Be moving to a residence where these items/services are not normally furnished.

4. Transition Assistance is not available for beneficiaries whose stay in a nursing facility is ninety (90) days or less.

5. Transition Assistance must be completed by the day the participant relocates from the institution.

6. Persons whose NF stay is temporary or rehabilitative, or whose services are covered by Medicare or other insurance, wholly or partially, are not eligible for this service.

7. Transition Assistance services must be provided by a Registered Nurse and/or a Rehabilitation Counselor.

F. Environmental Accessibility Adaptations are physical adaptations to the home, required by the individual's plan of care, necessary to ensure the health, welfare, and safety of the individual, or enables the individual to function with greater independence in the home.

1. Environmental accessibility adaptations must be included in the approved plan of care.

2. Environmental accessibility adaptations include the following:

   a) Installation of ramps and grab bars.

b) Widening of doorways.

c) Modification of bathroom facilities.

d) Installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies.

3. Environmental accessibility adaptations exclude the following:

a) Adaptations or improvements to the home which are not of direct medical or remedial benefit to the beneficiary.

b) Adaptations which add to the square footage of the home.

4. Requests for environmental accessibility adaptations must be evaluated by the MDRS Rehabilitation Counselor to determine if an Assistive Technology (AT) evaluation is indicated. If an AT evaluation is performed, it must be submitted to the Division of Medicaid along with the plan of care and the request for environmental accessibility adaptation.

5. Providers rendering environmental accessibility adaptation services must:

a) Meet all state or local requirements for licensure/certification including, but not limited to, building contractors, plumbers, electricians or engineers.

b) Provide services in accordance with applicable state housing and local building codes.

c) Ensure the quality of work provided meets standards identified below:

1) All work must be done in a fashion that exhibits good craftsmanship.

2) All materials, equipment, and supplies must be installed clean, and in accordance with manufacturer's instructions.

3) The contractor must obtain all permits required by local governmental bodies.

4) All non-salvaged supplies and/or materials must be new and of best quality, without defects.

5) The contractor must remove all excess materials and trash, leaving the site clear of debris at completion of the project,

6) All work must be accomplished in compliance with applicable codes, ordinances, regulations and laws.

7) The specifications and drawings cannot be modified without a written change order from the case manager.

8) No accessibility barriers can be created by the modification and/or construction process.

6. MDRS must certify and document that providers meet the criteria/standards in the waiver.

G. Financial Management Service (FMS):

1. FMS is a support service to assist the waiver participant who chooses the Participant-Directed Personal Care service. Participant-Directed Personal Care service recognizes the waiver participant as the employer of record.

2. The waiver participant performs budgetary and employer functions and has the ability to negotiate salaries and benefits with the personal care attendants.

3. The FMS agent assists the waiver participant with employer and budget authority by ensuring federal, state and local employment taxes and labor and worker's compensation insurance rules related to household employment and payroll are implemented in an accurate and timely manner as related to the personal care attendant.

4. The FMS agent ensures that the necessary employer related duties and tasks, including payroll, are carried out. The service must ensure initial orientation and ongoing training is provided related to responsibilities of being an employer and adhering to legal requirements for employers.

5. The FMS provider must:

a) Serve as the participant's employer agent which is the IRS designation of the entity responsible for IRS related responsibilities on behalf of the participant.

b) Provide assistance determining personal care attendant wages and benefits.

c) Provide assistance in hiring by verifying employees' citizenship status, conducting criminal background checks, and verifying the employee is not on the Mississippi Nurse Aide Abuse Registry or the Office of Inspector General (OIG) exclusion lists.

d) Verify and maintain documentation of employee qualifications, citizenship status, and documentation of services delivered.

e) Provide education on recruiting, hiring and terminating employees as well as identifying the need for special skills and determining duties and schedules.

f) Ensure appropriate payment by:

1) Collecting timesheets,

2) Processing timesheets,

3) Processing payroll and payables, and

4) Making withholdings for and payment of applicable and federal, state and local employment related taxes.

g) Provide quarterly written reports to the waiver participant of all expenditures and the status of the waiver participant's budget.

h) Maintain a separate account for each waiver participant.

i) Make services available only to those persons deemed eligible and referred by MDRS,

j) Establish contact with the participant within five (5) working days of the referral from MDRS,

k) Conduct a face-to-face visit to initiate the FMS process within five (5) working days of establishing contact with the participant,

l) Conduct at least one (1) face-to-face meeting annually with each participant to review and update the overall function of the FMS,

m) Ensure Division of Medicaid (DOM) access to the participant's case files.

n) Employ staff members with knowledge, experience and abilities to sufficiently carry out the FMS component of service.

o) Have Medicaid provider agreements with the Division of Medicaid with the following requirements.

1) Have a minimum of five (5) years of billing and payroll experience relevant to participant-directed medical care,

2) Have a working knowledge of disability etiquette, psychology, and social aspects of disability, vulnerable persons act including reporting requirements, HCBS waivers, especially the plans of care, and W-2 employee tax reporting requirements. If the FMS lacks a working knowledge of disability etiquette, psychology and social aspects of disability, vulnerable person's act and home and community based waivers, training must be provided to ensure the FMS has a solid foundation for working with individuals with disabilities.

p) Develop and maintain policies and procedures for the delivery of Financial Management Services.

q) Have qualifications verified by DOM initially and monitored annually or more frequently as indicated.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §440.180; 43-13-117(15); CFR §440.180(b)(9);Section 37-33-157 of the Mississippi code of 1972 ; CFR§ 441.302 Social Security Administration 1915(c)

History: Revised 01/01/2013

Rule 2.4: Prior Approval/Certification

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver program. Prior Approval is based on clinical eligibility requiring the beneficiary meet nursing facility (NF) level of care.

B. Clinical eligibility for waiver services is determined through the utilization of a comprehensive Pre-Admission Screening.

C. The physician must certify the participant is appropriate for Medicaid long term care services.

D. The plan of care is the fundamental tool which ensures the health and welfare of participants in the Independent Living Waiver.

1. A participant's plan of care must be based on a comprehensive preadmission screening process and is developed based on the waiver participant's goals, preferences and needs.

2. The case manager/counselor must engage the participant and other interested parties as requested by the participant in developing the plan of care that best meets the needs of the participant.

3. Plans of care must be approved by a Medicaid Program Nurse prior to services being provided.

4. Development of the plan of care must include an emergency preparedness plan.

5. The Plan of Care must be developed at the time of the PAS, updated quarterly, annually and as needed.

6. The Pre-Admission Screening (PAS) and the Plan of Care must be completed jointly by the Rehabilitation Counselor and Registered Nurse on initial certifications.

7. The PAS and the Plan of Care must be completed by the Rehabilitation Counselor or a combination of the Rehabilitation Counselor and the Registered Nurse at re-certification.

E. The application along with the Plan of Care must be submitted to the Division of Medicaid for approval after the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, as determined by the PAS.

F. A participant can only be enrolled in one (1) HCBS waiver program at a time.

G. Added services must be prior approved by the Division of Medicaid.

H. MDRS is responsible for implementation of the plan of care. DOM and MDRS are jointly responsible for monitoring the plan of care and the health and welfare of the participants. DOM, as the administrative agency of the waiver, has the overall oversight responsibility of assuring that processes are in place for plan of care implementation. Monitoring the implementation of the plan of care includes on site review activity, record reviews, annual recertification reviews, participant phone calls from the Medicaid agency, and other strategies as needed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §441.301(b)(1)(i)

History: Revised - 01/01/2013

Rule 2.5: Freedom of Choice

A. Division of Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services as outlined in Part 200, Chapter 3, Rule 3.6.

B. Adherence of Freedom of Choice is required of all qualified providers and is monitored by the operating agency and Division of Medicaid. The case management team must assist the individual and provide them with sufficient information and assistance to make an informed choice regarding services and supports, taking into account risks that may be involved for that individual.

C. Beneficiaries must be:

1. Informed of any feasible alternatives under the waiver,

2. Given the choice of either institutional or home and community-based services, and

3. Provided a choice among providers or settings in which to receive home and community-based services (HCBS) including non-disability specific setting options.

Source: 42 U.S.C. § 1396a; 42 C.F.R. § 431.51; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017; Revised 01/01/2013.

Rule 2.6: Quality Management

A. Providers must meet applicable service specifications as referenced in the waiver document approved by the Centers for Medicare and Medicaid Services (CMS).

B. Providers must report changes in contact information, staffing, and licensure within ten (10) calendar days to the Division of Medicaid.

C. All reports of abuse, neglect or exploitation, as defined below, must be reported by phone and written report immediately by the appropriate case manager to their supervisor at MDRS and the Department of Human Services (DHS). The potential abuse, neglect, or exploitation must be reported to the Division of Medicaid/Long Term Care within twenty-four (24) hours.

    1. Abuse (A) is defined as willful or non-accidental infliction of a single or more incidents of physical pain, injury, mental anguish, unreasonable confinement, willful deprivation of services necessary to maintain mental and physical health, and sexual abuse.

    2. Neglect (N) includes, but is not limited to, a single incident of the inability of a vulnerable person living alone to provide for himself and/or failure of a caretaker to provide what a reasonably prudent person would do.

    3. Exploitation (E) is the illegal or improper use of a vulnerable person or his resources for another's profit or advantage with or without the consent of the vulnerable person and includes acts committed pursuant to a power of attorney and can include but is not limited to a single incident.

D. The Department of Human Services (DHS), Division of Aging and Adult Services is responsible for investigating allegations of Abuse, Neglect and Exploitation. The Division of Medicaid and DHS have a Memorandum of Understanding (MOU) allowing a free flow of information between the two (2) agencies to ensure the health and welfare of waiver participants.

E. Quality Management Strategy for the waiver includes the following:

    1. Level of care determination consistent with the need for institutionalization,

    2. Plan of care consistent with the participant’s needs,

    3. Providers must meet the provider specifications of the CMS approved waiver, including licensure/certification requirements,

    4. Critical event/incident reporting mechanism for participants and caregivers to report concerns/incidents of abuse, neglect, and exploitation,

    5. Division of Medicaid retention of administrative authority over the waiver program,

6. Division of Medicaid retention of financial accountability for the waiver program.

F. When change in the Quality Improvement Strategy is necessary, a collaborative effort between DOM and MDRS is made to meet waiver reporting requirements.

Source: Miss. Code Ann. §43-13-117; §43-13-121; 42 CFR 441.302; Social Security Act 1915(c)

History: Revised – 01/01/2013

Rule 2.7: Participant Direction of Services

A. Participants are encouraged to make choices in regards to participant needs, goals, preferences and desires with all aspects of the services provided.

B. Participants have the choice of two (2) options for personal care service:

1. Co-Participant personal care service, the traditional personal care services, is a viable choice for participants who do not desire to be become the employer of record with budgetary control. Mississippi Department of Rehabilitation Services is recognized as the employer of record but allows the participant to recruit, hire and terminate employment of personal care attendants. The Co-Participant personal care service does not allow the participant to exercise budgetary authority, excluding salary negotiations and other budgetary authority such as withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance.

2. Participant-Directed personal care service allows the participant to exercise employer and budgetary authority for participants for the personal care service. The Participant-Directed personal care service recognizes the waiver participant as the common law employer of record. Waiver participants opting for the Participant-Directed personal care service are provided assistance of a Financial Management Service (FMS) agent to assist with employer and budgetary functions. The waiver participant has the ability to negotiate salaries and benefits with the personal care attendants while the FMS manages the time sheets, criminal background checks and other employment issues.

   a) The FMS provides assistance to the participant with management of the personal care attendant budget and employer duties as associated with the participant being the employer of record. The FMS must submit claims for attendant services to the Division of Medicaid for payment and is responsible for assisting with, including but not limited to, withholdings, tax reports, W2s, workers compensation, unemployment insurance and liability insurance. The participant must be given detailed information about all providers except Personal Care Service, and the participant has the opportunity and is encouraged to choose the provider they feel most comfortable and can best meet their needs.

b) The FMS must:

1) Provide support for financial management when the participant is the employer of the personal care attendant.

2) Assist participant in verifying personal care attendant citizenship status.

3) Collect and process timesheets of personal care attendants.

4) Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance.

5) Verify the personal care attendant is not listed on the Mississippi Nurse Aide Abuse Registry.

6) Verify the personal care attendant is not listed on the Office of Inspector General (OIG) exclusion list.

7) Ensure the participant receives initial orientation and ongoing training related to responsibilities of being an employer and adhering to legal requirements for employers.

8) Serve as the participant's employer agent which is the IRS designation of the entity responsible for IRS-related responsibilities on behalf of the participant.

9) Provide assistance determining employee wages and benefits.

10) Verify and maintain documentation of employee qualifications and documentation of services delivered.

11) Conduct criminal background checks on personal care attendants.

12) Assist the participant with recruitment of personal care attendants.

13) Maintain a separate account for each participant's participant-directed budget.

14) Track and report participant funds, disbursements and the balance of participant funds.

15) Process and pay invoices for personal care attendant services approved in the service plan.

16) Provide participant with periodic reports of expenditures and the status of the participant directed budget.

c) FMS providers must have a Medicaid provider agreement with the Division of

Medicaid. The Division of Medicaid is responsible for oversight of the FMS entities by compliance reviews conducted on an annual basis or more often if needed. Reviews are instigated in the event of a complaint regarding management of funds. Any participant under-utilization or over-utilization of services must be reported to the Division of Medicaid.

d) Waiver participant's failure to comply with participant directed service guidelines will result in a corrective action plan. Repetitive non-compliance disqualifies a waiver participant for the Participant-Directed Service option.

e) A waiver participant can change from the Participant-Directed Personal Care service to the Co-Participant Directed Personal Care service at any time at their request.

f) Immediate termination of the Participant-Directed personal care service option occurs if the following circumstances arise, including, but not limited to:

1) The participant's/employer's health or welfare is immediately jeopardized,

2) The personal care attendant is convicted of criminal offenses precluding him/her from working with the vulnerable population,

3) The participant/employer has not implemented an acceptable corrective action plan as required to continue Participant-Direction,

4) The waiver participant declines to the degree he/she is no longer able to express his/her ideas and wants verbally or nonverbally,

5) The waiver participant fails to provide adequate justification for underutilizing or over utilizing personal care services,

6) Fraud and/or abuse of funds, or

7) Unsafe environment for care providers.

Source: CFR§ 441.302 Social Security Administration 1915(c)

History: Revised 01/01/2013

Rule 2.8: Monitoring Safeguards

A. MDRS case managers are required to provide each waiver participant with written information regarding their rights as a waiver participant at the initial assessment.

B. Case managers must provide the participants information at the initial assessment regarding the Mississippi Vulnerable Person's Act and phone numbers of when and who to call if abuse, neglect or exploitation is alleged.

Source: Miss. Code Ann. § 43-13-121

History: Revised 01/01/2013

Rule 2.9: Additional Dispute Resolution Process

A. The Division of Medicaid and MDRS are responsible for operating the dispute mechanism separate from a fair hearing process. The Division of Medicaid has the final authority over any dispute.

B. The types of disputes addressed by an informal dispute resolution process include issues concerning service providers, waiver services, and other issues that directly affect their waiver services.

C. MDRS must inform the participant at the initial assessment, of the specific criteria for the dispute, complaint/grievance and hearing processes.

D. MDRS must inform the participant of their rights which address disputes, complaints/ grievances and hearings.

Source: Miss. Code Ann. § 43-13-121

History: Revised 01/01/2013

Rule 2.10: Financial Accountability

A. Claims for waiver services are based on state payment for waiver services that have been rendered to waiver participants as authorized by the plan of care, accurately billed by qualified waiver providers, and in accordance with the approved waiver.

B. The DOM conducts financial audits of waiver providers. If warranted, immediate action is taken to address compliance or financial discrepancies.

C. DOM denies payment for services when a waiver participant or applicant is not Medicaid eligible on the date of service.

D. DOM conducts post utilization reviews to ensure the services provided were on the participant's approved plan of care.

E. Records documenting the provision of services must be maintained by the operating agency (if applicable) and providers of waiver services for a minimum of three (3) years.

F. Payment for all waiver services is made through an approved Medicaid Management Information System (MMIS).

Source: 45 CFR § 92.42, Miss Code 43-13-121

History: Revised 01/01/2013

Rule 2.11: Hearing and Appeals

A. The Division of Medicaid provides an opportunity to request a Fair Hearing to individuals:

   1. Who are not given the choice of home and community-based services as an alternative to the institutional care,

   2. Who are denied the service(s) of their choice or the provider(s) of their choice, or

   3. Whose services are denied, suspended, reduced, or terminated.

B. MDRS must provide the individual with a Notice of Action (NOA) via certified mail as required in 42 CFR §431.210.

C. The NOA must include:

   1. A description of the action the provider has taken or intends to take,

   2. An explanation for the action,

   3. Notification that the participant has the right to file an appeal,

   4. Procedures for filing an appeal,

   5. Notification of participant's right to request a Fair Hearing,

   6. Notice the participant has the right to have benefits continued pending the resolution of the appeal, and

   7. The specific regulations or the change in Federal or State law that supports or requires the action.

D. The waiver participant or his/her representative may request to present an appeal through a local-level hearing, a state-level hearing, or both. The request for a local or state hearing must be made in writing by the participant or his/her legal representative.

E. The waiver participant may be represented by anyone he/she designates. If the participant elects to be represented by someone other than a legal representative, he/she must designate the person in writing.

F. The participant has thirty (30) days from the date the appropriate notice is mailed to request either a local or state hearing. This thirty (30) day filing period is extended if the participant can show good cause for not filing within (30) days.

G. A hearing cannot be scheduled until a written request is received by either the MDRS or the State DOM office. If the written request is not received within the thirty (30) days of the NOA, services will be discontinued.

H. At the local hearing level, MDRS issues a determination within thirty (30) days of the date of the initial request for a hearing.

I. The participant has the right to appeal a local hearing decision by requesting a State hearing; A State hearing request must be made within fifteen (15) days of the mailing date of the local hearing decision.

J. At the State hearing level, DOM issues a determination within ninety (90) days of the date of the initial request for a hearing.

K. The waiver participant or his representative has the following rights in connection with a local or state hearing:

   1. The right to examine at a reasonable time before the date of the hearing and during the hearing the contents of the applicant or recipient's case record.

   2. The right to have legal representation at the hearing and to bring witnesses.

   3. The right to produce documentary evidence and establish all pertinent facts and circumstances concerning eligibility.

   4. The right to present an argument without undue interference and to question or refute testimony or evidence, including an opportunity to confront and cross-examine adverse witnesses.

L. Services must remain in place during any appeal process, except when there is a threat of harm of the participant or the service provider.

Source: 42 CFR Part 431, Subpart E Item 1-F; 42 CFR §431.210, Miss Code 43-13-121

History: Revised 01/01/2013

Rule 2.12: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

1. Allow the person to lead the process where possible with the person's guardian and/or legal representative having a participatory role, as needed and as defined by the person and any applicable laws.

2. Include people chosen by the person.

3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

4. Be timely and occur at times and locations of convenience to the person.

5. Reflect cultural considerations of the person and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

6. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process.

8. Offer informed choices to the person regarding the services and supports they receive and from whom.

9. Include a method for the person to request updates to the PSS as needed.

10. Record the alternative HCBSs that were considered by the person.

B. The PSS must reflect the services and supports that are important for the person to meet the needs identified through an assessment of functional need, as well as what is important to the person with regard to preferences for the delivery of such services and supports and the level of need of the individual and must:

1. Reflect that the setting in which the person resides is:

   a) Chosen by the person,

b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

(1) Seek employment and work in competitive integrated settings,

(2) Engage in community life,

(3) Control personal resources, and

(4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

8. Identify the individual and/or entity responsible for monitoring the PSS.

9. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

10. Be distributed to the individual and other people involved in the plan.

11. Include those services, the purpose or control of which the individual elects to self-direct.

12. Prevent the provision of unnecessary or inappropriate services and supports.

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

1. A description of the individual's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports.

2. The outcomes identified by the individual and how progress toward achieving those outcomes will be measured.

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Providers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

Source: 42 C.F.R. § 441.301.

History: New rule eff. 01/01/2017.

Part 208 Chapter 3: Home and Community-Based Services (HCBS) Assisted Living Waiver

Rule 3.1: General

A. The Division of Medicaid covers certain Home and Community Based Services (HCBS) services as an alternative to institutional care in a nursing facility through the Assisted Living (AL) Waiver.

B. The AL Waiver is administered and operated by the Division of Medicaid.

Source: Social Security Act 1915(c); 42 CFR § 440.180; Miss. Ann. Code § 43-13-117.

Rule 3.2: Eligibility

A. To be eligible for the Assisted Living Waiver Program a waiver participant must:

1. Be twenty-one (21) years of age or older,

2. Require nursing facility level of care as determined by a standardized comprehensive preadmission screening, and

3. Be in the Supplemental Security Income (SSI) Category of Eligibility (COE) or an aged, blind or disabled individual who meets all factors of institutional eligibility. If income exceeds the current institutional limit, the individual must pay the Division of Medicaid the portion of their income that is due under the terms of an Income Trust in order to qualify.

B. To be eligible for care in a Traumatic Brain Injury Residential facility a participant must:

1. Meet all the requirements in Miss. Admin. Code Part 208, Rule 3.2.A.,

2. Have a diagnosis of an acquired traumatic brain injury defined by the Division of Medicaid as a non-degenerative structural brain damage excluding a brain injury that is congenital or due to injuries induced by birth trauma,

3. Have completed acute rehabilitation treatment,

4. Be in a crisis/high stress environment with behavioral needs which place the participant at high risk for institutionalization,

5. Have documentation as to why the services could not be provided inside the State of Mississippi, and

6. Have an Executive Director's Letter of Approval for Out-of-State Placement.

C. Persons enrolled in the Assisted Living Waiver who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice. Persons may receive non-duplicative waiver services in coordination with hospice services.

Source: 42 USC § 1396n; 42 CFR §§ 435.217, 440.180 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised eff. 08/01/2016; Added Miss. Admin. Code, Part 208, Rule 3.2.C. eff. 06/01/2016; Added Miss. Admin. Code, Part 208, Rule 3.2.B. to correspond with the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.3: Provider Enrollment

To become an HCBS/AL Waiver provider, the prospective provider must:

A. Submit a provider enrollment packet complete with all necessary information.

B. Submit a copy of the current and active license/certification to function as a Personal Care Home – Assisted Living Facility (PCH-AL) or meet licensure requirements deemed acceptable by the Division of Medicaid to meet minimum requirements specific for a Traumatic Brain Injury Residential facility.

C. Successfully pass a facility inspection by a Division of Medicaid inspector.

D. Satisfy all criteria and requirements for enrollment as a Medicaid provider in accordance with Miss. Admin. Code Part 208, Chapter 1, Rule 1.1, upon completion of items A., B. and C. in Miss. Admin. Code Part 208, Rule 3.3.

Source: 42 CFR Part 455, Subpart E; Miss. Code Ann. §§ 43-13-5; 43-11-13; 43-11-121.

History: Revised Miss. Admin. Code, Part 208, Rule 3.3.B. to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.4: Freedom of Choice

A. Medicaid beneficiaries have the right to freedom of choice of approved Medicaid providers for services as outlined in Miss. Admin. Code Part 200, Chapter 3, Rule 3.6.

B. The person and/or guardian or legal representative must be informed of setting options based on the person's needs and preferences, including non-disability specific settings. The setting options must be selected by the person and identified and documented in the plan of services and supports (PSS).

Source: 42 U.S.C. § 1396a; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017.

Rule 3.5: Prior Approval/Physician Certification

A. Prior approval must be obtained from the Division of Medicaid before an individual can receive services through the Home and Community-Based Waiver Program.

B. Functional eligibility for waiver services is determined through a comprehensive Pre-Admission Screening.

    1. The physician must certify that the individual meets nursing home level of care.

    2. Clinical eligibility must be determined annually using the pre-admission screening for continued AL Waiver services.

C. The Plan of Care must be developed that:

1. Is person-centered,

2. Involves collaboration between the case manager and the participant and/or their designated representative or responsible party,

3. Is all inclusive to meet the needs, desires and goals, including personal goals, for the participant, and

4. Is approved by the Division of Medicaid prior to enrollment into waiver services.

D. A waiver participant shall be locked into only one (1) waiver program at a time.

Source: 42 CFR § 441.301 (b)(1)(i); Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code, Part 208, Rule 3.5.C. to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.6: Covered Services

A. The Assisted Living (AL) Waiver covers Case Management Services provided by a social worker licensed to practice in the State of Mississippi with at least two (2) years of full-time experience in direct services to elderly and disabled individuals.

B. AL Services include the following:

1. Personal care services rendered by personnel of the licensed facility,

2. Homemaker services,

3. Attendant care services,

4. Medication oversight/administration with personnel operating within the scope of applicable licenses and/or certifications,

5. Therapeutic, social, and recreational programming services,

6. Intermittent skilled nursing services and interventions ordered by the physician and provided:

   a. At least eight (8) hours a day, including weekends and holidays, to assess and assist the waiver person with services including, but not limited to, medication administration and oversight, and

   b. By a nurse with an active and unencumbered license acting within their scope of

practice. If the facility employs a Licensed Practical Nurse (LPN), the LPN must have supervision by either a Registered Nurse (RN), nurse practitioner, or a physician.

7. Transportation services must be provided by the AL Waiver provider or through the Division of Medicaid's Non-Emergency Transportation (NET) program if the waiver person has not reached the maximum NET service limits.

8. An electronic emergency attendant call system in each Personal Care Home-Assisted Living (PCH-AL) facility which:

   a) Is available to waiver persons who are:

      1) At risk of falling,

      2) At risk of becoming disoriented, or

      3) Experiencing some disorder placing them in physical, mental or emotional jeopardy.

   b) Includes twenty-four (24) hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and provides for supervision, safety and security.

9. Provision of normal, daily personal hygiene items including, at a minimum, deodorant, soap, shampoo, toilet paper, facial tissue, laundry soap and dental hygiene products.

C. AL Waiver providers must provide:

1. A setting physically accessible to the person but not located in:

   a) A nursing facility,

   b) An institution for mental diseases,

   c) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),

   d) A hospital providing long-term care services, or

   e) Any other location that has qualities of an institutional setting, as determined by the Division of Medicaid including, but not limited to, any setting:

      1) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

      2) Located in a building on the grounds of or immediately adjacent to a public institution, or

3) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

2. A private, home-like living quarter with a bathroom consisting of a toilet and sink and must:

   a) Be a unit or room in a specific physical place that can be owned, rented or occupied under a legally enforceable agreement by the waiver person, and the person has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city or other designated entity. For settings in which landlord tenant laws do not apply, the Division of Medicaid must ensure that:

      (1) A lease, residency agreement or other form of written agreement will be in place for each HCBS person, and

      (2) That the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

   b) Provide each waiver person privacy in their sleeping or living unit with:

      1) Lockable entrance doors with only appropriate staff having keys to doors, and

      2) The option to share living units only at the choice of the person.

3. A setting which integrates and facilitates the person's full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community in the same manner as individuals without disabilities,

4. A setting selected by the person from among all available alternatives and is identified in the person-centered Plan of Services and Supports (PSS),

5. Protection of a person's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint,

6. Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact,

7. Individual choice regarding services and supports, and who provides them,

8. An assessment of safety needs of a person with cognitive impairment supported by a specific assessed need and addressed in the PSS,

9. Freedom and support of persons to control their own schedules and activities and have

access to food at any time,

10. Freedom to have visitors of their choosing at any time,

11. A living environment supportive of the person to exercise their rights to:

    a. Attend religious and other activities of their choice,

    b. Manage their own personal financial affairs or receive a quarterly accounting of financial transactions made on their behalf,

    c. Not be required to perform services for the facility,

    d. Receive mail unopened or in compliance with the facility policy,

    e. Be treated with consideration, kindness, respect and full recognition of their dignity and individuality,

    f. Retain and use personal clothing and possessions as space permits,

    g. Voice grievances and recommend changes in licensed facility policies and services,

    h. Not be confined to the licensed facility against their will and allowed to move about in the community at liberty,

    i. Free from physical and/or chemical restraints,

    j. Allowed to choose a pharmacy or pharmacist provider in accordance with State law,

    k. Decide when to go to bed and get up in the morning,

    l. Furnish and decorate their sleeping or living space within the lease or other agreement,

    m. Allows the person to decide when to eat his or her meals,

    n. Have nutritious snacks available at all times, and

    o. Use the dining room for congregate meals and socialization.

Source: 42 C.F.R. §§ 431.53, 440.170, 440.180; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017; Revised Miss. Admin. Code Part 208, Rule 3.6.B. and added Miss. Admin. Code Part 208, Rule 3.6.C. to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.7: Quality Management

A. AL Waiver providers must meet applicable service specifications. Refer to the Miss. Admin. Code, Part 208, Chapter 1.

B. AL Waiver providers must report changes in contact information, staffing, and licensure within ten (10) calendar days to Division of Medicaid.

C. Providers must maintain compliance with all current waiver requirements, regulatory rules and regulations and administrative codes as specified by the licensing agency.

   1. If an AL Waiver provider fails to maintain compliance, the Division of Medicaid may halt the acceptance of Medicaid referrals or waiver admissions until the AL Waiver provider demonstrates compliance with the regulatory agency.

   2. The decision to halt Medicaid referrals or waiver admissions is at the discretion of the Division of Medicaid.

D. Only the Division of Medicaid can initiate, in writing, any interpretation or exception to Medicaid rules or regulations.

Source: 42 CFR § 441.302; Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 208, Rule 3.7.C. to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.8: Documentation and Record Maintenance Requirements

A. Providers participating in the HCBS/AL Waiver program are required to:

   1. Maintain legible, accurate, and complete records.

   2. Document the services rendered and billed under the program including when a participant is out of the facility and the reason why.

   3. Make records available immediately, upon request, to representatives of the Division of Medicaid in substantiation of any and all claims.

   4 Maintain records for a minimum of six (6) years or until resolution of any pending investigation, audit or litigation.

   5. Maintain statistical and financial data supporting a cost report for at least five (5) years from the date of the cost report, or amended cost report or appeals submitted to the Division of Medicaid.

   6. Identify and maintain records of medication allergies of waiver participants.

7. Maintain a current, signed and dated copy of the Division of Medicaid approved admission agreement for each waiver participant which includes, at a minimum:

    a) Basic charges agreed upon separating costs for room & board and personal care services,

    b) Period to be covered,

    c) List of itemized charges, and

    d) Agreement regarding refunds for payments.

B. Providers must satisfy all requirements for maintenance of records outlined in Miss. Admin. Code Part 200, Chapter 1, Rule 1.3.

C. AL Waiver providers are required to submit copies of all service logs/documentation along with a copy of their billing for each waiver participant served, to the individual's case manager no later than the fifteenth (15th) of the following month in which the service was rendered.

Source: Miss. Code Ann. § 43-13-117; 43-13-118; 43-13-121; 43-13-129.

History: Added Miss. Admin. Code Part 208, Rule 3.8.A.6 and 3.8.A.7 to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.9: Beneficiary Cost Sharing

For waiver participants in a Home and Community-Based Service Waiver, the co-payment is exempt if the service is being paid through the Waiver. If services are being paid through regular Mississippi Medicaid, the co-payment is applicable unless exempt by one (1) of the beneficiary groups or services stated in Miss. Admin. Code Part 200, Chapter 3, Rule 3.7.

Source: Social Security Act 1902 (a)(14); 42 CFR § 447.50 – 447.59; Miss. Code Ann. § 43-13-121.

Rule 3.10: Reimbursement

A. Reimbursement for AL Waiver provider services cannot be requested earlier than the first (1st) day of the month following the month in which services were rendered.

B. Reimbursement for AL Waiver provider services is only for those services provided within the facility. The Division of Medicaid does not reimburse for room and board.

C. Transportation is an integral part of AL Waiver provider services and is not reimbursed separately.

Source: Miss. Code Ann. § 43-13-17, 121.

Rule 3.11: Hearings and Appeals for Denied/Terminated Services

A. Decisions made by the Division of Medicaid that result in services being denied, reduced or terminated, may be appealed in accordance with Part 300 of the Miss. Admin. Code.

B. The waiver participant/legal representative has thirty (30) days from the date of the notice regarding services to appeal the decision.

Source: 42 CFR §§ 431.210, 441.307, 441.308; Miss. Code Ann. § 43-13-121.

Rule 3.12: Education, Training and Supervision

A. All AL Waiver providers must have policies and procedures assuring safeguards to protect the safety, health and well-being of all waiver participants which must include:

    1. Definitions of abuse, neglect and exploitation,

    2. Education for employees in detection of abuse, neglect and exploitation,

    3. Guidance for facility staff to prevent abuse, neglect and exploitation, and

    4. Reporting requirements for abuse, neglect, exploitation and critical incidents.

B. AL Waiver providers must provide all staff with training upon hire and annually thereafter in the following areas:

    1. Vulnerable Persons Act regarding prevention of abuse, neglect and exploitation,

    2. Resident Rights and Dignity,

    3. Care of an Alzheimer's resident,

    4. Care of residents with mental illness, and

    5. How to deal with difficult residents.

C. The AL Waiver provider must maintain evidence of the training listed in the Miss. Admin. Code, Part 208, Rule 3.12.B. on file and easily accessible upon request of the Division of Medicaid.

D. The AL Waiver provider must assure:

1. Each direct care staff successfully completes forty (40) hours of course curriculum as identified by the State,

2. The training is provided prior to providing care to a waiver participant,

3. Documentation of completion of this course work be maintained at the facility and made available to the Division of Medicaid upon request.

E. AL Waiver providers must submit an acceptable plan of correction if all training requirements in the Miss. Admin. Code, Part 208, Rule 3.12 are not met continued noncompliance will result in suspension of Medicaid referrals and waiver admissions until successful completion of training requirements is met.

F. TBI Residential Waiver providers must train all staff upon hire in the following areas including, but not limited to:

1. Identifying, preventing and reporting abuse, neglect and exploitation,

2. Rights and dignity,

3. Crisis prevention and intervention,

4. Caring for individuals with cognitive impairments,

5. Assisting with activities of daily living,

6. HIPAA Compliance,

7. Stress reduction,

8. Behavior programs,

9. Recognition and care of individuals with seizures,

10. Rational/behavioral therapy,

11. Elopement risks,

12. Safe operation and care of individuals with assistive devices,

13. Caring for individuals with disabilities,

14. Safety, and

15. Training in CPR and first aid.

G. All program managers employed by a TBI residential provider must be nationally certified as a Brain Injury Specialist.

Source: 42 CFR §§ 431.210; 441.308; 441.307; Miss. Code Ann. § 43-13-121;

History: Added Miss. Admin. Code Part 208, Rule 3.14 to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.13: Background Checks

AL Waiver providers must:

A. Conduct a search of the Mississippi Nurse Aide abuse registry prior to hiring an individual who will provide care to waiver participants including, but not limited to:

   1. Any individual providing direct care or supervision to the residents,

   2. Owners,

   3. Operators, and

   4. Transportation drivers.

B. Maintain documented evidence in the personnel file of each employee to demonstrate to the Division of Medicaid that the Mississippi Nurse Aide Abuse Registry has been searched.

C. Conduct a disciplinary search with the professional licensing agency, if any, for each employee to determine if any disciplinary actions have been taken against the employee by the agency.

D. Conduct a National Criminal Background Check by submitting fingerprints to the licensing agency to be electronically submitted to the Federal Bureau of Investigations and the Mississippi Criminal Information Center as specified in the Minimum Standards For Personal Care Homes Assisted Living, Title 15: Mississippi State Department of Health, Part 3: Office of Health Protection, Subpart 1: Health Facilities Licensure and Certification.

E. Deny or terminate employment of any applicant/employee with a felony conviction, a guilty plea, and/or a plea of nolo contendere to a felony for one (1) or more of the following crimes which have not been reversed on appeal, or for which a pardon has not been granted:

   1. Possession or sale of drugs,

   2. Murder,

   3. Manslaughter,

4. Armed robbery,

5. Rape,

6. Sexual battery,

7. Sex offense listed in Section 45-33-23 (g), Mississippi Code of 1972,

8. Child abuse,

9. Arson,

10. Grand larceny,

11. Burglary,

12. Gratification of lust,

13. Aggravated assault, or

14. Felonious abuse and/or battery of vulnerable adult.

F. AL Waiver providers cannot grant a waiver for employment of any employee or applicant with offenses listed in Miss. Admin. Code Part 208, Rule 3.13 E.

Source: 42 CFR §§ 431.210, 441.307, 441.308; Miss. Code Ann. § 43-13-121.

History: Added Miss. Admin. Code Part 208, Rule 3.13 to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.14: Disaster Preparedness

A. AL Waiver providers must have disaster preparedness and management procedures to ensure that waiver participant's care, safety, and well- being are maintained during and following instances of natural disasters, disease outbreaks, or similar situations.

B. In the event of termination of an AL Waiver provider agreement, the Division of Medicaid, the participants and their designated representatives, and the licensing agency will work collaboratively to arrange for appropriate transfer of waiver participants to other Medicaid approved providers.

Source: 42 CFR §§ 431.210, 441.307, 441.308; Miss. Code Ann. § 43-13-121.

History: Added Miss. Admin. Code Part 208, Rule 3.14 to correspond with changes in the AL Waiver renewal (eff. 10/01/2013) eff. 05/01/2014.

Rule 3.15: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

   1. Allow the person to lead the process where possible with the person's guardian and/or legal representative having a participatory role, as needed and as defined by the person and any applicable laws.

   2. Include people chosen by the person.

   3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

   4. Be timely and occur at times and locations of convenience to the person.

   5. Reflect cultural considerations of the person and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

   6. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

   7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process.

   8. Offer informed choices to the person regarding the services and supports they receive and from whom.

   9. Include a method for the person to request updates to the PSS as needed.

   10. Record the alternative HCBSs that were considered by the person.

B. The PSS must reflect the services and supports that are important for the person to meet the needs identified through an assessment of functional need, as well as what is important to the person with regard to preferences for the delivery of such services and supports and the level

of need of the individual and must:

1. Reflect that the setting in which the person resides is:

    a) Chosen by the person,

    b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

        (1) Seek employment and work in competitive integrated settings,

        (2) Engage in community life,

        (3) Control personal resources, and

        (4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

8. Identify the individual and/or entity responsible for monitoring the PSS.

9. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

10. Be distributed to the individual and other people involved in the plan.

11. Include those services, the purpose or control of which the individual elects to self-direct.

12. Prevent the provision of unnecessary or inappropriate services and supports.

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

1. A description of the individual's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports.

2. The outcomes identified by the individual and how progress toward achieving those outcomes will be measured.

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Providers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

Source: 42 C.F.R. § 441.301.

History: New rule eff. 01/01/2017.

Part 208 Chapter 4: Home and Community-Based Services (HCBS) Traumatic Brain Injury/Spinal Cord Injury Waiver

Rule 4.1: General

A. The Division of Medicaid covers certain Home and Community-Based Services (HCBS) as an alternative to institutionalization in a nursing facility through its Traumatic Brain

Injury/Spinal Cord Injury (TBI/SCI) Waiver. Waiver services are available statewide.

1. Persons enrolled in the TBI/SCI Waiver must reside in private homes or a relative's home which is fully integrated with opportunities for full access to the greater community, and meet the requirements of the Home and Community-Based (HCB) settings.

2. The Division of Medicaid does not cover TBI/SCI waiver services to persons in congregate living facilities, institutional settings, on the grounds of or adjacent to institutions, or any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

B. The TBI/SCI Waiver is administered by the Division of Medicaid and jointly operated by the Division of Medicaid and Mississippi Department of Rehabilitative Services (MDRS).

Source: 42 U.S.C. § 1396n; 42 C.F.R. § 440.180; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017.

Rule 4.2: Eligibility

A. Eligibility is limited to individuals with the following disease(s) or condition(s):

1. Traumatic brain injury which the Division of Medicaid defines as an insult to the skull, brain, or its covering resulting from external trauma, which produces an altered state of consciousness or anatomic, motor, sensory, or cognitive/behavioral deficits.

2. Spinal cord injury which the Division of Medicaid defines as a traumatic injury to the spinal cord or cauda equina with evidence of motor deficit, sensory deficit, and/or bowel and bladder dysfunction. The lesions must have significant involvement with two (2) of the above three (3) deficits.

B. The extent of injury must be certified by the physician.

C. Brain or spinal cord injury that is due to a degenerative or congenital condition, or that result, intentionally or unintentionally, from medical intervention is excluded.

D. Individuals must be certified as medically stable by their physician. The Division of Medicaid defines medically stable as the absence of all of the following:

1. An active, life threatening condition requiring systematic therapeutic measures.

2. Intravenous drip to control or support blood pressure.

3. Intracranial pressure or arterial monitoring.

E. Individuals must qualify for full Medicaid benefits in one (1) of the following Categories of Eligibility (COE):

1. Supplemental Security Income (SSI),

2. Parents and Other Caretaker Relatives Program,

3. Disabled Child Living at home program,

4. Working Disabled,

5. Infants and Children under age nineteen (19) who meet the applicable income requirements,

6. Disabled Adult Child,

7. Protected Foster Care Adolescents,

8. Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,

9. IV-E Foster Children and Adoption Assistance Children, or

10. An aged, blind or disabled individual who meets all factors of institutional eligibility. If income exceeds the current institutional limit, the individual must pay the Division of Medicaid the portion of their income that is due under the terms of an Income Trust in order to qualify.

F. Persons enrolled in the TBI/SCI Waiver who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice. Persons may receive non-duplicative waiver services in coordination with hospice services.

Source: 42 USC § 1396n; 42 CFR §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised eff. 08/01/2016; Added Miss. Admin. Code Part 208, Rule 4.2.F. eff. 06/01/2016.

Rule 4.3: Freedom of Choice

A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.

B. Personal care services may be furnished by family members provided they are not legally responsible for the individual.

1. The Division of Medicaid defines a person legally responsible for an individual as the parent, or step-parent, of a minor child or an individual's spouse.

2. Family members must meet provider standards and must be certified competent to perform the required tasks by the beneficiary and the TBI/SCI counselor/registered nurse.

3. There must be adequate justification for the family member to function as the attendant.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(23)

Rule 4.4: Quality Assurance Standards

A. Waiver providers must meet applicable quality assurance standards.

B. Only the Division of Medicaid can initiate, in writing, any interpretation or exception to Medicaid rules or regulations.

Source: Miss. Code Ann. § 43-13-121; §43-13-117; §1915(c) of the Social Security Act; 42 CFR 441.302

Rule 4.5: Covered Services

A. The Division of Medicaid covers the following traumatic brain injury/spinal cord injury (TBI/SCI) Waiver services:

1. Case Management services are defined as services assisting beneficiaries in accessing needed waiver and other services, as well as needed medical, social, educational, and other services, regardless of the funding source for the services.

   a) Case Management services must be provided by Mississippi Department of Rehabilitation Services (MDRS) TBI/SCI counselors/registered nurses who meet minimum qualifications listed in the waiver.

   b) Responsibilities include, but are not limited to, the following:

      1) Initiate and oversee the process of assessment and reassessment of the person's level of care.

      2) Provide ongoing monitoring of the services included in the person's plan of care.

      3) Develop, review, and revise the plan of care at intervals specified in the waiver.

      4) Conduct monthly contact and quarterly face-to-face visits with the person.

      5) Document all contacts, progress, needs, and activities carried out on behalf of the person.

2. Attendant Care services are defined as support services provided to assist the person in meeting daily living needs and to ensure adequate support for optimal functioning at

home or in the community, but only in non-institutional settings.

a) Attendant Care is non-medical, hands-on care of both a supportive and health related nature and does not entail hands-on nursing care.

b) Services must be provided in accordance with the approved plan of care and is not purely diversional in nature.

c) Services may include, but are not limited to the following:

    1) Assistance with activities of daily living defined as assistance with eating, bathing, dressing, and personal hygiene.

    2) Assistance with preparation of meals, but not the cost of the meals.

    3) Housekeeping chores essential to the health of the person including changing bed linens, cleaning the person's medical equipment and doing the person's laundry.

    4) Assistance with community related activities including escorting the person to appointments, shopping facilities and recreational activities. The cost of activities or transportation is excluded.

d) Attendant Care providers must meet minimum requirements as specified in the waiver. MDRS TBI/SCI counselors and registered nurses are responsible for certifying and documenting that the provider meets the training and competency requirements as specified in the current waiver document.

e) Attendant Care services may be furnished by family members provided they are not legally responsible for the individual.

    1) The Division of Medicaid defines legally responsible for an individual as the parent (or step-parent) of a minor child or an individual's spouse.

    2) Family members must meet provider standards and they must be certified competent to perform the required tasks by the person and the TBI/SCI counselor/registered nurse.

    3) There must be documented justification for the relative to function as the attendant.

3. Respite services are defined as services to assistance beneficiaries unable to care for themselves because of the absence of, or the need to provide relief to the primary caregiver. Institutional Respite is limited to thirty (30) days or less annually. In-home Companion and Nursing respite is limited to sixty (60) hours per month.

    a) Services must be provided in the person's home, foster home, group home, or in a

Medicaid certified hospital, nursing facility, or licensed respite care facility.

b) All respite providers must be certified by the Mississippi Department of Rehabilitation Services (MDRS).

4. Specialized medical equipment and supplies are defined as devices, controls, or appliances that will enhance the person's ability to perform activities of daily living or to perceive, control, or communicate with the environment in which they live. This service also includes equipment and supplies necessary for life support, supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan.

   a) The need for/use of such items must be documented in the assessment/case file and approved on the plan of care.

   b) Items reimbursed with waiver funds are in addition to medical equipment and supplies furnished under Medicaid.

   c) Items not of direct medical or remedial benefit to the person are excluded.

   d) Equipment and supplies must meet the applicable standards of manufacture, design, and installation. MDRS is responsible for certifying and documenting that providers meet the criteria/standards in the waiver.

5. Environmental Accessibility Adaptation is defined as those physical adaptations to the home that are necessary to ensure the health, welfare and safety of the person, or which enable the person to function with greater independence, and without which, the person would require institutionalization.

   a) The need for these adaptations must be identified in the approved plan of care.

   b) Environmental accessibility adaptations include the following:

      1) Installation of ramps and grab bars the widening of doorways.

      2) Modification of bathroom facilities.

      3) Installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies.

   c) Environmental accessibility adaptations exclude the following:

      1) Adaptations or improvements to the home which are not of direct medical or remedial benefit to the person.

      2) Adaptations which add to the square footage of the home.

d) Providers rendering environmental accessibility adaptations must:

1) Meet all state or local requirements for licensure of certification.

2) Provide services in accordance with applicable state housing and local building codes.

3) Ensure the quality of work meets standards identified in the waiver.

e) MDRS is responsible for certifying and documenting that providers meet the criteria/standards in the waiver.

6. Transition Assistance services are defined as services provided to a person currently residing in a nursing facility who wishes to transition from the nursing facility to the TBI/SCI Waiver program.

a) Transition Assistance is a one (1) time initial expense required for setting up a household and is capped at eight hundred dollars ($800.00) for the one (1) time initial expense per lifetime. The expenses must be included in the approved plan of care.

b) To be eligible for Transition Services, the person must meet all of the following criteria:

1) Be a nursing facility resident whose nursing facility services are paid for by the Division of Medicaid.

2) Have no other source to fund or attain the necessary items/support.

3) Be moving from a nursing facility where these items/services were provided.

4) Be moving to a residence where these items/services are not normally furnished.

c) Transition Assistance Services include the following:

1) Security deposits required to obtain a lease on an apartment or home.

2) Essential furnishings defined as a bed, table, chairs, window blinds, eating utensils, and food preparation items. Televisions and cable TV access are not essential furnishings.

3) Moving expenses.

4) Fees/deposits for utilities and service access for a telephone.

5) Health and safety assurances defined as pest eradication, allergen control, or one-

time cleaning prior to occupancy.

d) Transition Assistance is not available for beneficiaries whose stay in a nursing facility is ninety (90) days or less.

Source: 42 C.F.R. § 440.180; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2017.

Rule 4.6: Prior Approval/Certification

A. Prior approval must be obtained from the Division of Medicaid before a beneficiary can receive services through the Home and Community-Based Waiver program. Prior Approval is based on clinical eligibility.

B. Clinical eligibility for waiver services is determined through the utilization of a comprehensive Pre-Admission Screening.

C. The physician must certify the level of care.

D. A physician must verify that the beneficiary has a traumatic brain/spinal cord injury. A brain or spinal cord injury that is due to a degenerative or congenital condition, or that result, intentionally or unintentionally, from medical intervention is excluded.

E. The Plan of Care must be developed by the case manager and, in conjunction with the Pre-Admission Screening, should contain objectives, types of services to be furnished, and frequency of services.

F. After the applicant has made an Informed Choice, understands the criteria for the waiver, and meets clinical eligibility, the application along with the Plan of Care (POC) must be submitted to the Division of Medicaid for approval.

G. At the time of the initial certification, the Pre-Admission Screening and the Plan of Care must be completed jointly by the TBI/SCI counselor and registered nurse.

H. At the time of recertification, the Plan of Care must be completed by the IL counselor or the registered nurse.

I. A beneficiary can only be enrolled in one HCBS waiver program at a time.

J. Request to add or change services listed on the approved plan of care requires prior approval.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.301 (b)(1)

Rule 4.7: Documentation and Record Keeping

A. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect

procedures set forth for applicable waiver quality assurance standards. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.

B. Waiver providers must submit copies of all service logs/documentation of visits.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 4.8: Beneficiary Cost Sharing

A. For beneficiaries covered under a Home and Community Based Services Waiver, the co-payment is exempt if the service is being paid through the Waiver.

B. If services are being paid through regular Mississippi Medicaid State Plan benefits, the co-payment is applicable unless exempt by one of the beneficiary groups or services outlined in Part 200, Chapter 3, Rule 3.7.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(14)

Rule 4.9: Reimbursement

Reimbursement for waiver services can be requested no earlier than the first day of the month following the month in which services were rendered.

Source: Miss. Code Ann. § 43-13-121

Rule 4.10: Due Process Protection

Whenever the service amounts, frequencies, duration, and scope are reduced, denied, or terminated, the beneficiary must be provided written notice of recourse/appeal procedures within ten (10) calendar days of the effective reduction or termination of services or within ten (10) calendar days of the decision to deny additional services.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 431.210

Rule 4.11: Hearings and Appeals

A. Decisions made by the Division of Medicaid that result in services being denied, terminated, or reduced may be appealed.

    1. The beneficiary/legal representative has thirty (30) days from the date of the notice regarding services to appeal the decision.

    2. All appeals must be in writing.

B. The beneficiary/legal representative is entitled to initially appeal at the local level with the MDRS TBI/SCI counselor/MDRS regional supervisor.

C. If the beneficiary/legal representative disagrees with the decision of the local agency, a written request to appeal the decision may be made to the Division of Medicaid. When a state hearing is requested, the MDRS staff will prepare a copy of the case record and forward it to the Division of Medicaid no later than five (5) days after notification of the state level appeal.

D. The Division of Medicaid must assign a hearing officer.

E. The hearing officer will make a recommendation, based on all evidence presented at the hearing, to the Executive Director. The Executive Director will make the final determination of the case and the beneficiary/legal representative will receive written notification of the decision.

F. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to possible danger, racial considerations, or sexual harassment by the service providers. The TBI/SCI counselor/registered nurse is responsible for ensuring that the beneficiary, receive all services that were in place prior to the notice of change.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 431.210; 42 CFR 441.307; 42 CFR 441.308

Rule 4.12: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

1. Allow the person to lead the process where possible with the person's guardian and/or legal representative having a participatory role, as needed and as defined by the person and any applicable laws.

2. Include people chosen by the person.

3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

4. Be timely and occur at times and locations of convenience to the person.

5. Reflect cultural considerations of the person and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

6. Include strategies for solving conflict or disagreement within the process, including clear

conflict-of-interest guidelines for all planning participants.

7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process.

8. Offer informed choices to the person regarding the services and supports they receive and from whom.

9. Include a method for the person to request updates to the PSS as needed.

10. Record the alternative HCBSs that were considered by the person.

B. The PSS must reflect the services and supports that are important for the person to meet the needs identified through an assessment of functional need, as well as what is important to the person with regard to preferences for the delivery of such services and supports and the level of need of the individual and must:

1. Reflect that the setting in which the person resides is:

   a) Chosen by the person,

   b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

      (1) Seek employment and work in competitive integrated settings,

      (2) Engage in community life,

      (3) Control personal resources, and

      (4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

8. Identify the individual and/or entity responsible for monitoring the PSS.

9. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

10. Be distributed to the individual and other people involved in the plan.

11. Include those services, the purpose or control of which the individual elects to self-direct.

12. Prevent the provision of unnecessary or inappropriate services and supports.

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

1. A description of the individual's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports.

2. The outcomes identified by the individual and how progress toward achieving those outcomes will be measured.

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager,

the allies, and providers in implementing the plan.

D. Providers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

Source: 42 C.F.R. § 441.301.

History: New rule eff. 01/01/2017.

Part 208 Chapter 5: Home and Community-Based Services (HCBS) Intellectual Disabilities/Developmental Disabilities Waiver

Rule 5.1: Eligibility

A. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver services are services covered by the Division of Medicaid as an alternative to institutionalization in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) which:

1. Are operated jointly with the Mississippi Department of Mental Health (DMH). The Division of Medicaid is the single state Medicaid agency having administrative responsibility in the administration and supervision of the ID/DD Waiver. DMH is responsible for the daily operation of the ID/DD Waiver,

2. Are available statewide, and

3. Carry no age restrictions for eligibility.

B. All of the following eligibility requirements must be met to receive ID/DD Waiver services:

1. Applicant must require a level of care (LOC) found in an ICF/IID.

2. Applicant must qualify for full Medicaid benefits in one (1) of the following eligibility categories:

a) Supplemental Security Income (SSI),

b) Parents and Other Caretaker Relatives Program,

c) Disabled Child Living at Home Program,

d) Working Disabled,

e) Infants and Children Under Age Nineteen (19) who meet the applicable income requirements,

f) Protected Foster Care Adolescents,

g) Child Welfare Services (CWS) Foster Children and Adoption Assistance Children,

h) Title IV-E Foster Children and Adoption Assistance Children,

i) Disabled Adult Child,

j) An aged, blind or disabled individual who meets all factors of institutional eligibility. If income exceeds the current institutional limit, the individual must pay the Division of Medicaid the portion of their income that is due under the terms of an Income Trust in order to qualify.

3. Applicant must have one (1) of the following:

a) An intellectual disability based on the following criteria:

1) An IQ score of approximately seventy (70) or below,

2) A determination of deficits in adaptive behavior, and

3) Disability which manifested prior to the age of eighteen (18).

b) A developmental disability, defined by the Division of Medicaid as a severe, chronic disability attributable to a mental or physical impairment including, but not limited to, cerebral palsy, epilepsy, or any other condition other than mental illness found to be closely related to an intellectual disability that results in impairments requiring similar treatment or services. A developmental disability must:

1) Have manifested prior to age twenty-two (22) and be likely to continue indefinitely,

2) Result in substantial functional limitations in three (3) or more of the following major life activities:

(a) Self-care,

(b) Understanding and use of language,

(c) Learning,

(d) Mobility,

(e) Self-direction, or

(f) Capacity for independent living.

3) Include individuals with a developmental delay, specific congenital or acquired condition from birth to age nine (9) that does not result in functional limitations in three (3) or more major life activities, but without services and supports would have a high probability of having three (3) or more functional limitations later in life, and

4) Require a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of individually planned and coordinated assistance that is life-long or of an extended duration.

c) Autism as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

C. Persons enrolled in the ID/DD Waiver can only be enrolled in one (1) home and community-based services (HCBS) waiver program at a time and must receive at least one (1) service a month to remain eligible for the ID/DD Waiver, and the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan.

D. Persons enrolled in the ID/DD Waiver who elect to receive hospice care may not receive waiver services which are duplicative of any services rendered through hospice. Persons may receive non-duplicative waiver services in coordination with hospice services.

Source: 42 USC § 1396n; 42 CFR §§ 435.217, 440.180, 441.301; Miss. Code Ann. §§ 43-13-115, 43-13-117, 43-13-121.

History: Revised eff. 08/01/2016; Added Miss. Admin. Code Part 208, Rule 5.1.D. eff. 06/01/2016; Revised to reflect changes with the ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.2: Provider Enrollment

A. The Division of Medicaid Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver providers must be certified by the Department of Mental Health (DMH) except for the providers listed below:

1. Occupational therapists,

2. Speech-language pathologists,

3. Physical therapists, and

4. Providers of specialized medical supplies.

B. The provider's listed in Miss. Admin. Code Part 208, Rule 5.2.A.1-4 must be in good standing with their state licensure agency and adhere to applicable state and federal regulations related to the license. The provider must comply with all rules and standards related to the ID/DD Waiver services and have a current Mississippi Medicaid provider number.

C. All providers must comply with the Centers for Medicare and Medicaid Services (CMS) regulations for home and community-based services (HCBS) and the ID/DD Waiver.

Source: 42 CFR § 455, Subpart E; Miss. Code Ann. § 43-13-121.

History: Revised to reflect changes with the ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.3: Freedom of Choice

A. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver persons have the right to freedom of choice of providers for Medicaid covered services. [Refer to Miss. Admin. Code Part 200, Rule 3.6]

B. The person and/or guardian or legal representative must be informed of alternatives available through the ID/DD Waiver, and given the option of choosing either institutional or home and community-based services (HCBS) once eligibility requirements for the ID/DD Waiver have been met.

C. The person and/or guardian or legal representative must be informed of setting options based on the person's needs and preferences, including non-disability specific settings and an option for a private unit in a residential setting with identified resources available for room and board. The setting options must be selected by the person and identified and documented in the plan of services and supports.

D. The choice made by the person and/or guardian or legal representative must be documented and signed by the person and/or guardian or legal representative and maintained in the ID/DD Waiver case record.

Source: 42 U.S.C. § 1396a; 42 C.F.R. §§ 431.51, 441.301, 441.302; Miss. Code Ann. § 43-13-121.

History: Revised 01/01/2017. Revised to reflect changes with the ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.4: Evaluation/Reevaluation of Level of Care (LOC)

A. A participant's level of care (LOC) is determined by an initial evaluation and required reevaluations to assess the needs for services through the Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver.

1. All LOC initial evaluations and required reevaluations must be conducted by one (1) of the five (5) Diagnostic and Evaluation (D&E) Teams housed at the Department of Mental Health's (DMH's) five (5) comprehensive regional programs.

2. The specific battery of standardized diagnostic and assessment instruments must accurately assess the individual's level of function in all areas of development and serve as a baseline for future reassessments.

3. There is not a single instrument/tool required to determine LOC eligibility requirements for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).

B. Initial LOC evaluations must:

1. Be conducted in an interdisciplinary team format that includes, at a minimum, a psychologist and social worker with other disciplines participating, as needed, based on the applicant's needs.

2. Be administered by evaluators:

a) Whose educational/professional qualifications are the same as evaluators of ID/DD Waiver and ICF/IID services, and

b) Who are appropriately licensed/certified under state law for their respective disciplines.

3. Include an ID/DD Waiver LOC reevaluation tool to establish a baseline for future assessments.

C. Reevaluations of LOC must be:

1. Conducted at least annually or when a significant change occurs which is defined as a decline or improvement in a participant's status including, but not limited to, a change:

a) In mental or physical status that will not normally resolve itself without intervention by staff or implementing standard disease-related clinical interventions,

b) That is not self-limiting for declines only,

c) That impacts more than one area of the participant's health status,

d) Which requires interdisciplinary review and/or revision of the Plan of Services and Supports (PSS),

2. Administered by ID/DD Waiver support coordinators,

3. Reviewed by Master's level staff before submission to DMH,

4. Reviewed by the Diagnostic and Evaluation (D&E) team if a significant change occurred since the baseline LOC assessment, and

5. Reviewed by DMH.

D. All participants must be initially certified by DMH as needing ICF/IID LOC before services provided through the ID/DD Waiver can begin.

Source: 42 USC § 1396n; 42 CFR §§ 440.180, 441.302, 483.20; Miss. Code Ann. § 43-13-121.

History: Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.5: Covered Services

A. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver services must only be provided to persons when approved by the Department of Mental Health (DMH) and authorized by the ID/DD Waiver support coordinator as part of the approved Plan of Services and Supports (PSS).

B. All providers must follow DMH Operational Standards regarding criminal background checks, valid driver's license and current vehicle insurance.

C. The ID/DD Waiver services include the following:

1. Support Coordination is defined by the Division of Medicaid as the monitoring and coordinating of all person services, regardless of funding source, to ensure the person's health and welfare needs are met.

a) Support Coordination activities must include:

1) Developing, reviewing, revising and ongoing monitoring and assessing of each person's PSS which must include,

(a) Information on the person's health and welfare, including any changes in health status,

(b) Information about the person's satisfaction with current services(s) and providers(s) (ID/DD Waiver and others),

(c) Information addressing the need for any new ID/DD Waiver or other services based upon expressed needs or concerns and/or changing circumstances and

actions taken to address the need(s),

(d) Information addressing whether the amount/frequency of service(s) listed on the PSS remains appropriate,

(e) A review of individual plans developed by agencies which provide ID/DD Waiver services to the person, and

(f) Ensuring all services a person receives, regardless of funding source, are coordinated to maximize the benefit for the person.

2) Informing each person about all services offered by certified providers on the person's PSS.

3) Submitting all required information for review, approval, or denial to DMH.

4) Notifying each person and/or guardian or legal representative of:

(a) Approval or denial of initial enrollment,

(b) Approval or denial of requests for recertification,

(c) Approval or denial of requests for readmission,

(d) Changes in service amounts or types,

(e) Discharge from the ID/DD Waiver, and

(f) Procedures for appealing the denial, reduction or termination of ID/DD Waiver services as well as providing a written copy of the appeals process.

5) Sending service authorizations to providers upon receipt of approval from DMH.

b) Support coordinators must:

1) Monitor implementation of the PSS, the person's health and welfare, and effectiveness of the back-up plan at least monthly,

2) Speak with the person and/or guardian, or legal representative:

(a) Face-to-face at least every three (3) months which must include rotation of service settings and communicating with staff, and

(b) At least one (1) time per month in the months when a face-to-face visit is not required,

3) Determine if necessary services and supports in the PSS have been provided,

4) Review implementation of strategies, guidelines, and action plans to ensure specified need, preferences, and desired outcomes are being met,

5) Review the person's progress and accomplishments,

6) Review the person's satisfaction with services and providers,

7) Identify any changes to the person's needs, preferences, desired outcomes, or health status,

8) Identify the need to change the amount or type of services and supports or to access new ID/DD Waiver or non-waiver services,

9) Identify the need to update the PSS,

10) Maintain detailed documentation of all contacts made with the person and/or guardian or legal representative in the ID/DD Waiver support coordination service notes,

11) Inquire and document about each person's health care needs and changes during monthly and quarterly contacts,

12) Perform all necessary functions for the person's annual recertification of Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care (LOC),

13) Educate families on the person's rights and the procedures for reporting instances of abuse, neglect, and exploitation, and

14) Compete the Risk Assessment Tool for the PSS for inclusion in the PSS and to be included in each provider's plan for the person.

2. In-Home Nursing Respite is defined by the Division of Medicaid as services provided in the person's family's home to provide temporary, periodic relief to the primary caregivers of eligible persons who are unable to care for themselves.

   a) In-Home Nursing Respite services:

      1) Must be provided by a registered nurse or licensed practical nurse in accordance with the Mississippi Nurse Practice Act and other applicable laws and regulations and employed by a DMH certified ID/DD Waiver provider,

      2) Must be billed separately for services provided to more than one (1) person in the same residence that are related as defined by the Division of Medicaid as siblings

or parents/siblings,

3) Must be ordered by a physician, nurse practitioner or a physician assistant and include:

   (a) Medications, treatments and other procedures the person needs in the absence of the primary caregiver, and

   (b) Time-frames for medication administration, treatments and other procedures.

4) Are provided when the primary caregiver is absent or incapacitated due to hospitalization, illness, injury, or death,

5) Are provided on a short-term basis,

6) Allows the person to be accompanied on short outings,

7) May be provided on the same day as the following ID/DD Waiver services, but not during the same time period:

   (a) Day Service-Adults,

   (b) Prevocational services,

   (c) Supported Employment,

   (d) Home and Community Supports,

   (e) Therapy services, and

   (f) Behavior Support services.

b) In-Home Nursing Respite services are not allowed:

1) To be performed in the home of the respite worker,

2) To comingle with personal errands of the respite worker, or

3) To be provided at the same time on the same day as private duty nursing through EPSDT.

c) In-Home Nursing Respite services are not covered for persons:

1) Living alone, in group homes or staffed residences,

2) In a hospital, nursing facility, ICF/IID, or other type of rehabilitation facility that

is billing Medicaid, Medicare, and/or private insurance, or

3) Receiving:

(a) Supported Living,

(b) Supervised Living,

(c) Host Home services,

(d) Shared Supported Living.

3. Community Respite is defined by the Division of Medicaid as services provided generally in the afternoon, early evening, and on weekends in a DMH certified community setting to give periodic support and relief to the participant's primary caregiver and promote the health and socialization of the participant through scheduled activities.

a) Community Respite service providers must:

1) Provide the person with assistance in toileting and other hygiene needs,

2) Offer persons a choice of snacks and drinks, and

3) Have meals available if services are provided during normal meal time.

b) Community Respite services are not provided:

1) To persons overnight,

2) To persons receiving:

(a) Supervised Living services,

(b) Host Home services, or

(c) Supported Living services.

3) In place of regularly scheduled day activities including, but not limited to:

(a) Supported Employment,

(b) Day Services-Adult,

(c) Prevocational Services, or

(d) Services provided through a school system.

c) Community Respite service settings must be physically accessible to the person and must:

1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.

3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

4) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

5) Facilitate individual choice regarding services and supports, and who provides them.

d) Community Respite settings do not include the following:

1) A nursing facility,

2) An institution for mental diseases,

3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),

4) A hospital, or

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:

(a) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

(b) Located in a building on the grounds of or immediately adjacent to a public institution, or

(c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

4. Supervised Living services are defined by the Division of Medicaid as services designed to assist the participant with acquisition, retention, or improvement in skills related to living in the community. Services include adaptive skill development, assistance with activities of daily living, community inclusion, transportation and leisure skill development. Supervised living, learning and instruction include elements of support, supervision and engaging participation to reflect that of daily living in settings owned or leased by a provider agency or by participants.

   a) Supervised Living providers must:

      1) Have staff available on site twenty-four (24) hours per day, seven (7) days per week who are able to respond immediately to requests or needs of assistance and must not sleep during billable hours.

      2) Provide an appropriate level of services and supports twenty-four (24) hours a day during the hours the person is not receiving day services or is not at work.

      3) Oversee the person's health care needs by assisting with:

         (a) Scheduling medical appointments,

         (b) Transporting and accompanying the person to appointments, and

         (c) Communicating with medical professionals if the person gives permission to do so.

      4) Provide furnishings used in the following areas if items have not been obtained from other sources including, but not limited to:

         (a) Den,

         (b) Dining,

         (c) Bathrooms, and

         (d) Bedrooms such as:

            (1) Bed frame,

            (2) Mattress and box springs,

            (3) Chest,

(4) Night stand, and

(5) Lamp.

5) Provide the following supplies:

(a) Kitchen supplies including, but not limited to:

(1) Refrigerator,

(2) Cooking appliance, or

(3) Eating and food preparation utensils,

(b) Two (2) sets of linens:

(1) Bath towel,

(2) Hand towel, and

(3) Wash cloth,

(c) Cleaning supplies.

6) Train staff regarding the person's PSS prior to beginning work with the person.

7) Provide nursing services as a component in accordance with the Mississippi Nurse Practice Act.

b) Supervised Living providers cannot:

1) Receive or disburse funds on the part of the person unless authorized by the Social Security Administration,

2) Bill for the cost of room and board, building maintenance, upkeep, or improvement, or

3) Bill for services provided by a family member of any degree.

c) Supervised Living is available to persons who are at least eighteen (18) years of age.

d) Supervised Living services cannot be provided to persons receiving:

1) Home and Community Supports,

2) Supported Living,

3) In-Home Nursing Respite,

4) Community Respite, or

5) Host Home services.

e) The cost to transport persons to work or day programs, social events or community activities when public transportation is not available is included in the payments made to the Supervised Living providers. Supervised Living providers may transport persons in their own vehicles as an incidental component of this service and must have a valid driver's license, current automobile insurance and registration.

f) Nursing services are also a component of Supervised Living services and must be provided in accordance with the Mississippi Nurse Practice Act.

g) Supervised Living settings must be physically accessible to the person and must:

1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences, and, for residential settings, resources available for room and board.

3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

4) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

5) Facilitate individual choice regarding services and supports, and who provides them.

h) Supervised Living services may be provided in settings owned or leased by a provider agency or settings owned or leased by persons.

1) The setting can be owned, rented, or occupied under a legally enforceable agreement by the person receiving services which the person has, at a minimum,

the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity.

2) If the landlord tenant laws do not apply to the setting, the DMH must ensure:

   (a) A lease, residency agreement or other form of written agreement is in place for each person, and

   (b) The agreement provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

3) Each person must have privacy in their sleeping or living unit which includes:

   (a) Entrance doors lockable by the person with only appropriate staff having keys to doors,

   (b) A choice of roommates if individuals are sharing units, and

   (c) The freedom to furnish and decorate their sleeping or living units within the lease or other agreement.

4) Persons must have the freedom and support to control their own schedules and activities, and have access to food at any time.

5) Persons are able to have visitors of their choosing at any time.

6) The setting is physically accessible to the person.

i) Supervised Living settings do not include the following:

   1) A nursing facility;

   2) An institution for mental diseases;

   3) An intermediate care facility for individuals with intellectual disabilities (ICF/IDD);

   4) A hospital; or

   5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid. Any setting that is located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment, or in a building on the grounds of, or immediately adjacent to, a public institution, or any other setting that has the effect of isolating persons receiving Medicaid HCBS from the broader community of individuals not receiving

Medicaid HCBS.

j) Individuals must have control over their personal resources. Providers cannot restrict access to personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. There must be documentation in each person's record regarding all income received and expenses incurred.

a) Each person must have access to food at any time, unless prohibited by his/her individual plan.

(b) Each person must have choices of the food they eat.

(c) Each person must have choices about when and with whom they eat.

k) Supervised Living sites must duplicate a "home-like" environment.

5. Day Services-Adult is defined by the Division of Medicaid as services designed to assist the participant with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Services focus on enabling the participant to attain or maintain his/her maximum functional level and are coordinated with physical, occupational, and/or speech-language therapies included on the PSS. Activities include environments designed to foster the acquisition and maintenance of skills, build positive social behavior and interpersonal competence which foster the acquisition of skills, greater independence and personal choice.

a) Day Services-Adult must:

1) Take place in a non-residential setting, separate from the home or facility in which the person resides,

2) Be physically accessible to the person and must:

(a) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, to the same degree of access as individuals not receiving Medicaid HCBS.

(b) Be selected by the person from among setting options including non-disability specific settings The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences,

(c) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(d) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical

environment, and with whom to interact

(e) Facilitate individual choice regarding services and supports, and who provides them.

(f) Allow persons to have visitors of their choosing at any time they are receiving Day Services-Adult services.

3) Have a community integration component that meets each person's need for community integration and participation in activities which may be:

(a) Provided at a DMH certified day program site or in the community, or

(b) Offered individually or in groups of up to three (3) people when provided in the community.

b) Day Services-Adult settings do not include the following :

1) A nursing facility,

2) An institution for mental diseases,

3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),

4) A hospital or,

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:

(a) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

(b) Located in a building on the grounds of or immediately adjacent to a public institution, or

(c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

c) Day Services-Adult providers must:

1) Not exceed one hundred thirty-eight (138) service hours in a month with twenty-three (23) working days or one hundred thirty-two (132) service hours in a month with twenty-two (22) working days.

2) Provide assistance with personal toileting and hygiene needs during the day as

well as a private changing/dressing area.

3) Provide each person assistance with eating/drinking as needed and as indicated in each person's PSS.

4) Provide choices of food and drinks to persons at any time during the day which includes, at a minimum:

   (a) A mid-morning snack,

   (b) A noon meal, and

   (c) An afternoon snack.

5) Provide transportation as a component part of Day Services-Adult.

   (a) The cost for transportation is included in the rate paid to the provider.

   (b) Time spent in transportation to and from the program cannot be included in the total number of service hours provided per day.

   (c) Transportation for community outings can be counted in the total number of service hours provided per day.

d) Day Service-Adult persons:

1) Must be at least eighteen (18) years old.

2) Can receive services that include supports designed to maintain skills and prevent or slow regression for persons with degenerative conditions and/or those who are retired.

3) Can also receive Supported Employment, Prevocational services, and Job Discovery, but not during the same time on the same day.

4) Can also receive Crisis Intervention services on same day at the same time.

6. Prevocational Services are defined by the Division of Medicaid as services intended to develop and teach a participant general skills that contribute to paid employment in an integrated community setting. These services cannot otherwise be available under a program funded under the Rehabilitation Act of 1973, 29 U.S.C. § 110 or IDEA, 20 U.S.C. § 1400-01.

a) Prevocational Services must:

1) Be physically accessible to the person and must:

(a) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

(b) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs and preferences.

(c) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

(d) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

(e) Facilitate individual choice regarding services and supports, and who provides them.

2) Be reflected in the person's PSS and be related to habilitative rather than explicit employment objectives.

3) Not exceed one hundred thirty eight (138) hours per month in a month which has twenty-three (23) working days or one hundred thirty-two (132) hours per month in a month which has twenty-two (22) working days.

4) Provide choices of food and drinks to persons who do not bring their own at any time during the day which includes, at a minimum:

(a) A mid-morning snack,

(b) A noon meal, and

(c) An afternoon snack.

5) Include personal care/assistance but cannot comprise the entirety of the service; however, participants cannot be denied Prevocational Services because they require the staff's assistance with toileting and/or personal hygiene.

6) Include a review with staff and the ID/DD Waiver support coordinator for the necessity and appropriateness of the services, when a person earns more than fifty percent (50%) of the minimum wage.

7) Be furnished in a variety of locations in the community and are not limited to fixed program locations.

b) Prevocational service providers must:

1) Provide transportation as a component part of prevocational services.

(a) The cost for transportation is included in the rate paid to the provider.

(b) Time spent in transportation to and from the program cannot be included in the total number of service hours provided per day.

(c) Transportation to and from the program for the purpose of training may be included in the number of hours of services provided per day for the period of time specified in the PSS.

2) Conduct an orientation annually informing persons about Supported Employment and other competitive employment opportunities in the community.

3) Offer community job exploration to persons monthly.

4) Bill only for actual amount of services provided:

(a) Bill for a maximum of one hundred thirty-eight (138) hours per month for a person who attends twenty-three (23) working days in a month, or

(b) Bill for a maximum of one hundred thirty-two (132) hours per month for a person who attends twenty-two (22) working days in a month.

c) Prevocational service persons:

1) Must be at least eighteen (18) years of age or older to participate.

2) May be compensated in accordance with applicable Federal Laws.

3) May pursue employment opportunities at any time to enter the general work force.

4) May also receive the following ID/DD Waiver services but not during the same time on the same day:

(a) Day Services-Adult,

(b) Job Discovery, and

(c) Supported Employment.

d) Prevocational service settings do not include the following:

1) A nursing facility,

2) An institution for mental diseases,

3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),

4) A hospital, or

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:

(a) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

(b) Located in a building on the grounds of or immediately adjacent to a public institution, or

(c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

e) The amount of staff supervision someone receives is based upon tiered levels of support determined by a person's score on the Inventory for Client and Agency Planning (ICAP).

7. Supported Employment services are defined by the Division of Medicaid as ongoing support enabling persons to obtain and maintain competitive employment. These services cannot otherwise be available under the Rehabilitation Act of 1973, 29 U.S.C. § 110 or IDEA, 20 U.S.C. § 1400-01.

a) Supported Employment services include:

1) Activities needed to sustain paid work by persons including:

(a) Job analysis,

(b) Job development and placement,

(c) Job training,

(d) Negotiation with prospective employers, and

(e) On-going job support and monitoring.

2) Services and supports to assist the person in achieving self-employment, but does not pay for expenses associated with starting up or operating a business, including the following:

   (a) Aiding the person in identifying potential business opportunities,

   (b) Assisting in the development of a business plan, including potential sources of financing and other assistance in developing and launching a business,

   (c) Identifying supports necessary for the person to successfully operate the business, and

   (d) On-going assistance, counseling and guidance once the business has launched.

3) Services provided at work sites where persons without disabilities are employed. Payment is made only for the adaptations, supervision, and training required by persons receiving ID/DD Waiver services.

4) Personal care/assistance as a component of Supported Employment, but it must not comprise the entirety of the service.

5) The ability for persons to receive other services in addition to Supported Employment if included in the approved PSS which include educational, Prevocational, Day Services-Adults, In-home Nursing Respite, Community Respite, ICF/IID Respite, Crisis Support, Home and Community Supports, Behavior Support/Intervention services, and/or physical therapy, occupational therapy or speech therapy. Persons can receive multiple services on the same day but not during the same time period except for Behavior Support or Crisis Intervention services which can be provided simultaneously with Supported Employment.

6) Providing transportation between the person's residence and/or other habilitation sites and the employment site as a component part.

   (a) The cost of transportation is included in the rate paid to the provider and covers transportation between the person's residence and job site and between habilitation sites.

   (b) Providers cannot bill separately for transportation services and cannot charge persons for these services.

b) Supported Employment services do not include:

1) Sheltered workshops or other similar types of vocational services furnished in specialized facilities,

2) Volunteer work,

3) Payment for the supervisory activities rendered as a normal part of the business setting, or

4) Facility based or other types of services furnished in a specialized facility that are not part of the general workforce.

c) Supported Employment providers must:

1) Notify the person's ID/DD Waiver support coordinator of any changes affecting the person's income, and

2) Collaborate with the person's support coordinator to maintain eligibility under the ID/DD Waiver and health and income benefits through the Social Security Administration.

d) Employment must be in an integrated work setting in the general workforce where a person is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by people without disabilities.

e) A person cannot receive Supported Employment services during the Job Discovery process.

8. Home and Community Supports (HCS) are defined by the Division of Medicaid as a range of services provided to persons that live in the family home and need assistance with activities of daily living, instrumental activities of daily living, and inclusion in the community and may be shared by up to three (3) persons who have a common direct service provider agency. Services ensure the person can function adequately both in the home and in the community. Services must also provide safe access to the community. HCS must be provided in a person's private residence and/or community settings.

a) HCS services include:

1) Accompanying and assisting the person in accessing community resources and participating in community activities.

2) Supervision and monitoring of the person in the home, during transportation, and in the community.

3) Assistance with housekeeping directly related to the person's disability and is necessary for the health and well-being of the person. This cannot comprise the entirety of the service.

4) Assistance with money management, but not receiving or disbursing funds on behalf of the person.

5) Grocery shopping, meal preparation and assistance with feeding, not to include the cost of the groceries.

6) Transportation as an incidental component, which is included in the rate paid to the provider. Providers must possess a valid driver's license andcurrent insurance, and must follow DMH Operational Standards regarding criminal background checks.

b) HCS services cannot:

1) Be provided in a school setting or in lieu of school services or other available day services.

2) Be provided by someone who:

(a) Lives in the same home as the person,

(b) Is the parent/step-parent of the person,

(c) Is a spouse,

(d) Legal guardian/representative, or

(e) Anyone else who is normally expected to provide care for the person.

3) Exceed 172 hours per month when provided by a DMH approved family member.

4) Be provided to persons:

(a) Living in a residential setting, or any other type of staffed residence,

(b) In a hospital, nursing facility, ICF/IID, or other type of rehabilitation facility if the facility is billing Medicaid, Medicare, and/or private insurance, or

(c) Receiving the following ID/DD Waiver services:

(1) Supported Living,

(2) Supervised Living, or

(3) Host Home services.

c) HCS providers seeking approval for family members excluding those listed in Miss. Admin. Code Part 208, Rule 5.5.B.8. to provide HCS services must obtain prior approval from DMH.

9. Behavior Support services are defined by the Division of Medicaid as services providing systematic behavior assessment, Behavior Support Plan development, consultation, restructuring of the environment and training for persons whose maladaptive behaviors are significantly disrupting their progress in habilitation, self-direction or community integration and/or are at risk for being placed in a more restrictive setting. This service also includes consultation and training provided to families and staff living with the person. The desired outcome of the service is long term behavior change. Behavior Support services cannot replace educationally related services available under IDEA, 20 U.S.C. § 1401 or covered under an individualized family service plan (IFSP) through First Steps. Early and Periodic Screening Diagnosis and Treatment (EPSDT) services must be exhausted before ID/DD Waiver services can be provided.

   a) Behavior Support service providers:

      1) Must provide services in the following settings:

         (a) Home,

         (b) Habilitation setting, or

         (c) Provider's office.

      2) Cannot provide services in a public school setting. The provider may observe the person in the school setting to gather information, but may not function as an assistant in the classroom by providing direct services.

   b) Behavior Support services include the following:

      1) Assessing the person's environment and identifying antecedents of particular behaviors, consequences of those behaviors, maintenance factors for those behaviors, and how those particular behaviors impact the person's environment and life.

      2) Developing a behavior support plan, implementing the plan, collecting the data measuring outcomes to assess the effectiveness of the plan, and training staff and/or family members to maintain and/or continue implementing the plan.

      3) Providing therapy services to the persons to assist him/her in becoming more effective in controlling his/her own behavior, either through counseling or by implementing the behavior support plan.

4) Communicating with medical and ancillary therapy providers to promote coherent and coordinated services addressing behavioral issues in order to limit the need for psychotherapeutic medications.

10. Therapy Services are defined by the Division of Medicaid as physical therapy, occupational therapy, and speech-language pathology services used for the purpose of maintaining a person's skill, range of motion, and function rather than for rehabilitative reasons.

    a) Therapy services:

        1) Are provided through the ID/DD Waiver after the termination of State Plan therapy services,

        2) Must be on the person's approved PSS,

        3) Are only available under the ID/DD Waiver when not available through the IDEA, 20 U.S.C. § 1401 or through EPSDT/Expanded EPSDT.

    b) Therapy services are limited to a:

        1) Maximum of three (3) hours per week for speech-language pathology,

        2) Maximum of three (3) hours per week for physical therapy, and

        3) Maximum of two (2) hours per week for occupational therapy.

11. Specialized Medical Supplies are defined by the Division of Medicaid as those supplies in excess of those covered in the Medicaid State Plan. These supplies which must be included on the person's PSS include:

    a) Specified types of catheters,

    b) Diapers, and

    c) Blue pads.

12. Supported Living is defined by the Division of Medicaid as services to assist participants with ADLs and IADLs who reside in their own residences (leased or owned) for the purpose of facilitating independent living in their home or community.

    a) Supported Living provides assistance with the following:

        1) Grooming,

        2) Eating,

3) Bathing,

4) Dressing,

5) Personal care needs,

6) Planning and preparing meals,

7) Cleaning,

8) Transportation or assistance with securing transportation,

9) Assistance with ambulation and mobility,

10) Supervision of person's safety and security,

11) Assistance with banking, budgeting, and shopping,

12) Facilitation of person's inclusion in community activities, and.

13) Use of natural supports.

b) Supported Living providers must:

1) Be on call twenty-four (24) hours a day seven (7) days a week to respond to emergencies via phone or to return to the program site depending on the type of emergency.

2) Provide transportation when necessary and have documentation of:

(a) A valid driver's license,

(b) Vehicle registration,

(c) Current insurance, and

(d) Must follow DMH Operational Standards regarding criminal background checks.

3) Not sleep during billable hours, and

4) Develop methods, procedures, and activities to provide meaningful days and independent living choices about activities/services/staff for people served in the community.

c) Supported Living participants:

1) May share Supported Living services with up to three (3) persons who may or may not live together and who have a common direct service provider agency.

2) May share Supported Living staff when:

(a) Agreed upon by the person, and

(b) Health and welfare can be assured for each person.

3) Must be at least eighteen (18) years of age to receive Supported Living services.

4) Cannot receive Supported Living services if they are currently:

(a) An inpatient of a:

(1) Hospital,

(2) Nursing Facility,

(3) ICF/IID, or

(4) Any type of rehabilitation facility.

(b) Receiving the following ID/DD Waiver services:

(1) Supervised Living,

(2) Host Home services,

(3) In-Home Nursing Respite,

(4) Home and Community Supports, or

(5) Community Respite.

13. Crisis Intervention is defined by the Division of Medicaid as immediate therapeutic intervention services available twenty-four (24) hours a day that are designed to stabilize the participant in crisis, prevent further deterioration of the participant, restore the participant to the level of functioning before the crisis, and provide immediate treatment in the least restrictive setting, including, but not limited to a participant's home, alternate community living setting, and/or a participant's day setting.

a) Crisis Intervention services, regardless of setting, must be delivered in a way to maintain the person's normal routine to the maximum extent possible and may be

billed at the same time on the same day as:

1) Day Services-Adult,

2) Prevocational Services, or

3) Supported Employment.

b) Crisis intervention must include consultations with family members, providers and other caregivers to design and implement individualized Crisis Intervention plans and provide additional services as needed to stabilize the situation.

c) Crisis intervention is authorized up to twenty-four (24) hours per day in seven (7) day segments with the goal to phase out the support as the person becomes able to function appropriately in his/her daily routines/environments and is able to return to his/her home or to Supervised Living or Supported Living.

14. Crisis Support is defined by the Division of Medicaid as time-limited services provided in a Division of Medicaid licensed and certified facility when a person's behavior, or family/primary caregiver's situation regarding behavior, warrants a need for immediate specialized services that exceed the capacity of Crisis Intervention or Behavior Support services.

a) Crisis Support services:

1) Provide the person with behavioral and emotional support necessary to allow the person to return to his/her living arrangement.

2) Cannot exceed the maximum of thirty (30) days per stay, unless prior authorization is obtained from DMH.

b) A person has to receive prior approval from DMH before admission to an ICF/IID program for crisis support.

15. Host Home services is defined by the Division of Medicaid as services in private homes where a person lives with and family and receives personal care and supportive services through a family living arrangement in which the principal caregiver in the Host Home assumes the direct responsibility for the person's physical, social, and emotional well-being and growth in a family environment. Host Home agencies must take into account compatibility with the Host Home family member(s) including age, support needs and privacy needs. The person receiving Host Home services must have his/her own bedroom.

a) Host Home services are limited to one (1) person per Host Home and include assistance with:

1) Personal care,

2) Leisure activities,

3) Social development,

4) Family inclusion, and

5) Access to medical services.

b) Host Home agencies must:

1) Ensure availability, quality, and continuity of Host Home services,

2) Recruit, train, and oversee the Host Home family,

3) Be available twenty-four (24) hours a day to provide back-up staffing for scheduled and unscheduled absences of the Host Home family, which includes back-up staffing for scheduled and unscheduled absences of the Host Home family, and

4) Ensure the person has basic bedroom furnishings if furnishings are not available from another source.

c) The Host Home family must:

1) Attend PSS meeting and participate in the development of the PSS,

2) Follow all aspects of the PSS,

3) Provide transportation,

4) Assist the person with attending appointments,

5) Meet all staffing requirements as outlined in the DMH Operational Standards, and

6) Participate in training provided by the Host Home agency.

d) Host Home families are not eligible for:

1) Room and board payment, or

2) Maintenance or improvement of Host Home family's residence.

e) Host Home persons must be

1) At least eighteen (18) years of age, and

2) Able to self-administer their medications.

f) Host Home persons are not eligible for the following ID/DD Waiver services:

1) Home and Community Supports,

2) Supported Living,

3) Supervised Living,

4) In-Home Nursing Respite, or

5) Community Respite.

16. Job Discovery is defined by the Division of Medicaid as time-limited services used to develop a person's person-centered career profile and employment goals or career plan

a) Job Discovery services include, but are not limited to, the following:

1) Assisting the person with volunteerism,

2) Self-determination and self-advocacy,

3) Identifying wants and needs for supports,

4) Developing a plan for achieving integrated employment,

5) Job exploration,

6) Job shadowing,

7) Informational interviewing,

8) Labor market research,

9) Job and task analysis activities,

10) Employment preparation, and

11) Business plan development for self-employment.

b) Job Discovery persons must be:

1) At least eighteen (18) years of age, and

2) Unemployed.

c) Staff must receive or participate in at least eight (8) hours of training on Customized Employment before providing Job Discovery services.

d) Job Discovery cannot exceed twenty (20) hours over a three (3) month period and must result in the development of a career profile and employment goals or career path.

e) Job Discovery persons are not eligible for the following ID/DD Waiver services during the same time on the same day:

1) Prevocational services, or

2) Day Services-Adult.

17. Transition Assistance is defined by the Division of Medicaid as a one-time, setup expense for persons who transition from an institution (ICF/IID or a Title XIX Nursing Home) to a less restrictive community living arrangement. These funds cannot be used if the person is using transitional funds from other sources.

a) Persons are eligible for transition assistance if:

1) There is no other funding source to attain essential furnishings to establish basic living arrangements,

2) The person is transitioning from a setting where essential furnishings were provided, and

3) The person is moving to a residence where essential furnishings are not normally provided.

b) Transition Assistance can only be used once and is a life-time maximum allowance of eight hundred dollars ($800.00) used to establish the person's basic living arrangement and must be on the person's PSS which may include the following:

1) Expenses to transport furnishings and personal possessions from the facility to the new residence,

2) Security deposits that are required to obtain a lease on an apartment or home that do not constitute paying for housing rent,

3) Utility set-up fees or deposits for utility or service access,

4) Health and safety assurances, such as pest eradication, allergen control or one-time cleaning prior to occupancy,

5) Initial stocking of pantry with basic food items,

6) Cleaning supplies,

7) Towels and linens,

8) Bed,

9) Table,

10) Chairs,

11) Window blinds, and

12) Eating utensils.

c) Transition Assistance does not include the following:

1) Monthly rental or mortgage expenses,

2) Monthly utility charges, or

3) Household appliances, items, or services that are intended purely for diversional or recreational activities.

d) Items purchased with these funds are for the persons use and are property of the person.

Source: 20 U.S.C. § 1401; 42 U.S.C. § 1396n; 42 C.F.R. §§ 431.53, 440.170, 440.180, 441.301; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2017; Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.6: [Reserved]

Rule 5.7: Reimbursement

A. Providers cannot bill the Division of Medicaid for Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver services until the first (1st) day of the month after the services were rendered.

B. Services can only be provided to participants when authorized by the ID/DD Waiver support coordinator as part of the approved PSS.

C. All ID/DD Waiver providers must be enrolled as a Mississippi Medicaid Provider and must maintain an active provider number.

D. All ID/DD Waiver providers must be certified by DMH, except providers of therapy services and specialized medical supplies.

Source: 42 CFR § 440.180; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.8: Serious Events/Incidents and Abuse/Neglect/Exploitation

A. Department of Mental Health (DMH) certified providers must receive training at least annually regarding Mississippi's Vulnerable Persons Act and the following:

   1. Education as to what constitutes possible abuse/neglect/exploitation,

   2. Abuse/neglect/exploitation reporting requirements and procedures, and

   3. Reporting of serious events/incidents to DMH as outlined in the DMH Operational Standards.

B. All service providers must provide to the person and/or guardian or legal representative upon admission and annually thereafter, oral and written communication of:

   1. DMH's program procedures for protecting persons from abuse, neglect, exploitation, and any other form of potential abuse and how to report any suspected violation of rights and/or grievances to DMH, and

   2. The person's rights which must:

      a) Provide information on how to report:

         1) Violation of rights,

         2) Grievances, and

         3) Abuse, neglect, or exploitation.

      b) Be explained in a way that is understandable to the person and/or his/her guardian or legal representative.

      c) Include a signed form that states the person and/or guardian or legal representative understood their rights.

      d) Include the DMH toll-free Helpline phone number.

C. All providers must post the DMH toll-free Helpline phone number in a prominent place throughout each program site. The toll-free Helpline is available twenty-four (24) hours a day, seven (7) days per week.

D. All providers must have a written policy for documenting and reporting all serious events/incidents. Documentation regarding serious events/incidents must include:

1. A written description of events/incidents and actions,

2. All written reports, including outcomes, and

3. A record of telephone calls to DMH.

E. Serious events/incidents involving program services or program staff on program property or at a program-sponsored event must be reported to DMH, the agency director, and the guardian or legal representative as identified by the person receiving services. Incident reports regarding the serious event/incident must be completed and maintained in a central file on site that is not the person's case record. A description of the event/incident must be documented in the person's case record.

F. Death of a person on provider property, participating in a provider-sponsored event or during an unexplained absence from a residential program site, being served through a certified community living program, or during an unexplained absence of the person from a community living residential program must be reported verbally to DMH within eight (8) hours of discovery with a subsequent written report within twenty-four (24) hours.

G. The following serious events/incidents must be reported to DMH as outlined in the DMH Operational Standards including, but not limited to:

1. Suicide attempts on provider property or at a provider-sponsored event,

2. Suspected abuse/neglect/exploitation,

3. Unexplained absence of any length from a community living or day program,

4. Emergency hospitalization or treatment of a person receiving Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver services,

5. Accidents associated with suspected abuse or neglect, or in which the cause is unknown or unusual,

6. Disasters including, but not limited to, fires, floods, tornadoes, hurricanes, earthquakes and disease outbreaks,

7. Use of seclusion or restraints, either mechanical or chemical. Providers are prohibited

from the use of:

a) Mechanical restraints, defined by the Division of Medicaid as the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body unless being used for adaptive support,

b) Seclusion,

c) Time-out, and

d) Chemical restraints, defined by the Division of Medicaid as medication used to control behavior or to restrict the person's freedom of movement and is not standard treatment of the person's medical or psychiatric condition,

8. Incidents involving person injury while on provider property or at a provider- sponsored event, and

9. Medication errors.

H. If an ID/DD Waiver provider has a question of whether or not an event/incident should be reported, the provider must contact DMH.

I. Suspected abuse/neglect/exploitation must also be reported to the appropriate authorities according to state law including, but not limited to, the Vulnerable Persons Unit (VPU) at the Attorney General's Office, and the Division of Family and Children Services (DFCS) and the Adult Protective Services (APS) at the Mississippi Department of Human Services (DHS), dependent upon the type of event.

J. If the alleged perpetrator of abuse/neglect/exploitation carries a professional license or certificate, a report must be made to the entity that governs their license or certificate.

K. Disease outbreaks at a provider site must be reported to the Mississippi State Department of Health (MSDH).

Source: 42 U.S.C. § 1396n; Miss. Code Ann. §§ 41-4-7, 43-13-121.

History: Revised eff. 01/01/2017; Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.9: Medication Management and Medical Treatment

A. Nurses employed by an agency enrolled as an Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver provider must practice within the current guidelines outlined in the Mississippi Nurse Practice Act and applicable state and federal laws and regulations, regardless of the setting.

1. A registered nurse (RN) and/or licensed practical nurse (LPN) must be supervised by appropriately qualified staff through a home health agency or other entity allowed by state and federal laws and regulations.

2. RNs and LPNs must be employed by a Medicaid provider and work under the direction of physician, physician assistant or nurse practitioner.

3. If a participant cannot self-administer medications and the guardian or legal representative is unavailable, only a licensed nurse, nurse practitioner, physician, physician assistant or dentist may administer or oversee administration of medications at ID/DD Waiver program sites in the community or in the home setting.

B. The following practices must be in place to protect the health and safety of a participant who requires medications or medical procedures/treatments:

1. Medications must be stored appropriately in their original containers if a licensed nurse is to administer them.

2. Licensed nurses may not prepare medications in a medication planner for a non-licensed provider(s) to dispense in his/her absence.

3. All medications must be documented in the participant's record by the appropriately licensed medical professional administering them.

4. Documentation must reflect whether the guardian or legal representative administers the participant's medications or if a participant self-administers his/her medications.

5. RNs must assess the participant for medication side effects and report any suspected side effects or untoward effects to the practitioner who prescribed them. Suspected side effects or potential health issues noted by an LPN must be reported promptly to an RN or appropriately qualified staff.

6. The first-line responsibility for monitoring a participant's medication regimen lies with the licensed medical professional who prescribes the medication. A licensed medical professional is defined by the Division of Medicaid as a physician, physician assistant, certified nurse practitioner, or licensed dentist who meets the state and federal licensing and/or certification requirements.

7. Second-line monitoring must be provided by the staff in the supervised living setting which focuses on areas of concern identified by the physician and/or pharmacist.

C. Supervised Living providers must make arrangements for a licensed nurse to administer medication(s) if a participant who requires medication cannot self-administer while receiving services. With the participant's permission, the licensed nurse or employing agency may accompany the participant to physician visits and/or communicate with the participant's

physician. After communicating with the physician, the licensed nurse employed by the Supervised Living provider or employing agency, must document the following:

1. Physician visits including the reason for the visit,

2. Physician instructions/orders,

3. New prescriptions including any detailed pharmacy information supplied with the prescription, and

4. Any pertinent information regarding the participant's medical status.

D. All medical treatments prescribed by a physician, physician assistant, or nurse practitioner must be provided or administered by a licensed nurse.

1. Documentation must contain an assessment of the treatment and the name of the healthcare professional, including credentials, who performed the required medical treatment.

2. If the physician, physician assistant, or nurse practitioner orders the participant and/or guardian or legal representative be taught to provide or administer treatments, only an RN may provide this service in accordance with current Mississippi nursing laws, rules and regulations.

E. Providers must have policies and procedures for the frequency of monitoring behavior, medication administration, side effects and adverse reactions.

Source: Miss. Code Ann. §§ 43-13-121, 73-15-1 to -35.

History: Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.10: Documentation and Record Maintenance

A. Documentation of each Intellectual Disabilities/Developmental Disabilities (ID/DD) service provided must be in the case record. [Refer to Miss. Admin. Code, Part 200, Rule 1.3.]

B. The entry or clinical note must include all of the following documentation:

1. Date of service,

2. Type of service provided,

3. Time service began and time service ended,

4. Length of time spent delivering service,

5. Identification of participant(s) receiving or participating in the service,

6. Summary of what transpired during delivery of the service,

7. Evidence that the service is appropriate and approved on the PSS, and

8. Name, title, and signature of individual providing the service.

C. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect the following:

1. Documentation requirements in the Centers for Medicare and Medicaid Services (CMS) approved ID/DD Waiver,

2. DMH Operational Standards,

3. Evidence that the service is appropriate and approved on the PSS, and

4. Documentation requirements in the DMH Record Guide.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129.

History: Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.11: Beneficiary Cost Sharing

A. For beneficiaries covered under a HCBS waiver, the co-payment is exempt if the service is being paid through the waiver.
B. If services are being paid through Mississippi Medicaid State Plan benefits, the co-payment is applicable unless exempt by one of the beneficiary groups or services outlined in Miss. Admin. Code Part 200, Rule 3.7.

Source: 42 USC § 1396a; 42 CFR §§ 447.50-.52; Miss. Code Ann. § 43-13-121.

History: Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.12: Grievances and Complaints

A. The Department of Mental Health (DMH) is responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by DMH. Grievances may be made via phone, written letter format or email.

B. Personnel issues are not within the purview of DMH.

C. A toll-free Helpline is available twenty-four (24) hours a day, seven (7) days per week. All providers are required to post the toll-free number in a prominent place throughout each program site.

D. Providers of waiver services must cooperate with both DMH and the Division of Medicaid to resolve grievances/complaints.

E. All grievances must be resolved within thirty (30) days of receipt by DMH unless additional time is required due to the nature of the grievance. The individual filing the grievance must be provided a formal notification from DMH of the resolution and all activities performed in order to reach the resolution.

F. Providers must ensure the person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

Source: 42 C.F.R. § 441.301; Miss. Code Ann. §§ 41-4-7, 43-13-121.

History: Revised eff. 01/01/2017; Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.13: Reconsiderations, Appeals, and Hearings

A. If it is determined that an applicant does not meet Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care (LOC) at the completion of an initial evaluation by the Diagnostic and Evaluation (D&E) team, the applicant and/or guardian or legal representative may request reconsideration from DMH.

B. Decisions that result in services being denied, terminated, or reduced may be appealed according to DMH appeal procedures.

   1. If the participant and/or guardian or legal representative disagrees with the decision made by DMH regarding services being denied, terminated, or reduced, a written request to appeal the decision may then be made to the Executive Director of the Division of Medicaid. [Refer to Miss. Admin. Code, Part 300.]

   2. During the appeals process, contested services that were already in place must remain in place, unless the decision is for immediate termination due to possible danger, racial considerations or sexual harassment of the service providers. The ID/DD Waiver support coordinator is responsible for ensuring that the beneficiary continues to receive all services that were in place prior to the notice of change.

Source: 42 CFR Part 431, Subpart E; Miss. Code Ann. §§ 41-4-7, 43-13-116, 43-13-121.

History: Revised to reflect changes with ID/DD Waiver renewal (eff. 07/01/2013) eff. 09/01/2015.

Rule 5.14: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

   1. Allow the person to lead the process where possible with the person's guardian and/or legal representative having a participatory role, as needed and as defined by the person and any applicable laws.

   2. Include people chosen by the person.

   3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

   4. Be timely and occur at times and locations of convenience to the person.

   5. Reflect cultural considerations of the person and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

   6. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

   7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process.

   8. Offer informed choices to the person regarding the services and supports they receive and from whom.

   9. Include a method for the person to request updates to the PSS as needed.

   10. Record the alternative HCBSs that were considered by the person.

B. The PSS must reflect the services and supports that are important for the person to meet the needs identified through an assessment of functional need, as well as what is important to the person with regard to preferences for the delivery of such services and supports and the level

of need of the individual and must:

1. Reflect that the setting in which the person resides is:

    a) Chosen by the person,

    b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

        (1) Seek employment and work in competitive integrated settings,

        (2) Engage in community life,

        (3) Control personal resources, and

        (4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

8. Identify the individual and/or entity responsible for monitoring the PSS.

9. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

10. Be distributed to the individual and other people involved in the plan.

11. Include those services, the purpose or control of which the individual elects to self-direct.

12. Prevent the provision of unnecessary or inappropriate services and supports.

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

1. A description of the individual's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports.

2. The outcomes identified by the individual and how progress toward achieving those outcomes will be measured.

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Providers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

Source: 42 C.F.R. § 441.301.

New rule eff. 01/01/2017.

Part 208 Chapter 6: Bridge to Independence (B2I)

Rule 6.1: General

A. Bridge to Independence (B2I), Mississippi's Money Follows the Person (MFP) initiative, is a six (6) year federal demonstration grant that was awarded to the Division of Medicaid on April 1, 2011, and is funded by the United States Department of Health and Human Services (DHHS) and the Centers for Medicare and Medicaid Services (CMS).

B. The purpose of B2I is to establish a person-driven and sustainable home and community-based long-term care system offering choice and access to quality services in the community for institutionalized individuals:

1. With a physical disability,

2. With a mental illness,

3. With an intellectual or developmental disability, or

4. Sixty-five (65) years of age or older.

Source: *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999); Section 6071 Deficit Reduction Act of 2005 Public Law 109-171; Section 2403, Affordable Care Act, Public Law 111-148; Miss. Code Ann. § 43-13-121.

History: New Rule to correspond with B2I grant (eff. 01/01/2012) eff. 06/01/2014.

Rule 6.2: Eligibility

A. To participate in the Bridge to Independence (B2I) demonstration project, the person:

1. Must reside in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) or a nursing facility for at least ninety (90) consecutive days with at least one (1) day of the stay reimbursed by Medicaid.

2. Cannot have received short-term rehabilitation services reimbursed under Medicare during the ninety (90) day stay requirement.

3. Must be eligible for one (1) of the following Medicaid Home and Community-Based Services (HCBS):

   a) Assisted Living (AL) Waiver,

   b) Elderly and Disabled (E&D) Waiver,

   c) Independent Living (IL) Waiver,

   d) Intellectual Disability/Developmental Disability (ID/DD) Waiver,

   e) Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver, and/or

   f) Community Mental Health Center (CMHC) Services/Rehabilitation option of the State Plan.

4. Must meet the level of care criteria for an ICF/IID or a nursing facility and, if not for the provision of HCB long-term care services, the person would continue to require the level of care provided in the facility.

B. Qualified residences for transitioning persons must pass a U.S. Department of Housing and Urban Development Housing Quality Standards inspection and meet one (1) of the following criteria:

1. A home owned or leased by the transitioning person or the person's family member,

2. An apartment with lockable access leased to the transitioning person which includes living, sleeping, bathing, and cooking areas over which the person or the person's family has domain and control, or

3. A residence in a community-based residential setting in which no more than four (4) unrelated persons reside.

Source: 42 USC § 1369a; Miss. Code Ann. § 43-13-121; *Olmstead v. L.C.,* 119 S. Ct. 2176 (1999).

History: Revised eff. 04/01/2016; Revised to correspond with CMS approved Operational Protocol (eff. 11/04/2014) eff. 09/01/2015; New Rule to correspond with B2I grant (eff. 01/01/2012) eff. 06/01/2014.

Rule 6.3: Covered Services

The following services are available to B2I persons as documented in the Plan of Services and Supports (PSS):

A. Transition Care Management, defined as transition care planning occurring for up to one-hundred eighty (180) days pre-discharge from the institution and post-transition care planning for three hundred sixty-five (365) days following transition into the community.

1. Transition Care Management includes:

a) Crisis Support, defined as a response to the transitioning person and/or person's caregiver who is experiencing a crisis event during the transition process.

1) The service must be available twenty-four (24) hours a day, seven (7) days a week.

2) Initial contact may take place over the telephone, but if the situation is determined to be an emergency, the provider must provide in-person support.

3) Staff must be available to meet with the person in transition, as well as any other member of the person-centered planning team, to resolve the crisis and thereby

enable the person to remain in the community.

b) Person-Centered Planning (PCP), defined as a process directed by the person or family with long-term care needs which:

1) Identifies the strengths, capacities, preferences, needs and desired outcomes of the person.

2) Includes participants freely chosen by the person or family who are able to serve as important contributors.

3) Assists the person to identify and access personalized paid and non-paid services and supports.

4) The person identifies planning goals to achieve those personal outcomes in collaboration with those that the person has identified, including medical and professional staff.

5) The identified personally-defined outcomes and the training supports, therapies, treatments and/or other services the person is to receive to achieve those outcomes as part of the Plan of Services and Supports (PSS).

6) Meets all the following minimum PCP service contact requirements:

(a) Initial PCP meeting held within thirty (30) days of the person choosing a B2I provider,

(b) Pre-transition PCP meeting held a minimum of every thirty (30) days,

(c) Post-transition PCP meeting held a minimum of every sixty (60) days, and

(d) Interim PCP meetings held as circumstances change, the person and/or guardian or legal representative requests a meeting, and/or the needs of the person require that the team meet on a more frequent basis to best coordinate care.

7) Includes the following documentation in the enrolled person's record:

(a) Discovery interviews including, but not limited to, Community Navigator Notes, dates, and individuals interviewed, such as the person and caregivers,

(b) Activities and observations including, but not limited to, activity, location, Community Navigator Notes, and dates,

(c) Profile,

(d) Dated Action Plans from each PCP meeting,

(e) Sign-in sheets of all meetings and dates, and

(f) Minutes from all PCP meetings.

8) Includes the development of the PSS which is retained in the person's record and contains:

(a) B2I services, including, but not limited to, service amounts, provider name, and beginning and end dates of services provided,

(b) Other services received, regardless of payer source, including, but not limited to, service amounts, provider name, and beginning and end dates of services provided, and

(c) Narrative of services, supports, needs and outcomes.

9) Includes a Risk Mitigation Plan, defined as a comprehensive and pro-active safety/risk mitigation plan developed to address any safety issue/risk that has been identified through discovery and planning. The Risk Mitigation Plan must be retained in the person's record and address any safety issue/risk in the following categories and include a detailed mitigation plan for any safety issue/risk including, but not limited to:

(a) Medical and physiological,

(b) Behavioral and psychiatric,

(c) Environmental including, but not limited to, living conditions or loss of a home,

(d) Financial,

(e) Activities of daily living including, but not limited to, loss of natural supports,

(f) Service disruption,

(g) Legal including, but not limited to, prior convictions and recidivism risk,

(h) Natural disaster plan including, but not limited to, fire, flooding, hurricane and earthquake evacuation plan including emergency contact information,

(i) B2I provider staff contact number available twenty-four hours a day, seven days a week (24/7),

(j) Emergency contact numbers including, but not limited to, 911, local law enforcement office, local hospital, and regional CMHC, and

(k) A written and oral explanation of appropriate responses to emergencies, including health or mental health emergencies versus situations in need of immediate attention, including broken medical equipment or failure of a service provider to make an appointment.

2. Transition Care Management must be provided by a qualified community navigator who cannot be the person's HCB waiver/CMHC case manager and who meets the criteria in one (1) of the following:

   a) Licensed social worker (LSW) with valid state license and a minimum of one (1) year of relevant work experience,

   b) Case manager with at least one (1) year of relevant work experience and certified by the Department of Mental Health (DMH),

   c) Registered nurse (RN) with valid state license and a minimum of one (1) year of relevant work experience, or

   d) Others with relevant experience and training with a minimum of a bachelor's degree and one (1) year of work experience in a social or health service setting or a comparable technical and human service training will be considered and approved by the Division of Medicaid, B2I.

3. The community navigator must document in a narrative form in a Community Navigator Notes section in the record all contacts made with, about and/or on behalf of the person and include:

   a) Date of the service,

   b) Beginning and end time of the service,

   c) Type of contact including, but not limited to, face-to-face, phone, e-mail, PCP meeting notes and activities, meetings and third party calls,

   d) Who the contact was with including, but not limited to, the person, family member, community/natural resource, service providers, and housing partners,

   e) Reason for the contact as well as the content and issues discussed,

   f) All follow-up activities,

   g) When, why, and what type of information is received about or by the person,

h) When, why, and what type of information is sent to another party about the person,

i) Any change in services,

j) Other situations based on individual circumstances, and

k) Community navigator's signature.

4. A Community navigator must provide the following minimum service contacts:

a) Face-to-face meeting with the person and interested parties scheduled within ten (10) days of a B2I provider receiving referral,

b) One (1) contact per week with the person and/or family which includes during the Pre-Transition period up to one hundred eighty (180) days and the Post-Transition period during the first ninety (90) days,

c) One (1) face-to-face visit per month with the person Pre-Transition and Post-Transition, not including PCP meeting,

d) One (1) PCP team meeting every thirty (30) days Pre-Transition and every sixty (60) days Post-Transition with the initial PCP meeting held within the first thirty (30) days after the Consent to Participate Phase II is signed, and

e) One (1) contact per month with an assigned HCB waiver/CMHC case manager to ensure service coordination during the Post-Transition period.

5. A community navigator's case load cannot exceed:

a) A total of thirty (30) persons, or

b) Fifteen (15) persons in each of the following categories:

1) Pre-Transition refers to persons for whom a community navigator is providing Transition Care Management services on an ongoing basis prior to transition up to one hundred eighty (180) days and in the first ninety (90) days after transition.

2) Ninety (90) days Post-Transition refers to persons for whom a community navigator is continuing to provide ongoing Transition Care Management services but whose primary health care oversight and management responsibilities have been turned over to appropriate HCB waiver/CMHC case managers.

B. Life Skills Training, defined as assisting persons with transitioning to the community through independent living skills that include, but are not limited to, money management, the use of technology, accessing community resources, employment skills development, grooming and personal hygiene, and interpersonal relationships with others in the community.

1. A life skills service plan must be developed with the person's input to address life skills needed which must be contained in the person's record and include:

    a) Date of life skills service plan,

    b) Life skills to be addressed,

    c) Activities used to meet the life skill need, and

    d) Date of goals met and improvement of life skills.

2. Documentation of services provided must be retained in the person's record and contain:

    a) Date of the service,

    b) Beginning and end time of the service delivery,

    c) Description of the service, and

    d) Signature of staff person providing service.

C. Peer Supports, defined as counseling from peers with similar circumstances who may be able to share their own experiences with the person to reduce feelings of isolation and to promote inclusion.

1. Peer supporters must meet the following criteria:

    a) Be a resident of Mississippi,

    b) Self-identify as a current or former recipient of disability services for persons with physical, intellectual, developmental, and/or mental disabilities,

    c) Complete all training required by the provider agency,

    d) Demonstrate a minimum of six (6) consecutive months in self-directed recovery and/or of successful community living, and

    e) Demonstrate emotional readiness to provide supports to a peer.

2. Documentation of services provided must be retained in the person's record and contain:

    a) Date of the service,

    b) Beginning and end time of the service delivery,

c) Description and summary of the service, and

d) Signature of staff person providing the service.

D. Caregiver Support, defined as a service to enable the caregiver to transition into a more active role and to assist identified and qualified caregivers of persons enrolled in B2I to cope with stress and to develop caregiver skills in order to help them become a source of support for the transitioning person. Caregivers qualified to receive caregiver support must perform or assist the person in one (1) or more life activities, such as finances, health care, or general decision making, and includes:

1. Peer-to-Peer service designed for identified caregivers of the person enrolled in B2I to assist with the management of stress and the development of caregiver skills and must be provided by an individual who must:

a) Identify as a former or current caregiver of someone with a physical, intellectual, developmental or mental disability,

b) Complete all training required by the provider agency, and

c) Demonstrate emotional readiness to provide emotional support to another caregiver and understand when to seek professional help for a caregiver.

2. Individual Therapy Support, defined as services designed to assist identified caregivers of the person enrolled in B2I through therapy/counseling sessions and must be:

a) Provided by an individual who holds a master's degree and professional license as a licensed professional counselor (LPC), licensed psychologist, licensed certified social worker (LCSW) or licensed marriage and family therapist (LMFT), and

b) Documented in the person's record and contain:

1) Date of the service,

2) Beginning and end time of the service delivery,

3) Description and summary of the service, and

4) Signature of staff providing service.

E. Transportation, defined as any appropriate form of transporting the person from one (1) location to another to maximize community inclusion for the person.

1. Documentation of services provided must be retained in person's record and contain:

a) Date of service,

b) Time of service,

c) Destination to and from, and

d) Signature of staff providing service.

F. Security and Utility Deposits, defined as specific up-front costs to establish a residence in the community with detailed receipts retained in the person's record.

G. Household Furnishings and Goods, defined as, but not limited to, essential items and furnishings, appliances, household supplies, and pantry items required to set-up a household in the HCB setting based on the needs of the person with detailed receipts retained in the person's record.

H. Moving Expenses, defined as moving costs associated with a transition for items transported from the facility in which the person is residing to their new community residence or community-based setting and may also cover commercial transportation of household furnishings from a store to the person's community residence or community-based setting with detailed receipts retained in the person's record.

I. Environmental Accessibility Adaptations, defined as certain required modifications completed by a licensed and bonded contractor to the person's residence to enable the care of the person in a HCB setting with detailed receipts retained in the person's record. Only persons enrolled in the E&D or ID/DD Waivers are eligible for Environmental Accessibility Adaptations.

J. Durable Medical Equipment (DME), defined as medically necessary equipment, based on the person's PSS, which allows for community living. Only persons enrolled in the E&D, ID/DD or AL Waivers are eligible for DME.

K. Extended Pharmacy, defined as up to three (3) additional prescriptions over the Medicaid five (5) prescription limit allowed in the State Plan for a total not to exceed eight (8) prescriptions per month with no more than five (5) of which may be non-generics.

1. The person is only eligible for the extended pharmacy benefit if their prescriptions are in excess of the Medicaid monthly prescription limit.

2. Community navigators must assist the person in managing the extended pharmacy benefit to access needed pharmacy services under existing options in the Mississippi State Plan.

3. Community navigators must coordinate with the person's community providers including, but not limited to, physicians and pharmacists for medication management.

4. The person enrolled in B2I should utilize preferred medications on the Universal Preferred Drug List (PDL) and the Ninety (90) Day Maintenance List when possible, to

maintain the person on the least amount of prescriptions required for therapeutic benefit.

L. Adaptive Equipment/Technology, defined as an assistive equipment/technological device which includes an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, used to increase, maintain, or to improve the person's level of independence, ability to access needed supports and services in the community or maintain or improve the person's safety with detailed receipts retained in the person's record.

Source: *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999); Section 6071 Deficit Reduction Act of 2005 Public Law 109-171; Section 2403, Affordable Care Act, Public Law 111-148; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with CMS approved Operational Protocol (eff. 11/04/2014) eff. 09/01/2015; New Rule to correspond with B2I grant (eff. 01/01/2012) eff. 06/01/2014.

Rule 6.4: Quality Management

B2I providers must maintain quality control measures to ensure the health, safety, and welfare of individuals including, but not limited to:

A. A twenty-four (24) hours a day, seven (7) days a week crisis and response system,

B. A critical incident reporting system, and

C. A system to assess and mitigate risks to individuals.

Source: *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999); Section 6071 Deficit Reduction Act of 2005 Public Law 109-171; Section 2403, Affordable Care Act, Public Law 111-148; Miss. Code Ann. § 43-13-121.

History: New Rule to correspond with B2I grant (eff. 01/01/2012) eff. 06/01/2014.

Rule 6.5: Appeals and Hearings

A. Decisions made by B2I staff or representatives resulting in reduced, suspended or terminated services of the Division of Medicaid may be appealed. [Refer to Miss. Admin. Code Part 300: Appeals, Chapter 1: Appeals]

Source: *Olmstead v. L.C.*, 119 S. Ct. 2176 (1999); Section 6071 Deficit Reduction Act of 2005 Public Law 109-171; Section 2403, Affordable Care Act, Public Law 111-148; Miss. Code Ann. § 43-13-121.

History: New Rule to correspond with B2I grant (eff. 01/01/2012) eff. 06/01/2014.

Part 208 Chapter 7: 1915(i) HCBS

Rule 7.1: Eligibility

A. The Division of Medicaid covers certain 1915(i) Home and Community-Based Services (HCBS) as an alternative to institutionalization in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) through its State Plan. The State Plan services:

   1. Offer broad discretion, not generally afforded, so that the needs of beneficiaries under the State Medicaid Plan may be addressed,

   2. Are operated jointly with the Mississippi Department of Mental Health (DMH),

   3. Are available statewide,

   4. Carry no age restrictions, and

   5. Are covered only for beneficiaries not enrolled in any HCBS Waiver program.

B. All of the following eligibility requirements must be met to receive 1915(i) State Plan services:

   1. A beneficiary must have one (1) of the following:

      a) An intellectual disability defined by the Division of Medicaid as meeting all the following criteria:

         1) An IQ score of approximately seventy (70) or below,

         2) A determination of deficits in adaptive behavior, and

         3) Manifestation of disability prior to the age of eighteen (18).

      b) A developmental disability defined by the Division of Medicaid as a severe, chronic disability which is a condition attributable to cerebral palsy, epilepsy, or any other condition other than mental illness found to be closely related to an intellectual disability, because it results in impairment of general intellectual functioning or adaptive behavior similar to that of an individual with an intellectual disability and requires similar treatment/services.

         1) The condition is manifested prior to age twenty-two (22) and is likely to continue indefinitely.

         2) The condition results in substantial functional limitations in three (3) or more of the following major life activities:

i) Self-care,

ii) Understanding and use of language,

iii) Learning,

iv) Mobility,

v) Self-direction, or

vi) Capacity for independent living and economic self-sufficiency.

3) The individual also requires a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of individually planned and coordinated assistance that is life-long or of an extended duration.

4) An exception to this definition is an individual, from birth to age nine (9), who has a substantial developmental delay or specific congenital or acquired condition. He or she may be considered developmentally disabled without meeting all of the above criteria if, without services and supports, there is a high probability of meeting those criteria later in life.

c) Autism as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.

2. Applicant must qualify for full Medicaid benefits in one (1) of the following categories:

a) SSI,

b) Low Income Families and Children Program,

c) Disabled Child Living at Home Program,

d) Working Disabled,

e) Children Under Age Nineteen (19) Under 100% of Poverty,

f) Protected Foster Care Adolescents,

g) CWS Foster Children and Adoption Assistance Children,

h) IV-E Foster Children and Adoption Assistance Children, or

i) Child under Age six (6) at 133% Federal Poverty Level.

Source: Social Security Act § 1915(i); Miss. Code Ann. § 43-13-121.

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.2: Provider Enrollment

A. Division of Medicaid 1915(i) providers must be certified by the Mississippi Department of Mental Health (DMH), Bureau of Quality Management, Operations and Standards (BQMOS). DMH Certification is dependent upon compliance with the Mississippi Department of Mental Health Operational Standards.

B. The provider must be in good standing with their state licensure agency and adhere to applicable state and federal regulations related to the license. The provider must comply with all rules and standards related to the 1915(i) services and have a current Mississippi Medicaid provider number.

C. All providers must comply with the CMS approved 1915(i) State Plan.

Source: Social Security Act § 1915(i); Miss. Code Ann. § 43-13-121.

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.3: Freedom of Choice

A. Medicaid persons have the right to freedom of choice of providers for Medicaid covered services. [Refer to Miss. Admin. Code Part 200, Rule 3.6]

B. Targeted Case Managers must facilitate individual choice regarding services and supports and who provides them. Targeted Case Managers must inform the person/legal representative of qualified providers initially and annually thereafter as well as when new qualified providers are identified or if a person is dissatisfied with their current provider.

C. Settings are selected by the person from among setting options including non-disability specific settings based on the person's needs and preferences which are identified and documented in the plan of services and supports.

D. The choice made by the person/legal representative must be documented and signed by the person/legal representative and must be maintained in the person’s record.

Source: 42 U.S.C. § 1396n; 42 C.F.R. § 441.710; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017. New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.4: Level of Care Evaluation/Reevaluation and Plan of Care Development

A. Level of care (LOC) evaluations and reevaluations for eligibility must be conducted by one (1) of the five (5) Diagnostic and Evaluation (D&E) Teams housed at the DMH's five (5) comprehensive regional programs.

   1. Re-evaluations are only required if the beneficiary has a significant change in condition.

   2. Evaluations and reevaluations must be conducted in an interdisciplinary team format which must include a psychologist and social worker.

      a) Additional team members, including, but not limited to, physical therapists and dieticians, may be utilized dependent upon the needs of the individual being evaluated or reevaluated.

      b) All members of the D&E Teams must be licensed and/or certified through the appropriate State licensing/certification body for their respective disciplines.

B. An initial Person-Centered Plan of Care must be facilitated by the Case Manager and be reviewed at least every twelve (12) months and when there is a significant change in the beneficiary's circumstances that may affect his/her level of functioning and needs. The Case Manager must:

   1. Have a minimum of a Bachelor's degree in a mental health/IDD related field and be credentialed by the MS Department of Mental Health or be a Qualified Mental Retardation Professional (QMRP)/Qualified Developmental Disabilities Professional (QDDP).

   2. Complete training in Person-Centered planning and demonstrate competencies associated with that process.

   3. Seek active involvement from beneficiaries and their families and/or legal guardians to develop and implement a plan of care that is person-centered and addresses the outcomes desired by the beneficiaries.

   4. Educate beneficiaries and their families and/or legal guardians about the person-centered planning process.

   5. Assist beneficiaries participating in 1915(i) and/or their family members and legal representatives to determine who is included in their planning process.

   6. Encourage the inclusion of formal and informal providers of support to the beneficiaries in the development of a person-centered plan.

Source: Social Security Act § 1915(i); Miss. Code Ann. § 43-13-121.

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.5: Covered Services

A. A person can receive:

1. 1915(i) services if not eligible for services available:

   a) For Prevocational Services under a program funded under Section 110 of the Rehabilitation Act of 1973 or Sections 602(16) and (17) of the Individuals with Disabilities Education Act , 20 U.S.C. 1401 (16) and (17), or

   b) For Supported Employment under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

2. Only those 1915(i) services which are documented on the Plan of Services and Supports (PSS) by the Case Manager and approved by the Department of Mental Health (DMH), and

3. Multiple 1915(i) services on the same day but not during the same time of the day.

B. Transportation between the person's residence, other habilitation sites and the employment site is a component part of Habilitation Services.

1. The cost of transportation is included in the rate paid to the provider.

2. Providers cannot bill separately for transportation services and cannot charge the persons for transportation.

C. The 1915(i) State Plan services are:

1. Day Habilitation Services defined by the Division of Medicaid as services designed to assist the person with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities and environments are designed to foster the acquisition and maintenance of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Day Habilitation Services:

   a) Must take place in a non-residential setting separate from the home or facility in which the person resides.

   b) Settings must be physically accessible to the person and must:

      1) Be integrated in and supports full access of persons receiving Medicaid Home and Community-Based Settings (HCBS) to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the

community, to the same degree of access as individuals not receiving Medicaid HCBS.

2) Be selected by the person from among setting options including non-disability specific settings. The setting options are identified and documented in the person-centered service plan and are based on the person's needs, preferences.

3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

4) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

5) Facilitate individual choice regarding services and supports, and who provides them.

c) Do not include the following:

1) A nursing facility,

2) An institution for mental diseases,

3) An intermediate care facility for individuals with intellectual disabilities (ICF/IID),

4) A hospital, or

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:

(a) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

(b) Located in a building on the grounds of or immediately adjacent to a public institution, or

c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

d) Must be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, or as specified in the person’s PSS.

e) Must be provided in DMH certified sites/community settings.

2. Prevocational Services defined by the Division of Medicaid as services to prepare a

person for paid employment. Services address underlying habilitative goals which are associated with performing compensated work. Services include, but are not limited to, teaching concepts such as compliance, attendance, task completion, problem solving and safety. Services are not job task oriented but instead are aimed at a generalized result. Prevocational Services:

a) Must be included in the person's PSS and be directed towards habilitative objectives and not explicit employment objectives.

b) Provide choices of food and drinks to persons at any time during the day to meet their nutritional needs which includes, at a minimum:

    1) A mid-morning snack,

    2) A noon meal, and

    3) An afternoon snack.

c) May include personal care/assistance as a component but it cannot comprise the entirety of the service. Beneficiaries cannot be denied Prevocational Services because they require assistance from staff with toileting and/or personal hygiene.

d) Beneficiaries must be compensated in accordance with applicable federal laws and regulations. If a person is performing productive work as a trial work experience that benefits the provider or that would have to be performed by someone else if not performed by the person, the provider must pay the person commensurate with members of the general work force doing similar work per federal wage and hour regulations.

e) Must be reviewed for necessity and appropriateness by the person, appropriate staff and the Case manager if the person earns more than fifty percent (50%) of the minimum wage.

f) Providers must inform beneficiaries about Supported Employment opportunities and other competitive employment activities in the community on an annual basis.

g) May be furnished in a variety of locations in the community and are not limited to fixed program locations. Community job exploration activities must be offered to each person at least one (1) time per month.

h) Include transportation. Time spent in transportation to and from the program cannot be included in the total number of service hours provided per day, unless it is for the purpose of training.

i) Settings must be physically accessible to the person and must:

1) Be integrated in and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.

2) Be selected by the person from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the person's needs and preferences.

3) Ensure a person's rights of privacy, dignity and respect, and freedom from coercion and restraint.

4) Optimize, but not regiment, a person's initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.

5) Facilitate individual choice regarding services and supports, and who provides them.

c) Settings do not include the following:

1) A nursing facility,

2) An institution for mental diseases,

3) An intermediate care facility for individuals with intellectual disabilities,

4) A hospital, or

5) Any other locations that have qualities of an institutional setting, as determined by the Division of Medicaid, including but not limited to, any setting:

(a) Located in a building that is also a publicly or privately operated facility that provides inpatient institutional treatment,

(b) Located in a building on the grounds of, or immediately adjacent to a public institution, or

(c) Any other setting that has the effect of isolating persons receiving Medicaid Home and Community-Based Services (HCBS).

3. Supported Employment services defined by the Division of Medicaid as intensive, ongoing support to persons who, because of their disabilities, require support to obtain and maintain an individual job in competitive or customized employment, or self-

employment. Employment must be in an integrated setting in the general workforce for whom a person is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities. Supported Employment:

a) Is based on an Activity Plan that must be developed for each person based on his/her PSS.

b) Includes assessment, job development and placement, job training, negotiation with prospective employers, job analysis, systematic instruction, and ongoing job support and monitoring.

c) Includes services and supports to assist the person in achieving self-employment through the operation of a home or community based business, and may include the following:

    1) Aiding the person in identifying potential business opportunities.

    2) Assisting in the development of a business plan, including potential sources of financing and other assistance in developing and launching a business.

    3) Identifying supports necessary for the person to successfully operate the business.

    4) On-going assistance, counseling and guidance once the business has launched.

d) Cannot use Medicaid funds to defray the expenses associated with starting or operating a business.

e) Must be provided at work sites where persons without disabilities are employed and where payment is made only for the adaptations, supervision, and training required by beneficiaries receiving 1915(i) services and does not include payment for the supervisory activities rendered as a normal part of the business setting.

f) Must include transportation between the person's place of residence and the site of the person's job or between or between habilitation sites (in cases where the person receives habilitation services in more than one place) as a component of supported employment. Transportation cannot comprise the entirety of the service.

g) May include personal care/assistance as a component of Supported Employment but cannot comprise the entirety of the service.

h) Do not include sheltered work or other similar types of vocational services furnished in specialized facilities or volunteer work.

Source: 42 U.S.C. § 1396n; 42 C.F.R. § 441.710; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017; New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.6: Serious Events/Incidents and Abuse/Neglect/Exploitation

A. All Department of Mental Health (DMH) providers, including support coordinators and targeted case managers, must receive training at least annually regarding Mississippi's Vulnerable Persons Act and the following:

   1. Education as to what constitutes possible abuse/neglect/exploitation,

   2. Abuse/neglect/exploitation reporting requirements and procedures, and

   3. Reporting of serious events/incidents to DMH as outlined in the DMH Operational Standards.

B. Providers must provide the person/legal guardian with the provider's procedures for protecting persons from abuse, neglect, exploitation, and any other form of potential abuse.

   1. The procedures must be provided upon admission and at least annually thereafter.

   2. The procedures must be given orally and in writing.

   3. Documentation must include the person/legal guardian's signature indicating the rights have been explained in a way that is understandable to them.

   4. The person/legal guardian must be given instructions for reporting suspected violation to the DMH, Office of Consumer Support (OCS) or Disability Rights Mississippi.

   5. The DMH toll free Helpline must be posted in a prominent place throughout each program site and provided to the person/legal representative.

C. All providers must have a written policy for documenting and reporting all serious events/incidents. Documentation regarding serious events/incidents must include:

   1. A written description of events and actions,

   2. All written reports, including outcomes, and

   3. A record of telephone calls and written reports to DMH.

D. Serious events/incidents involving program services or program staff on program property or at a program-sponsored event must be reported to DMH, the agency director, and the parent/guardian/legal representative/significant person as identified by the person receiving services.

E. DMH must submit a summary of serious incidents/events to the Division of Medicaid with each quarterly report.

F. Serious events/incidents involving beneficiaries that must be reported to the DMH and other appropriate authorities within twenty-four (24) hours or the next business day, by telephone or written report include, but are not limited to, the following:

1. Suicide attempts on program property or at a program-sponsored event.

2. Suspected abuse/neglect/exploitation, which must also be reported to other authorities in accordance with State law.

3. Unexplained absence from a residential program of twelve (12) hours duration.

4. Absence of any length of time from an adult day center providing services to persons with Alzheimer's disease and/or other dementia.

5. Emergency hospitalization or emergency room treatment of a person receiving 1915(i) services.

6. Accidents which require hospitalization and may be related to abuse or neglect, or in which the cause is unknown or unusual.

7. Disasters including fires, floods, tornadoes, hurricanes, earth quakes and disease outbreaks.

8. Use of seclusion or restraint, either mechanical or chemical. Providers are prohibited from the use of:

a) Mechanical restraints, defined by the Division of Medicaid as the use of a mechanical device, material, or equipment attached or adjacent to the person's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body unless being used for adaptive support,

b) Seclusion,

c) Time-out, and

d) Chemical restraints, defined by the Division of Medicaid as medication used to control behavior or to restrict the person's freedom of movement and is not standard treatment of the person's medical or psychiatric condition,

G. Death of a person on program property, at a program sponsored event or during an unexplained absence from a residential program site must be reported to the DMH within eight (8) hours of the death.

H. If a provider has any question whether or not a situation/incident should be reported, the provider must contact DMH.

I. Reporting guidelines are determined by the setting in which the suspected abuse/neglect/exploitation occurred.

1. Suspected abuse/neglect/exploitation that occurs in a home setting must be reported to the Vulnerable Adults Unit (VAU) at the Attorney General's Office and the Division of Family and Children Services (DFCS) at the Mississippi Department of Human Services (DHS).

2. Complaints of abuse/neglect/exploitation of persons in health care facilities must be reported to the Medicaid Fraud Control Unit (MFCU) and the Office of the State Attorney General (AG)..

3. Suspected abuse/neglect/exploitation that occurs in any Day Support services facility, which Division of Medicaid defines as a community-based group program for adults designed to meet the needs of adults with impairments through individual PSS, which are structured, comprehensive, planned, nonresidential programs providing a variety of health, social and related support services in a protective setting, enabling beneficiaries to live in the community must be reported to DMH if the facility is certified by the DMH.

4. If the alleged perpetrator carries a professional license or certificate, a report must be made to the entity which governs their license or certificate.

5. Disease outbreaks at a provider site must be reported to Mississippi State Department of Health (MSDH).

Source: 42 U.S.C. § 1396n; 42 C.F.R. § 441.710; Miss. Code Ann. §§ 41-4-7, 43-13-121.

History: Revised eff. 01/01/2017; New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.7: Documentation and Record Maintenance

A. Documentation of each service provided must be in the case record. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.

B. The entry or service note must include all of the following documentation:

1. Date of service,

2. Type of service provide,

3. Time service began and time service ended,

4. Length of time spent delivering service,

5. Identification of beneficiary(s) receiving or participating in the service,

6. Summary of what transpired during delivery of the service,

7. Evidence that the service is appropriate and approved on the Plan of Care, and

8. Name, title, credential, and signature of individual providing the service.

C. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect the following:

1. Documentation requirements in the CMS approved 1915(i) State Plan Amendment,

2. DMH Operational Standards,

3. Evidence that the service is appropriate and approved on the Plan of Care, and

4. Documentation requirements in the DMH Record Guide.

Source: Social Security Act § 1915(i); Miss. Code Ann. § 43-13-121.

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.8: Grievances and Complaints

The Department of Mental Health (DMH), Office of Consumer Support (OCS) is responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by DMH. The DMH, Quality Management Workgroup assists the OCS in development of procedures for receiving, investigating, and resolving the grievances/complaints.

B. Personnel issues are not within the purview of DMH.

C. A toll-free Helpline must be available twenty-four (24) hours a day, seven (7) days per week. All providers are required to post the DMH toll-free number in a prominent place throughout each program site.

D. Providers of 1915(i) services must cooperate with both DMH and the Division of Medicaid to resolve grievances/complaints.

Source: 42 U.S.C. § 1396n; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017; New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.9: Appeals and Hearings

A. If it is determined that a person does not meet 1915(i) eligibility criteria or if decisions made by the Department of Mental Health (DMH) result in services being denied, terminated, or reduced the /legal representative has the right to request an appeal from the DMH.

B. If the person and/or guardian/legal representative disagrees with the decision made by the DMH Executive Director a written request to appeal the decision may be made to the Executive Director of the Division of Medicaid. [Refer to Miss. Admin. Code Part 300]

C. During the appeals process, contested services must remain in place, unless the decision is made for immediate termination due to immediate or perceived danger, racial discrimination or sexual harassment by the service providers. The Targeted Case Manager is responsible for ensuring that the person continues to receive all services that were in place prior to the notice of change.

D. Providers who must be certified by DMH may appeal issues related to certification to DMH as outlined in the DMH Operational Standards and Administrative Code.

Source: 42 U.S.C. § 1396n; Miss. Code Ann. §§ 41-4-7, 43-13-121.

History: Revised eff. 01/01/2017; New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 04/01/2014.

Rule 7.10: Person Centered Planning (PCP)

A. The Division of Medicaid defines Person-Centered Planning (PCP) as an ongoing process used to identify a person's desired outcomes based on their personal needs, goals, desires, interests, strengths, and abilities. The PCP process helps determine the services and supports the person requires in order to achieve these outcomes and must:

1. Allow the person to lead the process where possible with the person's guardian and/or legal representative having a participatory role, as needed and as defined by the person and any applicable laws.

2. Include people chosen by the person.

3. Provide the necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.

4. Be timely and occur at times and locations of convenience to the person.

5. Reflect cultural considerations of the person and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and

persons who are limited English proficient.

6. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.

7. Provide conflict free case management and the development of the PSS by a provider who does not provide home and community-based services (HCBS) for the person, or those who have an interest in or are employed by a provider of HCBS for the person, except when the only willing and qualified entity to provide case management and/or develop PSS in a geographic area also provides HCBS. In these cases, conflict of interest protections including separation of entity and provider functions within provider entities, must be approved by the Centers of Medicare and Medicaid Services (CMS) and these persons must be provided with a clear and accessible alternative dispute resolution process.

8. Offer informed choices to the person regarding the services and supports they receive and from whom.

9. Include a method for the person to request updates to the PSS as needed.

10. Record the alternative HCBSs that were considered by the person.

B. The PSS must reflect the services and supports that are important for the person to meet the needs identified through an assessment of functional need, as well as what is important to the person with regard to preferences for the delivery of such services and supports and the level of need of the individual and must:

1. Reflect that the setting in which the person resides is:

   a) Chosen by the person,

   b) Integrated in, and supports full access of persons receiving Medicaid HCBS to the greater community, including opportunities to:

      (1) Seek employment and work in competitive integrated settings,

      (2) Engage in community life,

      (3) Control personal resources, and

      (4) Receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

2. Reflect the individual's strengths and preferences.

3. Reflect clinical and support needs as identified through an assessment of functional need.

4. Include individually identified goals and desired outcomes.

5. Reflect the services and supports, both paid and unpaid, that will assist the person to achieve identified goals, and the providers of those services and supports, including natural supports. The Division of Medicaid defines natural supports as unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.

6. Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

7. Be written in plain language and in a manner that is accessible to persons with disabilities and who are limited English proficient so as to be understandable to the person receiving services and supports, and the individuals important in supporting the person.

8. Identify the individual and/or entity responsible for monitoring the PSS.

9. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.

10. Be distributed to the individual and other people involved in the plan.

11. Include those services, the purpose or control of which the individual elects to self-direct.

12. Prevent the provision of unnecessary or inappropriate services and supports.

13. Document the additional conditions that apply to provider-owned or controlled residential settings.

C. The PSS must include, but is not limited to, the following documentation:

1. A description of the individual's strengths, abilities, goals, plans, hopes, interests, preferences and natural supports.

2. The outcomes identified by the individual and how progress toward achieving those outcomes will be measured.

3. The services and supports needed by the individual to work toward or achieve his or her outcomes including, but not limited to, those available through publicly funded programs, community resources, and natural supports.

4. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

5. The estimated/prospective cost of services and supports authorized by the community mental health system.

6. The roles and responsibilities of the individual, the supports coordinator or case manager, the allies, and providers in implementing the plan.

D. Targeted Case Managers must review the PSS and revise as indicated:

1. At least every twelve (12) months,

2. When the individual's circumstances or needs change significantly, or

3. When requested by the person.

Source: 42 C.F.R. § 441.710.

History: New rule eff. 01/01/2017.

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 209
Durable Medical Equipment
And
Medical Supplies

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Title 23: Division of Medicaid

Part 209: Durable Medical Equipment and Medical Supplies

Part 209 Chapter 1: Durable Medical Equipment

Rule 1.1: Provider Participation

In order to participate as a Durable Medical Equipment (DME) supplier in the Medicaid program, a provider must:

A. Be certified to participate as a DME supplier under Title XVII (Medicare) of the Social Security Act and provide current documentation of their authorization to participate in the Title XVII program to Medicaid.

B. Meet all applicable requirements of law to conduct business in the State.

C. Execute a participation agreement with Medicaid.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1861, Subpart E

Rule 1.2: Provider Enrollment Requirements

DME providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

B. Provide written confirmation from the IRS confirming the tax identification number and legal business name,

C. Provide a copy of current Medicare certification for the servicing location. Explanation of Medicare Benefits (EOMB) is not acceptable, and

D. Provide a copy of DME or pharmacy permit from MS State Board of Pharmacy for the servicing location.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E

Rule 1.3: Definitions

A. Medicaid defines Durable Medical Equipment (DME) as an item meeting all four (4) criteria below:

1. It can withstand repeated use,

2. Is primarily and customarily used to serve a medical purpose,

3. Is generally not useful to a person in the absence of illness, injury, or congenital defect, and

4. Is appropriate for use in the home.

B. Prior authorization, as used in this chapter, is defined as prior authorization for a service or item based on medical necessity review by the Utilization Management/Quality Improvement Organization (UM/QIO) contracted by the Division of Medicaid.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1861(n)

Rule 1.4: Reimbursement

A. The Division of Medicaid covers Durable Medical Equipment (DME). [Refer to Miss. Admin. Code Part 207 for DME coverage in a long-term care facility.]

B. The Division of Medicaid requires certification requests be submitted prior to or within thirty (30) days of delivery of the DME. The Division of Medicaid does not allow the beneficiary to be billed if the DME provider chooses to deliver the item/service prior to submitting a certification request and approval is not given.

C. All standard DME, excluding custom motorized/power wheelchair systems, must have a manufacturer's warranty of a minimum of one (1) year.

1. If the provider supplies equipment that is not covered under a warranty, the provider is responsible for any repairs, replacement or maintenance that may be required within one (1) year.

2. The warranty begins on the date of the delivery to the beneficiary.

3. The DME provider must keep a copy of the warranty and repair information in the beneficiary's file.

4. The Division of Medicaid reserves the right to request copies of the warranty and repair information for audit/review purposes when necessary.

5. The Division of Medicaid investigates cases suggesting malicious damage, neglect, or wrongful misuse of the equipment. If the provider suspects such damage of equipment, the provider should report it immediately to the Division of Medicaid for investigation and notify the beneficiary that the cost for repairs/replacement may be the responsibility of the beneficiary if the Division of Medicaid determines malicious damage, neglect, or wrongful misuse of the equipment.

6. DME suppliers must provide a two (2) year warranty of the major components for custom motorized/power wheelchairs.

    a) The main electronic controller, motors, gear boxes, and remote joystick must have a two (2) year warranty from the date of delivery.

    b) Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects, if the surface does not remain intact due to normal wear.

    c) Powered mobility bases must have a lifetime warranty on the frame against defects in material and workmanship for the lifetime of the beneficiary.

    d) If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the provider is responsible for any repairs, replacement or maintenance that may be required within two (2) years.

    e) The warranty begins the date of delivery to the beneficiary.

D. The Division of Medicaid covers repairs, including labor and delivery, of DME that is owned by the beneficiary not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.

1. DME suppliers providing custom wheelchairs, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, with a technician available during normal business hours, between eight (8) a.m. and five (5) p.m. Monday through Friday. Each technician must keep, on file, records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.

2. The Division of Medicaid requires prior authorization from the Utilization Management/Quality Improvement Organization UM/QIO for the repair and must include an estimated cost of necessary repairs, including labor, and a statement from the practitioner stating that there is a continued need for the equipment.

3. Labor and delivery charges are included in the repair cost and are not covered separately.

4. The Division of Medicaid does not cover repair of a rental item.

5. The Division of Medicaid does not cover repairs when it has been determined that the equipment has been abused or neglected by the beneficiary, caregiver or family.

6. The Division of Medicaid covers, under extenuating circumstances as determined by the UM/QIO, rental of an item on a short-term basis while equipment owned by the beneficiary is being repaired.

E. The Division of Medicaid covers the replacement of DME necessitated by wear, theft, irreparable damage, or loss by disasters only if there is sufficient documentation that warrants the need for replacement.

1. The Division of Medicaid covers for replacement every three (3) years if the item cannot be repaired, and if it is more cost effective to replace it. The Division of Medicaid covers, under extenuating circumstances, requests to replace items at a lesser frequency on an individual consideration basis.

2. The Division of Medicaid covers replacement of power wheelchairs, hospital beds, and ventilators at a minimum of every five (5) years, unless there are extenuating circumstances.

3. The Division of Medicaid requires a report from law enforcement or a fire department in cases of theft or fires.

4. The Division of Medicaid covers the purchase of DME when it is determined by the UM/QIO to be more economical than renting and when the period of need is estimated by the physician to be ten (10) or more months.

F. The Division of Medicaid covers rental of equipment up to ten (10) months, or up to the purchase price, whichever is the lesser.

1. After rental benefits are paid for ten (10) months, the DME becomes the property of the beneficiary, unless otherwise authorized by Medicaid through specific coverage criteria.

2. There cannot be sales tax on “rental only” items as there is no sale or purchase.

3. A trial period for equipment must be applied toward the ten (10) month rental.

4. The rental allowance includes the equipment, delivery, freight and postage, set-up, all supplies necessary for operation of the equipment, education of the patient and caregiver, all maintenance and repairs or replacement, labor including respiratory therapy visits, and servicing charges.

G. The Division of Medicaid defines a trial period as the time required to assess the effectiveness and beneficiary compliance.

1. The initial trial period may be waived for the replacement of an identical or existing piece of equipment.

2. The Division of Medicaid applies the rental fees paid for any trial period toward the maximum reimbursement for purchase.

3. The Division of Medicaid does not cover a rental trial period in addition to the full purchase price.

4. The DME item must be returned to the DME provider after it is no longer required, if the rental period is less than ten (10) months.

H. The Division of Medicaid covers DME at the lesser of the provider charge or the Medicaid allowable fee. Medicaid allowable fees are set as follows:

1. Purchased items are set at eighty percent (80%) of the Medicare fee.

2. Rental items are set at ten percent (10%) of the Medicaid allowable fee.

3. Used DME and repairs are set at fifty percent (50%) of the Medicaid allowable.

I. The Division of Medicaid manually prices items that do not have a Medicaid allowable fee.

1. The UM/QIO performs the manual pricing of the item.

2. When requesting manually priced items, the DME provider must indicate the name of the product, the product number, and the name of the manufacturer or distributor and must provide the required documentation for pricing.

3. The Division of Medicaid uses two (2) methods for manual pricing:

a) Most manually priced items are priced at the Manufacturer's Suggested Retail Price (MSRP) minus twenty percent (20%).

1) It is expected that most items will have a retail price; therefore, providers should request MSRP pricing for all manually priced items unless there is absolutely no retail price.

2) Other acceptable terms that represent MSRP include suggested list price, retail price, or price.

3) The provider must submit clear, written, dated documentation from a manufacturer or distributor that specifically states the MSRP for the item. This documentation must be provided with an official manufacturer's or distributor's letterhead, price list, catalog page, or other forms that clearly show the MSRP.

4) A manufacturer's or distributor's quote may be substituted for an MSRP if the manufacturer does not make an MSRP available. The quote must be in writing from the manufacturer or distributor and must be dated.

b) Items that do not have a fee or MSRP may be priced at the provider's cost plus twenty percent (20%).

1) The provider must attach a copy of a current invoice indicating the cost to the provider for the item dispensed and a statement that there is no MSRP available for the item.

2) If the provider purchases from the manufacturer, a manufacturer's invoice must be provided.

3) If the provider purchases from a distributor and not directly from the manufacturer, the invoice from the distributor must be provided.

4) Quotes, price lists, catalog pages, computer printouts, or any form of documentation other than an invoice are not acceptable for this pricing solution.

5) The invoice must not be older than one (1) year prior to the date of the request. Exceptions to the one (1) year requirement may be approved only for unusual circumstances.

J. [Reserved]

K. [Reserved]

Source: Social Security Act § 1834(a); Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 209, Rule 1.4.A, D.1, J., and K. eff. 01/02/2015.

Rule 1.5: DME Co-payments

Medicaid applies the following DME co-payments to DME rental and purchase and orthotics and prosthetics.

A. The DME co-payments will not apply to repairs or medical supplies.

B. For DME billed with unspecified or miscellaneous procedure codes, a three dollar ($3.00) co-payment must be collected.

C. The co-payment amounts for procedure codes other than unspecified or miscellaneous procedure codes are listed below:

1. Ten dollars ($10.00) or less the co-payment is fifty cents ($0.50),

2. Ten dollars and one cent ($10.01) to twenty five dollars ($25.00) the co-payment is one dollar ($1.00),

3. Twenty five dollars and one cent ($25.01) to fifty dollars ($50.00) the co-payment is two dollars ($2.00), and

4. Fifty dollars and one cent ($50.01) or more the co-payment is three dollars ($3.00).

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1834 (a); 42 CFR § 409.50

Rule 1.6: Items and Services Not Covered through the DME Program

A. Items not listed as covered by Medicaid through the DME program are either not considered durable medical equipment items, do not meet medical necessity or standard of care criteria, or are not billable by a DME provider.

B. Maintenance contracts and servicing fees are not covered under the DME program. For charges related to repair of durable medical equipment, refer to Rule 1.4 of this chapter.

C. Implantable devices such as implantable pumps, cochlear implant devices, and implantable breast prostheses are not covered through the DME program.

D. DME, medical supplies, orthotics, and prosthetics related to the terminal illness for those Medicaid beneficiaries receiving benefits in the Hospice Program cannot be reimbursed through the DME program.

E. Medicaid does not reimburse DME providers for drugs, including oral, intravenous, intramuscular, topical, or inhaled. Medicare crossover claims are paid to DME and Pharmacy DME providers for drugs covered under Medicare Part B.

F. DME billed by a physician or clinic is not covered.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1834 (a)

Rule 1.7: Dual Eligibles

Medicaid covers durable medical equipment not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. For dual eligible beneficiaries covered by both Medicare and Medicaid, Medicaid reimburses the Medicare deductible and co-insurance for those items on crossover claims.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1834

Rule 1.8: Duplication of Equipment

Medicaid covers the duplication of DME on an individual basis only. Medicaid covers the duplication of DME item(s) that are not portable, not mobile, or the size/weight of the item is such that daily or frequent transportation is not feasible.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1834

Rule 1.9: Documentation

A. Medicaid requires that the beneficiary and/or the legal guardian, with medically appropriate assistance of the medical practitioner, have an active role in the selection of the DME provider and must be informed of all equipment, services and charges to be billed to Medicaid.

B. The following must be available to Medicaid at all times:

   1. DME licenses,

   2. Permits,

   3. Ownership information,

   4. Employee roster of current and past employees,

   5. DME Surety Bond information, and

   6. Original purchase invoices for equipment and supplies.

C. A DME provider file must be maintained on each beneficiary, kept in the DME's office at the business location and must contain the following information:

   1. A copy of the completed Certificate of Medical Necessity and Plan of Care when required.

      a) This must include the date, diagnosis, type of equipment being requested and anticipated length of need.

      b) Frequency and specific orders must be specified for wound care, diabetic supplies, and the like, in order to determine quantity.

   2. A copy of the original prescription from the ordering practitioner.

   3. The date and method of delivery of equipment to the beneficiary.

   4. The delivery ticket or proof of receipt for equipment and/or services, signed and dated by the beneficiary or responsible party, which describes the services and/or equipment provided at that time, and the cost of the service and/or equipment, signed and dated by the delivering employee of the DME provider. If delivered by a third party delivery service such as FedEx, UPS, or U.S. mail, a copy of the delivery ticket describing the piece of equipment and/or supply with date and signature of the receiving party.

   5. Record of the manufacturer or brand, and quantity/units of the supply provided.

6. Reason or description and date for each and every repair or maintenance procedure on equipment in the possession of the beneficiary or returned to the DME company for repair or maintenance; and if out of the possession of the beneficiary, the time period it was unavailable for his/her use and any arrangements made to accommodate the beneficiary during the time period.

7. Indicate if new or used, manufacturer's name, model number or name, serial number if marked on the device, any optional attachments, enhancements, or improvements added by the manufacturer or DME provider which results in an increased charge amount that supports the justification for and proves the delivery of the complete equipment product as billed to and paid by Medicaid or Medicare.

8. Records of any maintenance supplies delivered and/or used.

9. For customized equipment or appliances, the name(s), business name and address, and telephone number of the therapist or technician who determines the measurements necessary to modify, build, or complete the custom item.

10. Copies of any specialized documents required:

    a) Copy of environmental assessment if needed for potential accommodation of equipment.

    b) Copies of any teaching, training or instruction given to beneficiary/caregiver and response.

11. The physician, nurse practitioner, or physician assistant ordering the DME, medical supply, orthotics or prosthetics must maintain documentation relating to the medical necessity for the item.

    a) The information must be recorded in the beneficiary's medical record or on the appropriate Medicaid Certificate of Medical Necessity.

    b) The physician, nurse practitioner, or physician assistant must retain a copy of the completed Certificate of Medical Necessity in the file.

12. Records must be documented and maintained in accordance with requirements set forth in Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 1.10 Apnea Monitors

A. Medicaid defines an apnea monitor as a device used to monitor respiratory movements. This may be accomplished by use of an apnea alarm mattress or by use of alarm sensitive devices to measure thoracic and abdominal movement and heart rate.

B. Medicaid covers apnea monitors for all beneficiaries:

1. When prior authorization is received.

2. For an initial three (3) month rental trial period, then recertification is required. The three (3) month rental trial period applies toward the maximum reimbursement for purchase.

3. When ordered by a physician, nurse practitioner or physician assistant.

4. When the beneficiary is/had at least one (1) of the following:

   a) An infant who has a diagnosis of apnea of prematurity.

   b) A preterm infant with continued symptomatic apnea past thirty-six (36) weeks gestational age.

   c) Been observed having or has a recorded episode of prolonged apnea within the last three (3) months that is documented by medical personnel and associated with bradycardia, reflux, cyanosis, or pallor. Medicaid defines prolonged apnea as cessation of breathing greater than twenty (20) seconds or bradycardia episodes less than sixty (60) beats per minute (bpm) for greater than five (5) seconds.

   d) An infant who is a sibling of a child with sudden infant death syndrome (SIDS), or has two (2) siblings with a diagnosis of apnea.

   e) Had an event or events requiring vigorous stimulation or resuscitation within the past three (3) months.

   f) A tracheotomy.

   g) An infant with bronchopulmonary dysplasia who requires oxygen and displays medical instability.

   h) An adult or child has demonstrated symptomatic apnea due to neurological impairment, craniofacial malformation, central hyperventilation syndrome, or is secondary to gastrointestinal reflux

C. Medicaid will cover diagnoses not included above on an individual basis with appropriate documentation.

D. Medicaid does not cover apnea monitors for terminally ill beneficiaries or for those who have "do not resuscitate" orders.

E. Medicaid covers apnea monitors for an initial three (3) month certification. After the three (3) month initial certification, apnea monitors may be recertified up to seven (7) additional months with a new prescription or letter of medical necessity.

   1. Medicaid will not reimburse for a three (3) month trial period then pay full purchase price.

   2. Medicaid does not cover supplies, such as a battery pack, safety lead wires, electrodes, electrode belts, event recording downloads, or remote alarms separately.

   3. Medicaid requires that apnea monitors must be returned to the DME provider after it is no longer required if the rental period is less than ten (10) months.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(7); Social Security Act § 1834

Rule 1.11: Augmentative Communication Device

A. Medicaid defines an augmentative, or alternative, communication device (ACD) as any type of system that allows beneficiaries with severe, expressive communication disorders, or speech-language impairments, to overcome the disabling effects of communication impairment by representation of vocabulary or ideas and expression of messages.

B. Medicaid covers ACD's for all beneficiaries, when prior authorized for rental up to the purchase amount, or purchase as indicated when the following criteria is met:

   1. When ordered by a pediatrician, neurologist, or a physiatrist, a physician specializing in physical rehabilitation, and who has documented training in assessment for and prescription of ACD's.

   2. Documentation that the beneficiary's ability to communicate using speech and/or writing is insufficient for communication purposes.

   3. Documentation clearly supports that the patient is mentally, emotionally, and physically capable of operating/using an ACD.

   4. When the prescription includes specification for ACD, component accessories, and all necessary therapies and/or training.

C. Medicaid requires an evaluation and recommendation be performed by a team of licensed, qualified professionals including, but not limited to, a speech-language pathologist, a licensed psychologist with expertise in administering non-verbal tests for intelligence, and a physical or an occupational therapist.

   1. A written copy of the evaluation and recommendation must be submitted with the request for approval. This evaluation must include at a minimum:

a) Communication status and limitations, abilities to meet communication needs through other means such as sign language, manual communication, and the like;

b) Current speech and language skills;

c) Prognosis for speech and/or written communication;

d) Cognitive readiness, interactional/behavioral and social abilities;

e) Capabilities and needs including intellectual, including educational, postural, physical, sensory, including visual and auditory, motor, and cognitive;

f) Motivation to communicate;

g) Environmental, including residential, vocational and educational, assessment;

h) Current seating or positioning equipment and any modification that would be required secondary to the ACD;

i) Integration of communication with other behavior;

j) Alternative ACD(s) considered with comparison of capabilities;

k) Other communication methods/devices tried;

l) Ability of recommended ACD to be implemented/integrated into environments;

m) Ability to meet projected communication needs, like growth potential, projected length of time the patient will be able to use the proposed system;

n) Anticipated changes, modifications, or upgrades with projected short and long term time frames;

o) Anticipated prognosis with the specific device requested;

p) Training plan including dates, names, addresses, and capabilities of available caregivers; and

q) Statement of other funding resources that have been explored.

D. Medicaid allows for a trial period of at least thirty (30) days, not to exceed ninety (90) days, to ensure that the beneficiary's needs are met by the proposed system and in the most cost-effective manner.

E. Medicaid does not cover carrying cases separately.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1834; 43-13-117(17)

Rule 1.12: Bath Bench/Shower Chair

A. Medicaid defines a bath bench/shower chair as an apparatus that can be placed into a tub or shower to allow the beneficiary to sit while bathing.

B. Medicaid covers for all beneficiaries when prior authorized, for purchase only, for a bath bench/shower chair if ordered by a physician, nurse practitioner, or physician assistant, and one of the following criteria is met:

    1. The beneficiary has a condition that will not allow him/her to stand alone in a shower/tub and bathe, or

    2. No shower is available, and the beneficiary is unable to get into and out of a bathtub with or without assistance.

C. Medicaid does not cover specialized bath or shower equipment.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1834; 43-13-117(17)

History: Revised – 01/01/2013

Rule 1.13: Battery and Battery Charger

A. Medicaid defines the following:

    1. Battery is a device for generating electric current by chemical action.

    2. Battery charger is a device that adds electrical energy to a battery.

B. Medicaid covers a sealed battery and single mode battery charger for all beneficiaries when prior authorized, for purchase only, when all of the following criteria is met:

    1. Ordered by a physician, nurse practitioner, or physician assistant,

    2. Batteries and battery chargers are associated with the purchase of equipment and is included in the maximum reimbursement for that equipment, and

    3. Replacement batteries if meets coverage criteria.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1834; 43-13-117(17)

History: Revised – 01/01/2013

Rule 1.14: Bi-level Positive Airway Pressure Device (BIPAP) With or Without an In-Line Heated Humidifier

A. Medicaid defines a bi-level positive airway pressure (BiPAP) device as a non-continuous, bi-level airway management device that cycle between the inspiratory and expiratory pressure levels in response to the patient's respiratory effort. The rise in pressure, during inspiration, supports the patient's breathing by splinting the airway to overcome the additional collapsing forces from inspiratory efforts. When inspiration has ended, the pressure drops at the point of exhalation removing the sensation of expiratory effort while still maintaining a therapeutic level of pressure in the circuit necessary to overcome collapsing forces in the airway.

B. Medicaid covers a BiPAP for all beneficiaries when prior authorized, for rental for an initial three (3) months trial period, when ordered by a physician, nurse practitioner, or physician assistants and if one (1) or more of the following is met:

    1. The beneficiary was unable to tolerate the necessary CPAP pressures,

    2. The beneficiary has frequent central apneas that do not resolve with administration of CPAP, or

    3. The beneficiary's baseline hypoxemia in cases involving chronic lung disease or hypoventilation syndromes is not corrected with administration of CPAP.

C. All related supplies are considered an integral part of the rental or purchase allowance of the BiPAP unit and separate charges for supplies or respiratory services are not covered.

D. Medicaid covers appropriate supplies for BiPAP units if owned by the beneficiary at maximum amounts expected to be medically necessary. Medicaid covers for amounts exceeding the maximum amount if there is documented justification and on individual bases.

E. After an initial three (3) month trial period, the BiPAP may be recertified up to seven (7) additional months with a BiPAP Compliance Medicaid Certificate of Medical Necessity completed by the ordering physician.

    1. If the equipment was not effective or if the beneficiary was non-compliant, the equipment may be returned to the vendor.

    2. The rental fees paid for the three (3) month trial period must apply toward the maximum reimbursement for purchase.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1834; 43-13-117(17)

Rule 1.15: Breast Pumps

A. The Division of Medicaid defines a breast pump as a device used to extract breast milk from a lactating mother.

B. The Division of Medicaid covers the following types of breast pumps for nursing mother beneficiaries when medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO) and ordered by a physician, physician assistant, or nurse practitioner.

   1. The Division of Medicaid defines a manual breast pump as a single-user device manually operated to express breast milk from a lactating mother and is covered for purchase when:

      a) Used to promote lactation when natural breastfeeding has been insufficient in maintaining adequate nutritional needs of the infant, or

      b) Used to provide lactation support when natural breastfeeding is not possible.

   2. The Division of Medicaid defines an electric breast pump as an electronic device used to express breast milk from a lactating mother and is covered for rental up to purchase amount, or for purchase when one (1) of the following is met:

      a) The infant:

         1) Is preterm or term and requires hospitalization longer than the mother,

         2) Has a cleft palate or cleft lip,

         3) Has cranial-facial abnormalities,

         4) Is unable to suck adequately,

         5) Is Failure to Thrive,

         6) Has a low birth weight, or

         7) Has other medical conditions that interfere with breastfeeding.

      b) The mother:

         1) Has a breast abscess,

         2) Has mastitis,

         3) Is hospitalized due to illness or surgery on short term basis,

4) Is unable to effectively use a manual pump to promote or maintain lactation due to a medical condition or physical limitation,

5) Is undergoing treatment with short-term medications which requires the pumping and discarding of breast milk, or

6) Has other medical conditions that interfere with breastfeeding.

C. All prior authorization requests must:

1. Be in the mother beneficiary's name,

2. Include the mother beneficiary's Medicaid ID number, and

3. Include an estimate of how many weeks or months the mother will require the electric breast pump.

Source: 42 CFR §§ 440.60, 440.166, 440.210, 440.220; PHSA § 2713; SSA §§ 1834, 1905; Miss. Code Ann. §§ 43-13-117, 121.

History: Revised eff. 05/01/2014.

Rule 1.16: Cane

A. Medicaid defines a cane as an assistive device held in the hand and used for support during ambulation. This includes canes of all materials, single, quad or three pronged, adjustable or fixed.

B. Medicaid covers canes for all beneficiaries when prior authorized for rental up to purchase amount or purchase when indicated and all the following criteria met:

1. When ordered by a physician, nurse practitioner, or physician assistant; and

2. When condition or injury causing impaired ambulation and when there is a potential for ambulation.

C. Tips, handgrips, adjustment features or other accessory items are inclusive in the rental or purchase of the cane.

D. Straight, single post canes may be either fixed or height adjustable. Medicaid covers straight canes for the following indications:

1. To relieve stress on a joint in post-surgery beneficiaries.

2. To aid beneficiaries with decreased balance due to vestibular, neurological, or orthopedic conditions.

E. Three prong or quad canes may be either fixed or height adjustable. Medicaid covers these canes for the following indications:

1. For beneficiaries who require an added base of support (BOS) provided with the cane for stance and ambulation.

2. For beneficiaries who have achieved increased ambulation skills and no longer require a walker but still need an assistive device with a wider BOS than a straight cane will offer.

F. All canes issued to children should be height adjustable to provide for growth.

G. Some beneficiaries may require two (2) canes for greater stability.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.17: Combination Positive Expiratory Pressure, Airway Oscillation, and Intermittent Flow Acceleration Device

A. Medicaid defines a combination positive expiratory pressure, airway oscillation, and intermittent flow acceleration device as a unit for mobilizing respiratory tract secretions in a beneficiary with chronic lung conditions such as, but not limited to:

1. Chronic obstructive lung disease,

2. Chronic bronchitis,

3. Cystic fibrosis, or

4. Emphysema.

B. Medicaid covers this device for all beneficiaries when prior authorized for purchase, only when ordered by a physician, nurse practitioner or physician assistant, and when the beneficiary has one (1) of the following diagnosis:

1. A chronic lung condition where mobilization of respiratory secretions is hindered,

2. Cystic fibrosis,

3. Bronchiectasis,

4. Chronic bronchitis/COPD, and

5. Atelectasis, or

6. Any other disease process in which secretion mobilization is needed.

C. Medicaid does not cover a combination positive expiratory pressure, airway oscillation, and intermittent flow acceleration device, and other separate devices used to reach the same goals.

D. Beneficiary teaching must be documented along with the beneficiary's ability to properly use and clean the device.

E. The item may not be appropriate for children less than six (6) years of age.

1. For the item to be considered for children under age six (6), the prescribing practitioner must document that the child is able to use the device correctly.

2. Individual consideration will be given for children under age six (6).

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.18: Commode Chairs and Other Toileting Aids

A. Medicaid defines commode chairs as toileting aids used to assist beneficiaries who are not able to use regular toilet facilities due to their physical condition.

B. Medicaid covers commode chairs and raised toilet seats for all beneficiaries when prior authorized, for rental up to purchase amount, or purchase when indicated and all the following criteria met:

1. When ordered by a physician, nurse practitioner, or physician assistant.

2. When the beneficiary's physical condition is such that the beneficiary is unable to use regular toilet facilities.

3. A commode chair with detachable arms, if used to facilitate transferring the beneficiary or if the beneficiary has a body configuration that requires extra commode width.

4. A heavy duty or extra wide commode chair, with or without detachable arms, if the beneficiary's body measurements are greater than the measurements specified by the manufacturer for the equipment or the beneficiary's weight is three hundred (300) pounds or greater. Documentation must be maintained for weight and measurements.

5. A raised toilet seat if the beneficiary has a medical condition such as being convalescent from hip surgery which prevents the beneficiary from using a regular commode without a raised seat.

6. A raised toilet seat if the beneficiary does not have a bedside commode capable of fitting over the toilet.

C. Medicaid does not cover:

1. Mobile commode chairs,

2. Footrests for the commode chair, or

3. Potty seats and adaptive commode equipment.

D. Medicaid covers both commode chairs and raised toilet seats, but not both at the same time.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.19: Compressors

A. Medicaid defines compressors as machines that compress air into storage tanks for use by air driven equipment.

B. Medicaid covers for all beneficiaries when prior authorized for rental up to the purchase amount or purchase when ordered by a physician, nurse practitioner, or physician assistant.

C. Medicaid covers compressors for separate reimbursement when used in conjunction with a ventilator, nebulizer, or other types of humidification equipment that is not self-contained or cylinder driven.

Source: Miss. Code Ann. § 43-13-121

Rule 1.20: Continuous Positive Airway Pressure (CPAP) With or Without an In-Line Heated Humidifier

A. Medicaid defines continuous positive airway pressure (CPAP) with or without an in-line heated humidifier as a non-invasive provision of air pressure through nasal administration and a flow generator system to prevent collapse of the oropharyngeal walls during sleep. For Medicaid purposes, apneas and hypopneas physiologically represent the same compromise, will be considered as equivalents, and will be referred to as "respiratory events."

B. Medicaid covers for all beneficiaries when prior authorized, for rental up to three (3) months trial period, when the following criteria is met:

1. When ordered by a physician, nurse practitioner or physician assistant,

2. When one (1) of the following is met:

a) The beneficiary is an adult and the polysomnogram demonstrates a minimum recording time of six (6) to seven (7) hours with an average of five (5) or more respiratory events per hour, each lasting a minimum of ten (10) seconds or more.

b) The beneficiary is a prepubescent child and the polysomnogram demonstrates an average of one (1) or more respiratory events per hour.

c) The beneficiary is a child who has documented measurements of increased end-tidal carbon dioxide (CO_2) values that confirm the presence of obstructive sleep apnea.

d) The beneficiary has a diagnosis of upper airway resistance syndrome with the presence of at least ten (10) respiratory related electroencephalogram (EEG) arousals per hour of sleep accompanied by a history of clinically significant daytime sleepiness or documented excessive daytime sleepiness as determined by a Multiple Sleep Latency Test, with a significant reduction in EEG arousals following administration of CPAP.

C. Medicaid will review, for determination of coverage for a CPAP, with appropriate documentation, the following medical conditions:

1. Persistent hypoxemia of oxygen saturation (SaO_2) less than ninety percent (90%) during sleep even in the absence of obstructive sleep apnea,

2. Central sleep apnea,

3. Chronic alveolar hypoventilation syndrome,

4. Intrinsic lung disease,

5. Neuromuscular disease.

D. After the initial three (3) month trial period, the CPAP may be recertified up to seven (7) additional months with a CPAP Compliance Certificate of Medical Necessity completed by the ordering physician.

1. If the equipment was not effective or, if the beneficiary was non-compliant, the equipment must be returned to the vendor.

2. The rental fees paid for the three (3) month trial period will apply toward the maximum reimbursement for purchase.

E. All related supplies are considered an integral part of the rental or purchase allowance of the CPAP unit and separate charges for supplies or respiratory services are not reimbursable.

F. If a beneficiary owns the CPAP unit, Medicaid reimburses the DME supplier for the supplies listed below:

1. Full face mask used with a positive airway pressure device, one (1) every three (3) months,

2. Face mask interface, replacement for full face mask, one (1) every three (3) months,

3. Replacement pillows for nasal application device, one (1) every three (3) months,

4. Replacement pillow for nasal application device, one (1) pair every three (3) months,

5. Nasal interface, either a mask or cannula type, used with positive airway pressure device with or without head strip, one (1) every three (3) months,

6. Headgear used with positive airway pressure device, one (1) every six (6) months,

7. Chin strap used with positive airway pressure device, one (1) every six (6) months,

8. Tubing used with positive airway pressure device, one (1) every month,

9. Disposable Filter, used with positive airway pressure device, two (2) every month,

10. Non-Disposable Filter, used with positive airway pressure device, one (1) every six (6) months, and

11. Oral interface used with positive airway pressure device, one (1) every three (3) months.

G. Medicaid does not cover for more than the usual maximum replacement amount unless documentation is submitted that justifies a larger quantity in the individual case.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.21: Crutches

A. Medicaid defines crutches as assistive devices used for support during ambulation.

1. Crutches may provide underarm or forearm support.

2. Crutches may be made of wood or metal, fixed or adjustable in height and must be supplied with tips.

B. Medicaid covers crutches for all beneficiaries when prior authorized for purchase only when ordered by a physician, nurse practitioner, or physician assistant.

1. Medicaid covers underarm crutches when the following criteria are met:

a) Post-op or post injury to reduce or alleviate weight bearing through the lower extremities.

b) Progression to ambulation without an assistive device.

2. Medicaid defines forearm crutches as crutches that decrease energy consumption during ambulation and provide increased support through the upper extremities.

a) Forearm crutches can be made of various materials, adjustable or fixed, and must be dispensed as a pair complete with handgrips.

b) Medicaid covers forearm crutches when the following criteria is met:

1) For those who will be long-term crutch users;

2) For use with beneficiaries whose balance does not require the base of support (BOS) provided by a walker; and

3) For beneficiaries who need the assistance provided by the crutch to increase their independence in the community. Beneficiaries may use a reciprocating, swing through, or swing to type of gait.

C. Medicaid covers customized crutches with prior authorization based on medical necessity.

D. Attachments to crutches are indicated when one (1) or both upper extremities are compromised due to surgical intervention, decreased range of motion, or contracture. The beneficiary may also need the attachment to provide a greater area of support.

E. Platform attachments are indicated when one (1) or both upper extremities have decreased range of motion at the elbow, shoulder, or wrist and allow the beneficiary to grasp and hold onto the crutch.

F. Tips, hand grips, adjustment features, and other accessory items not specifically listed as covered are inclusive in the rental or purchase of the crutches and Medicaid does not reimburse these as separate items.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.22: Diapers and Underpads

Refer to Part 209, Chapter 2: Medical Supplies, Rule 2.5.

History: Revised – 01/01/2013

Rule 1.23: Electromyography (EMG) Biofeedback Device

A. Medicaid defines an electromyography (EMG) biofeedback device as a device that uses recording equipment to detect, amplify and display a physiological response.

   1. EMG uses surface electrodes that are attached to the skin over a specific muscle or group of muscles.

   2. The EMG has an amplifier that is used to record the small electrical signals that are produced by contraction of the muscle fibers. These signals are amplified and converted into auditory and/or visual signals for display.

   3. Biofeedback instruction can teach a patient to learn to modify or reinforce voluntary control of specific responses.

B. Medicaid covers for all beneficiaries when prior authorized for rental up to three (3) months, then requires recertification, when ordered by a physician, nurse practitioner, or physician assistant and when one (1) or more of the following treatment is prescribed:

   1. The beneficiary is in a prescribed therapeutic exercise program,

   2. The beneficiary has musculoskeletal pain,

   3. The beneficiary has musculoskeletal stress related injuries, or

   4. The beneficiary is on a pre-chronic pain and headache program.

C. After the three (3) month rental period, the device may be recertified when documentation demonstrates desired outcomes are being achieved. The DME provider must thoroughly document that the beneficiary is capable of using and understanding the mechanism of biofeedback.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.24: Cochlear Implants and Implantable and Non-Implantable Auditory Osseointegrated Devices, Batteries and Battery Chargers

A. The Division of Medicaid covers repairs and external replacement parts for cochlear implant devices when medically necessary, prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designee , and ordered by an audiologist, otologist, otolaryngologist or other physician specialty who has documented training in assessment for and prescription of cochlear implant devices.

B. The Division of Medicaid covers repairs and external replacement parts of an implantable auditory osseointegrated device (AOD) when medically necessary, prior authorized by a UM/QIO, the Division of Medicaid, or designee and ordered by an audiologist, otologist, otolaryngologist or other physician specialty who has documented training in assessment for and the prescription of AODs.

C. The Division of Medicaid covers repairs and replacement parts of non-implantable AODs when medically necessary, prior authorized by a UM/QIO, the Division of Medicaid, or designee and ordered by an audiologist, otologist, otolaryngologist or other physician specialty who has documented training in assessment for and the prescription of AODs.

D. The Division of Medicaid covers batteries and battery chargers for cochlear implants and implantable and non-implantable AODs when medically necessary, prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designee, and ordered by an audiologist, otologist, otolaryngologist or other physician specialty who has documented training in assessment for and the prescription of AODs.

E. The manufacturer must provide a minimum one (1) year warranty for all items. [Refer to Part 209, Rule 1.4.]

Source: 42 USC §§ 1395m, 1395x; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2015.

Rule 1.25: Gait Trainer

A. Medicaid defines a gait trainer as a device similar to a walker and consists of a wide based steel frame with four (4) casters/wheels and may include a seat or support accessories. The user has difficulty with balance and control of the trunk, has an unsteady gait and is uncoordinated in ambulation.

B. Medicaid covers for all beneficiaries when prior authorized, for rental up to three (3) months, then requires recertification when ordered by a physician who specializes in physical medicine, orthopedics, or neurology and the following criteria is met:

1. The beneficiary has a condition which causes unsteady gait and difficulty with ambulation,

2. The beneficiary has been evaluated by a physical therapist (PT) or occupational therapist (OT) not employed by the DME supplier,

3. The PT/OT evaluation report must be submitted with the request for prior approval and must document medical necessity and indicates the approximate length of time the beneficiary will need the gait trainer,

4. The beneficiary's functional level is such that he/she is trainable in use of a gait trainer,

5. The beneficiary has the potential to be ambulatory and is involved in therapy to regain or strengthen ambulatory function,

6. There is enough space in the beneficiary's home for the beneficiary to utilize gait trainer, and

7. There are no medical contraindications to use of the gait trainer.

C. Medicaid does not cover "belt like" devices used in gait training.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.26: Glucose Monitoring Devices

A. The Division of Medicaid defines glucose monitoring devices as equipment for home use to measure glucose levels which includes a:

   1. Blood glucose monitor defined as a portable battery-operated meter used to determine the beneficiary's blood glucose level by exposing a reagent strip to a small blood sample resulting in the strip's colorimetric reaction to glucose concentrations, and

   2. Continuous glucose monitoring system (CGMS) defined as equipment used to detect trends and patterns in the beneficiary's glucose levels in the interstitial or intracellular fluid.

      a) The glucose levels are recorded by an external recorder that stores the data until it is downloaded for review or sent via a transmitter to an external monitor for beneficiary interaction.

      b) These readings are intended to supplement the information obtained from beneficiary self-monitoring of blood glucose via a blood glucose monitor.

B. The Division of Medicaid covers a blood glucose monitor for rental up to amount of purchase, or purchase when indicated, when ordered by a physician, nurse practitioner or physician assistant and when all the following are criteria are met:

   1. The beneficiary has one (1) of the following diagnoses:

      a) Insulin dependent diabetes mellitus.

      b) Non-insulin dependent diabetes mellitus:

         1) With a documented history of blood glucose fluctuating outside the normal range as specified by the physician,

         2) Requiring oral diabetes medication, and

         3) Requiring a prescribed specialized diet.

c) Gestational diabetes mellitus requiring treatment.

2. The medical record contains documentation that the beneficiary or caregiver is able to demonstrate the ability to accurately perform the blood glucose testing and accurately report the results.

3. The blood glucose monitor is specifically designed for home use rather than clinical use.

C. The Division of Medicaid covers a minimally invasive CGMS for rental up to amount of purchase, or purchase when indicated, when approved by the Federal Drug Administration (FDA) for home use, medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the 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:

1. Has an established diagnosis of type I diabetes mellitus that is poorly controlled as defined below:

a) Unexplained hypoglycemic episodes,

b) Nocturnal hypoglycemic episode(s),

c) Hypoglycemic unawareness and/or frequent hypoglycemic episodes leading to impairments in activities of daily living,

d) Suspected postprandial hyperglycemia,

e) Recurrent diabetic ketoacidosis, or

f) Unable to achieve optimum glycemic control as defined by the most current version of the American Diabetes Association (ADA).

2. Has documented self-monitoring of blood glucose at least four (4) times per day.

3. Requires insulin injections three (3) or more times per day or requires the use of an insulin pump for maintenance of blood sugar control.

D. The Division of Medicaid does not cover the following for a CGMS:

1. Additional software or hardware required for downloading data to a device such as a personal computer or tablet to aid in self-management of diabetes,

2. Combination devices that include a glucose monitor combined with a cellular telephone or other device not specifically indicated for the management of diabetes mellitus,

3. Insulin pump and CGMS combined into one (1) unit that requires no beneficiary interaction, or

4. Non-invasive CGMS.

Source: 42 U.S.C. 1395m; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: Revised eff. 07/01/2015; Revised eff. 01/01/2013.

Rule 1.27: Hip Abductor Pillow/Wedge

A. Medicaid defines a hip abductor pillow wedge as a foam triangular shaped device placed between the beneficiary's thighs and secured with straps. The device maintains constant abduction.

B. Medicaid covers hip abductor pillow wedges for all beneficiaries when prior authorized, for purchase only, when ordered by a physician, nurse practitioner or physician assistant and one (1) of the following apply:

1. A diagnosis which has resulted in a condition that requires maintaining the beneficiary's hips and thighs in abduction,

2. Subluxing or dislocating hip(s),

3. A diagnosis of an unstable hip,

4. Following the reduction of a dislocated hip,

5. Following hip replacement (hemi or total),

6. Following hip arthroplasty or hip fracture surgery,

7. Following adductor tenotomy or abductor advancement surgery, or

8. Wheelchair patients who must maintain a degree of hip abduction.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834.

Rule 1.28: Hospital Beds

A. The Division of Medicaid defines a hospital bed as a medical device with:

1. An articulating frame allowing adjustment of the head and foot of the bed,

2. A headboard,

3. A footboard,

4. A mattress, and

5. Side rails.

B. The Division of Medicaid covers hospital beds when medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO) and ordered by a physician, physician assistant or nurse practitioner for purchase or rental up to the purchase amount.

1. The Division of Medicaid defines a manual fixed-height hospital bed as one with manual head and leg elevation adjustments but no height adjustment and is covered when a beneficiary meets one (1) of the following:

   a) Requires positioning of the body in ways not feasible with a non-hospital bed in order to alleviate pain,

   b) Requires the head of the bed to be elevated thirty (30) degrees or more due to a medical condition including, but not limited to, congestive heart failure, chronic pulmonary disease, or risk of aspiration,

   c) Has failed to achieve the desired clinical outcome, with pillows or wedges,

   d) Requires equipment that can only be attached to a hospital bed,

   e) Has a disease, injury, or condition causing paralysis, immobility, or severe malaise and weakness requiring the performance of bathing, bodily functions, and other treatment or care while in bed, or

   f) Is semi-comatose or comatose.

2. The Division of Medicaid defines a manual variable-height hospital bed as one with manual height, head and leg elevation adjustments and is covered when a beneficiary:

   a) Meets one (1) of the criteria listed in Miss. Admin. Code Part 209, Rule 1.28.B.1., and

   b) Requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

3. The Division of Medicaid defines a semi-electric hospital bed as one with manual height adjustment and with electric head and leg elevation adjustments and is covered when a beneficiary:

a) Meets one (1) of the criteria in Miss. Admin. Code Part 209, Rule 1.28.B.1.a) through e) and B.2.b),

b) Is able to operate the bed controls, and

c) Lives alone or with assistance of a caregiver, but without continuous twenty-four (24) hours per day caregiver support.

4. The Division of Medicaid defines bariatric hospital beds as heavy duty extra wide and extra-heavy duty extra wide hospital beds used for beneficiaries whose weight and/or body measurements exceed the manufacturer's limit for size or weight of a standard hospital bed and is covered when:

a) The beneficiary meets one (1) of the criteria listed in Miss. Admin. Code Part 209, Rule 1.28.B.1., and

b) Documentation includes current weight and body measurements that exceed the manufacturer's limit for size and weight of a standard hospital bed which is obtained within thirty (30) days of request.

C. The Division of Medicaid does not cover:

1. A total-electric hospital bed defined as one with electric height, head and leg elevation adjustments.

2. Institutional type hospital beds, including but not limited, to:

a) Oscillating beds,

b) Circulating beds, or

c) Stryker frame beds.

3. Pressure reducing hospital beds, including but not limited to,

a) Powered air flotation beds (low air loss therapy), or

b) Air fluidized beds.

Source: SSA § 1834; Miss. Code Ann. §§ 43-13-117, 121.

History: Revised eff. 05/01/2014.

Rule 1.29: Hydraulic Lift with Seat or Sling

A. Medicaid defines a patient hydraulic lift as a device used to transfer a beneficiary between a bed, a chair, wheelchair or portable commode chair but not solely for use in the bathroom.

B. Medicaid covers hydraulic lifts for all beneficiaries when prior authorized, for rental up to purchase amount, or purchase when ordered by a physician or nurse practitioner and all the following criteria is met:

   1. Documentation that the beneficiary's condition is such that periodic position adjustment is necessary to effect improvement or to arrest or retard deterioration in his/her condition,

   2. The beneficiary is bed or chair confined, and

   3. There is an available caregiver in the home trained in the safe operation of the hydraulic lift.

C. Medicaid covers the seat or sling in the initial purchase price or the monthly rental price.

D. Medicaid does not cover an electric lift mechanism.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.30: Infusion Pump, Enteral/Parenteral/External

A. Medicaid defines an enteral pump as a device used to deliver nutritional requirements to the stomach or small bowel via a tube, including nasogastric, gastrostomy, jejunostomy and PEG tubes.

B. Medicaid covers enteral pumps for all beneficiaries if prior authorized, for rental up to purchase amount, or for purchase when ordered by a physician, nurse practitioner or physician assistant and if the following criteria is met:

   1. The beneficiary is tube fed, and

   2. The enteral feedings are the sole source of nutrition.

C. Medicaid defines a parenteral pump as a device used to deliver nutritional requirements intravenously. Intravenous nutrition is also referred to as Total Parenteral Nutrition (TPN) or hyperalimentation therapy.

D. Medicaid covers parenteral pumps if prior authorized, for rental up to purchase amount, or for purchase if indicted for all beneficiaries when ordered by a physician, nurse practitioner, or physician assistant for beneficiaries who cannot absorb nutrients by the gastrointestinal tract.

E. Medicaid defines an ambulatory infusion pump as a small portable electrical device that is used to deliver parenteral medication. It is designed to be carried by or worn by the beneficiary.

F. Medicaid defines a stationary infusion pump as an electrical device which serves the same purpose as an ambulatory pump, but is larger and typically mounted on a pole.

G. Medicaid covers ambulatory and stationary pumps when prior authorized, for rental up to purchase amount, or purchase if indicated when ordered by a physician, nurse practitioner, or physician assistant for home use when the following criteria is met:

    1. Parenteral administration of the medication in the home is reasonable and medically necessary; and

    2. An infusion pump is necessary to safely administer the medication.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.31: Insulin Pumps

A. Medicaid defines an insulin pump as a small battery-driven pump that delivers insulin subcutaneously. The pump can be programmed to deliver varying doses of insulin in accordance with changes in need for insulin during different conditions such as eating, exercise, sleep, or at a specific time of day.

B. Medicaid covers insulin pumps for all beneficiaries when prior authorized, for rental up to purchase amount, or purchase when ordered by an endocrinologist or other physician, nurse practitioner, or physician assistant experienced in the treatment of diabetes and in the management of the insulin pump therapy and when one (1) or more of the following criteria is met:

    1. The beneficiary has insulin dependent diabetes where control has been difficult to achieve, or

    2. The beneficiary has fluctuating blood sugars and is on three (3) or more injections per twenty four (24) hours, or

    3. The beneficiary is receiving treatment of secondary diabetic complications that require closer blood glucose control.

C. Medicaid requires the prescribing provider, with experience in the use of the pump and in a position to monitor the clinical course of the beneficiary, to document that the beneficiary and/or caregiver demonstrates:

    1. Motivation to control the diabetes and to comply with the pump regiment,

2. The ability to learn how to use the pump effectively and the ability to comply with the regimen of the pump care, and

3. A commitment to comply with diet, exercise, medications, and frequent self-monitoring of blood glucose.

D. The prescribing provider and supplier of the pump must also ensure that the beneficiary and/or caregiver are fully educated about the beneficiary's diabetic condition and use of the insulin pump.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.32: IV Poles

A. Medicaid defines an IV pole as a device to suspend fluid to be administered by gravity or pump.

B. Medicaid covers IV poles for all beneficiaries when prior authorized, for rental up to purchase amount, or purchase when ordered by physician, nurse practitioner, or physician assistant when the beneficiary is receiving enteral or parenteral fluids or IV medications and the beneficiary is not using an ambulatory infusion pump.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.33: Nebulizer

A. Medicaid defines a nebulizer as an apparatus for producing a fine spray or mist primarily for use in administering drugs by inhalation.

1. This may be accomplished by rapidly passing air through a liquid or by vibrating a liquid at a high frequency so that the particles produced are extremely small.

2. Medicaid expects that the practitioner will have considered the use of a metered dose inhaler with and without a reservoir or spacer device, if age appropriate, and has determined that, for medical reasons, it was not sufficient for the administration of needed inhalation drugs.

B. Medicaid covers nebulizers for all beneficiaries when prior authorized, for rental up to purchase amount, or purchase when indicated and ordered by a physician, nurse practitioner or physician assistant as follows:

1. A nebulizer is covered for rental only when a beneficiary has an acute condition, such as pneumonia or acute bronchitis, which is expected to resolve in a short time.

2. A nebulizer is covered for purchase when a beneficiary has a chronic condition that is not expected to resolve in a short time or is expected to recur frequently. Medical conditions that may be chronic or long term, but are not limited to:

    a) Chronic bronchitis,

    b) Cystic fibrosis,

    c) Asthma,

    d) Diaphragmatic hernia,

    e) Congenital heart anomaly,

    f) Respiratory distress syndrome,

    g) Chronic obstructive pulmonary disease, and

    h) Bronchopulmonary dysplasia.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.34: Neuromuscular Electrical Stimulator (NMES)

A. Medicaid defines a neuromuscular electrical stimulator (NMES) as a device that transmits an electrical impulse to the skin over selected muscle groups by way of electrodes to treat disuse atrophy where the nerve supply to the muscle is intact.

B. Medicaid covers for all beneficiaries when prior authorized, for rental only, when ordered by an orthopedist, neurologist or physiatrist, a physician specialized in physical rehabilitation, and when there is a documented diagnosis of disuse atrophy and the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves and one (1)of the following apply:

    1. The beneficiary has or has had casting or splinting of a limb.

    2. The beneficiary has a contracture(s) due to scarring of soft tissue as in burn lesions.

    3. The beneficiary has had hip replacement surgery, until orthotic training begins.

    4. The beneficiary requires one (1) of the following:

        a) Relaxation of muscle spasms,

        b) Prevention or retardation of disuse atrophy,

c) Re-education of muscle,

d) Increasing of local blood circulation, or

e) Maintenance or increasing of range of motion.

C. The beneficiary and/or caregiver must be able to demonstrate proper use and care of equipment.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.35: Oxygen and Oxygen Related Equipment

A. Medicaid covers oxygen and oxygen related equipment that allows for the safe delivery of oxygen in the home. Oxygen and oxygen related equipment, as DME, include:

1. Stationary gaseous oxygen systems,

2. Stationary liquid oxygen systems,

3. Portable gaseous or liquid oxygen systems,

4. Oxygen concentrators, and

5. Oxygen contents, liquid or gaseous.

B. Medicaid covers oxygen and oxygen related equipment for all beneficiaries with prior authorization, for rental up to six (6) months, then recertification is required for purchase, if preferred, when the following criteria is met:

1. When ordered by a physician, nurse practitioner, physician assistant,

2. For beneficiaries with significant hypoxemia in the chronic stable state provided the following conditions are met:

a) The attending or consulting practitioner has determined that the beneficiary has a severe lung disease or hypoxia related symptoms that might be expected to improve with oxygen therapy.

b) The beneficiary can be classified in either the following Group I or Group II:

1) Group I includes beneficiaries with significant hypoxia defined by Medicaid as:

i) The beneficiary's oxygen (O_2) saturation must be eighty-eight percent (88%) or less by oximetry, partial oxygen pressure (pO_2) fifty-five (55) millimeters

(mm) of mercury (Hg) or less by arterial blood gases (ABG); either at rest, during or after exercise, or while asleep; or

ii) The beneficiary has:

(1) During sleep, the beneficiary's O_2 saturation must fall greater than five percent (5%) by oximetry or the pO_2 ten (10) mm Hg or less by ABG, and there are signs of hypoxia,

(2) Cor pulmonale, "P" pulmonale on electrocardiogram (ECG), with P wave greater than three (3) mm in standard leads II, III, or AVF,

(3) Documented pulmonary hypertension, or

(4) Erythrocytosis with a hematocrit of fifty-two percent (52%) or greater.

iii) For beneficiaries who meet criteria for home oxygen therapy only during sleep, only nocturnally provided oxygen will be approved.

2) Group II includes beneficiaries with mild hypoxia defined by Medicaid as the beneficiary's O_2 saturation must be eighty-nine (89%), pO_2 fifty-six (56) to fifty-nine (59) mm Hg by ABG, and

a) There is dependent edema caused by congestive heart failure,

b) There is documentation supportive of pulmonary hypertension or cor pulmonale by any combination of gated blood pool scan, echocardiogram, or "P" pulmonale on ECG, with P wave greater than three (3) mm in standard leads II, III, or AVF, or

c) There is erythrocytosis with a hematocrit of fifty-two (52%) or greater.

3. Documentation of O_2 saturation levels must be obtained on room air.

a) For those cases in which it would be detrimental to the life of the beneficiary to obtain a room air saturation level, the prescribing practitioner must provide written documentation as to the reason the beneficiary has had increased dyspnea on prior trials on room air, due to one (1) or more of the following:

1) Has had dysrhythmias,

2) Takes a long time to regain adequate O_2 saturation after previous trials on room air,

3) Has a chronic or progressive condition which has not improved, or

4) Other reasons.

b) Documentation of concurrence by a consulting pulmonologist or thoracic surgeon is a prerequisite for approval of home oxygen therapy for those beneficiaries whose arterial pO_2 is between fifty-six (56) and fifty-nine (59) mm Hg, an O_2 saturation of eighty-nine percent (89%), without signs or symptoms of congestive heart failure, pulmonary hypertension, or cor pulmonale.

4. A prescription that specifies the oxygen flow rate, frequency, and duration of use, and estimates the period of need for oxygen and type of oxygen delivery system to be used, such as gas, liquid, or concentrator. A prescription containing only "oxygen PRN" is not sufficient.

C. Medicaid does not cover conditions for which oxygen therapy is not medically necessary including, but is not limited to, the following:

1. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.

2. Dyspnea without cor pulmonale or evidence of hypoxia.

3. Severe peripheral vascular disease resulting in clinically evident desaturation in one (1) or more extremities. There is no evidence that increased pO_2 will improve the oxygenation of tissues with impaired circulation.

4. Terminal illnesses that do not affect the respiratory system.

D. Medicaid covers for rental or purchase.

1. For rental, Medicaid covers the following:

a) Regulators,

b) Tubing,

c) Cannulas/mask,

d) Monthly home visits by a qualified professional employee or consultant of the DME provider for equipment evaluation and monthly saturation measurements,

e) Oxygen contents (refills), except for refills for portable units, and

f) Backup equipment.

E. When the DME provider conducts the monthly home visit, the following information must be documented in the beneficiary record:

1. Date of home visit,

2. Monthly check of operation and safety of equipment,

3. Determination of oxygen output,

4. Changing of filters,

5. Proper functioning of the backup system, and

6. Monthly saturation measurements by pulse oximetry. O_2 saturation levels must be obtained within thirty (30) days prior to review submission.

F. It is the responsibility of the DME provider to notify the practitioner of significant changes in the oxygen saturation level.

G. Backup oxygen equipment, either stationary and/or portable which functions only as a stand-by device or a precautionary device is the responsibility of the DME provider and is inclusive in the monthly rental allowance. Backup oxygen equipment cannot be separately billed to Medicaid.

H. Medicaid covers portable oxygen equipment for a beneficiary who needs continuous oxygen and requires portable units:

1. While en route to a practitioner's office or hospital,

2. When the practitioner has ordered an exercise program requiring the beneficiary to be away from his/her stationary oxygen, or

3. During activities that cannot be accomplished with the use of stationary oxygen equipment.

I. Requests for portable refills, exceeding one (1) per day, require additional justifications from the physician. For cases in which the number of refills required is less than one (1) per day, additional information may be requested by the UM/QIO, if necessary to justify the medical necessity for the refills.

J. Oxygen contents, either gaseous or liquid, are included in the monthly rental allowance for rented equipment. Oxygen contents may be billed separately to Medicaid only if the beneficiary owns the oxygen equipment.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.36: Pacemaker Monitor

A. Medicaid defines a pacemaker monitor as a self-contained device used in the evaluation of a pacemaker by trans-telephonic monitoring of the transmission of the generator's pulse rate.

   1. By means of special equipment, the sound tone of the patient's pacemaker is transmitted over the telephone to a receiving system at a pacemaker clinic.

   2. The sounds are converted into an electronic signal and permanently recorded on an ECG strip.

B. Medicaid covers pacemaker monitors for all beneficiaries with prior authorization, for rental up to purchase amount, or purchase when indicated when ordered by a physician, nurse practitioner or physician assistant and all the following criteria is met:

   1. The beneficiary has a pacemaker implanted for a cardiac arrhythmia.

   2. The beneficiary/caregiver is capable of performing the pacemaker monitoring function.

   3. The beneficiary has access to a telephone for transmission.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.37: Pulse Oximeter

A. Medicaid defines pulse oximeter as a photoelectric apparatus for determining the amount of oxygen in the blood. This is usually done by measuring the amount of light transmitted through a translucent part of the skin.

B. Medicaid covers pulse oximeters for all beneficiaries when prior authorized, for rental up to purchase amount, or purchase if indicated when ordered by a physician, nurse practitioner, or physician assistant and one (1) of the following criteria is met for a non-recording pulse oximeter:

   1. The beneficiary has a documented serious respiratory diagnosis and requires short-term oximetry to rule out hypoxemia and/or determine the need for supplemental oxygen.

   2. The beneficiary is dependent on a ventilator with supplemental oxygen.

   3. The beneficiary has a tracheostomy and requires monitoring of O_2 saturation as determined by the practitioner.

   4. The beneficiary requires supplemental oxygen and has unstable saturations.

   5. The beneficiary is on supplemental oxygen and weaning is in process.

C. Medicaid covers a recording pulse oximeter when all the following criteria is met:

1. The beneficiary's condition meets one (1) of the criteria for a non-recording oximeter, and

2. The recording oximeter is being ordered by the practitioner to monitor the beneficiary during a specific event such as a weaning attempt from oxygen or ventilator, feeding times for an infant, or other times for which the physician needs documentation of the patient's blood oxygen saturation.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.38: Spacer/Aerosol-Holding Chamber

A. Medicaid defines a spacer/aerosol-holding chamber as a cylinder shaped device usually four (4) to eight (8) inches long with a one (1) way valve.

   1. The device is attached to a metered dose inhaler (MDI).

   2. Use of the spacer/aerosol-holding chamber slows the delivery of medication from the pressurized MDI and decreases the amount of medication deposited in the mouth and throat.

B. Medicaid covers spacer/aerosol-holding chambers for all beneficiaries for purchase only when ordered by a physician, nurse practitioner or physician assistant and all the following criteria is met:

   1. The beneficiary is unable to coordinate spraying the metered dose inhaler and inhaling.

   2. The beneficiary has a medical diagnosis of asthma, chronic bronchitis or emphysema.

   3. The beneficiary must have a metered dose inhaler.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.39: Suction Pump, Respiratory/Gastric

A. Medicaid defines a mobile or stationary home model suction pump as a lightweight, compact, electric aspirator designed for upper respiratory oral, pharyngeal and tracheal suction for use in the home. A suction device must be appropriate for home use without technical or professional supervision.

B. Medicaid covers stationary home model suction pump for all beneficiaries when prior authorized, for rental up to purchase amount, or purchase when indicated when ordered by a physician, nurse practitioner, or physician assistant and if the beneficiary is unable to clear the airway of secretions by coughing secondary to, but not limited to, one (1) of the following:

   1. Cancer or surgery of the throat,

2. Paralysis of the swallowing muscles,

3. Tracheostomy, or

4. Comatose or semicomatose condition.

C. A mobile suction machine includes a vacuum regulator and is battery operated. The device includes a rechargeable battery and charger device, vehicle adapter cable, canister or bottle, connector and carrying case. Medicaid covers a mobile unit if all of the following apply:

1. Prescribed because the beneficiary is subject to secretions that require suctioning during travel.

2. The beneficiary is not being transported by an ambulance.

3. There is sufficient documentation to justify the medical necessity for both stationary and portable units.

D. Medicaid requires those using the suction apparatus must be sufficiently trained to adequately, appropriately and safely use the device.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.40: Traction Equipment

A. Medicaid defines traction equipment as encompassing a variety of equipment used to apply a pulling force to a part of the body. It may be used to minimize muscle spasms, to reduce, align, and immobilize fractures, to lessen deformity or to increase space between opposing surfaces within a joint.

B. Medicaid covers traction equipment for all beneficiaries when prior authorized, for rental up to three (3) months, then requires recertification when all the following criteria is met:

1. When ordered by an orthopedic physician, neurosurgeon, neurologist or a physiatrist, a physician who specializes in physical rehabilitation.

2. The beneficiary has a cervical or pelvic orthopedic impairment verified by radiographic documentation or has a documented history of chronic pain from an orthopedic impairment that has been unrelieved by other treatment modalities.

C. Medicaid requires all traction equipment must be of a type appropriate for use in the beneficiary's home.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.41: Transcutaneous Electrical Nerve Stimulator (TENS)

A. Medicaid defines a transcutaneous electrical nerve stimulator (TENS) as a device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the patient's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins.

B. Medicaid covers TENS for all beneficiaries when prior authorized, for rental up to purchase amount, or purchase when indicated when ordered by a physician, nurse practitioner, or physician assistant and one (1) of the following criteria is met:

   1. The TENS unit is being used for acute post-operative pain, the beneficiary is within thirty (30) days post-op, other treatment modalities have failed and the patient is being treated at home rather than an inpatient hospital. Approval is limited to thirty (30) days rental.

   2. The beneficiary has intractable chronic pain of at least three (3) months duration from date of onset and a history of failed response to other treatment modalities. A thirty (30) to sixty (60) day trial period is required.

C. Medicaid covers for a conductive garment to be used with a TENS unit when ordered by the practitioner only if one (1) of the following apply:

   1. The beneficiary cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires.

   2. The beneficiary cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires.

   3. The beneficiary has a documented medical condition, such as a skin condition, that precludes the application of conventional electrodes, adhesive tapes, and lead wires.

   4. The beneficiary requires electrical stimulation beneath a cast to treat chronic intractable pain.

D. Medicaid requires for purchase to be considered, the practitioner must provide a copy of the re-evaluation performed at the end of the trial period and documentation that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time.

E. If a four (4) lead TENS unit is ordered, the practitioner must document why two (2) leads are insufficient to meet the patient's needs.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.42: Transfer Board

A. Medicaid defines a transfer board as a wooden or plastic device used to transfer individuals from one (1) surface to another. It may be used by caregivers to assist with bed mobility of a dependent patient.

B. Medicaid covers transfer boards for all beneficiaries when prior authorized, for rental up to purchase amount, or purchase when indicated when ordered by a physician, nurse practitioner, or physician assistant and one (1) of the following criteria is met:

   1. The patient has decreased to absent lower extremity function and the board can be used by the patient or caregivers for successful transfer.

   2. The patient is obese and unable to transfer without lifting.

   3. It is required by the caregiver to assist with the bed mobility of the patient.

   4. The caregiver is unable to lift the patient for transfer.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.43: Trapeze Bar/Equipment

Medicaid covers trapeze bars/equipment for all beneficiaries when prior authorized, for rental up to purchase amount, or purchase when indicated and when ordered by a physician, nurse practitioner, or physician assistant and one of the following criteria is met:

A. A trapeze bar or freestanding trapeze equipment when a beneficiary has truncal or lower extremity weakness and needs this device in order to rise to sit, change body position, or get in and/or out of bed.

B. An attached trapeze bar when it is either an integral part of or used on a hospital bed, and it has been determined that both the hospital bed and the trapeze bar are medically necessary.

C. A freestanding trapeze only when used with a non-hospital bed. The beneficiary must not be renting or own a hospital bed.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.44: Ventilator

A. Medicaid defines a ventilator as a mechanical device used for artificial ventilation of the lungs.

B. Medicaid covers ventilators for all beneficiaries when prior authorized, for rental only, and ordered by a physician, nurse practitioner, or physician assistant and one (1) of the following criteria is met:

1. The beneficiary is unable to maintain spontaneous respiration.

2. The beneficiary is unable to maintain safe levels of arterial carbon dioxide or oxygen with spontaneous breathing.

3. The beneficiary has a medical condition that requires mechanically assisted ventilation that is appropriate for home use, without continuous technical or professional supervision.

C. Medicaid covers the rental allowance which includes:

1. The equipment,

2. Delivery,

3. Freight and postage,

4. Set-up,

5. All supplies necessary for operation of the equipment,

6. Education of the patient and caregiver,

7. All maintenance and repairs or replacement,

8. Labor including respiratory therapy visits, and

9. Servicing charges.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.45: Walker

A. Medicaid defines a walker as an assistive device used to provide a wide base of support (BOS) for ambulation and stance.

1. It may be rigid or folding, rolling or a pickup type, and/or fixed or height adjustable.

2. The walker may have accessories to provide increased support.

B. Medicaid covers walkers for all beneficiaries when prior authorized, for rental up to purchase amount, or purchase when indicated and must be ordered by a physician, nurse practitioner or physician assistant.

1. For a rigid or folding walker the following criteria must also be satisfied:

   a) The beneficiary has a medical condition which causes impaired ambulation, but there is potential for the beneficiary to ambulate, and

   b) There is a need for greater stability and security than can be provided by canes or crutches.

2. For a rigid pickup walker the same criteria apply, but the following specific criteria must also be met:

   a) The beneficiary must be able to maintain balance while picking up the walker and moving it forward.

   b) The beneficiary or caregiver must have means to transport a rigid walker.

   c) Rigid walkers must provide a stable base of support:

   d) For beneficiaries with impaired lower extremity weight-bearing ability such as spinal cord injury, cerebral palsy, congestive heart failure, stroke, post-operative conditions.

   e) For beneficiaries with impaired balance during ambulation.

   f) For ambulation training in newly braced children, adults in rehabilitation, and other diagnoses as medically necessary.

3. For wheeled walkers the same criteria applies but must meet also the following specific criteria:

   a) The beneficiary must be able to maintain balance during ambulation with the rolling motion. It may be two (2) or four (4) wheeled.

   b) Wheeled walkers are appropriate for beneficiaries who have difficulty using a rigid walker.

4. For folding walkers that are fixed, with or without wheels or seat, the same criteria from Rule 1.45 B. 1-3 above applies. Medicaid covers folding walkers that are push or pull types with two (2) or four (4) wheels.

5. For heavy duty walkers, multiple braking system, variable wheel resistance walkers the same criteria applies from Rule 1.45 B. 1-3 above, but must also meet the following criteria:

a) For larger or obese beneficiaries, or beneficiaries, who are unable to use a standard walker due to severe neurological disorders or restricted use of one (1) hand,

b) Beneficiaries whose gait patterns apply excessive force on the walker, and

c) Beneficiaries at risk of falling.

6. For attachments to walkers the same criteria applies from Rule 1.45 B. 1-3 above but must also meet the following:

a) When one (1) or both upper extremities are compromised due to surgical intervention, decreased range of motion, or contracture,

b) Provide a greater area of support,

c) When the beneficiary has decreased mobility and requires rest periods,

d) Seating attachments when beneficiaries who need rest periods during ambulation to conserve energy and maintain their endurance, and

e) Platform attachments for beneficiaries when one (1) or both upper extremities have decreased range of motion at the elbow, shoulder, or wrist that allows the beneficiary to grasp and hold onto the walker.

C. Medicaid covers for hand brakes when medically necessary.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.46: Wedge Seat Insert, Custom

A. Medicaid defines a custom wedge seat insert as an item that is made of various materials and is inserted into a seating system. It is used either for positioning or pressure reduction and has been uniquely constructed or substantially modified for a specific beneficiary.

B. Medicaid covers custom wedge seat inserts for all beneficiaries with prior authorization for purchase only, when ordered by pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist, a physician specializing in physical rehabilitation, and has a stable seating device or a mobility device such as a buggy/stroller, stable seating device, or wheelchair to allow use of the item and is needed to:

1. Decrease posterior pelvic tilt, or

2. Assist with proper positioning for stable seating.

C. Medicaid requires that the assessment or evaluation must be performed by a physical therapist or occupational therapist not employed by the DME supplier or manufacturer.

D. If the beneficiary has an existing wheelchair custom seating system or a custom wheelchair seat that provides similar benefits, Medicaid does not cover this.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

Rule 1.47: Wheelchairs

A. The Division of Medicaid defines a wheelchair as a seating system that is designed to increase the mobility of beneficiaries who would otherwise be restricted by inability to ambulate or transfer from one place to another.

B. The Division of Medicaid covers wheelchairs for all beneficiaries when ordered by the appropriate medical professional, is medically necessary and prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO) for rental up to purchase amount or for purchase as follows:

1. The provider must fully assess the beneficiary's needs and must ensure that the prescribed wheelchair is adequate to meet those needs, including measuring to ascertain proper height, width and weight and providing an automatic or special locking mechanism for those who are unable to apply manual brakes to prevent falls.

2. The beneficiary, family or caregiver and supplying vendor must be present for the wheelchair assessment. It is also recommended that each of these people be present at the delivery of the wheelchair.

3. At a minimum, all wheelchairs must include a seat, back, armrests (may be desk or full length, fixed or removable), leg rest (may be fixed, swing away detachable, or elevating), footplates, safety belts, anti-tipping device, wheels, and an appropriate type of wheel-locking mechanism, manual or automatic.

4. A standard wheelchair is covered when the beneficiary's condition is such that without the use of a wheelchair, he/she would be otherwise bed or chair confined.

5. An amputee wheelchair is covered if the beneficiary has had an amputation of one (1) or both lower extremities.

6. Hemi-wheelchairs are covered with appropriate documentation and medical necessity justification.

7. A tilt-in-space wheelchair is one that maintains the congruency of the seat to back angle while tilting the patient in space.

C. Standard manual wheelchairs with added accessories do not qualify as custom wheelchairs. Standard manual wheelchairs must be ordered by a physician, physician assistant or nurse practitioner.

1. A heavy duty standard manual wheelchair:

   a) Is covered if the beneficiary meets the criteria for a standard manual wheelchair and meets one of the following criteria:

      1) Weighs more than two hundred fifty (250) pounds, or

      2) Body measurements do not conform to a standard manual wheelchair, or

      3) Has severe spasticity.

   b) Documentation must include:

      1) Specific weight or measurements that cause the beneficiary to require this type chair, or

      2) The specific condition causing the beneficiary to be unable to function with a standard manual wheelchair.

2. An extra heavy duty standard manual wheelchair:

   a) Is covered if the beneficiary meets the criteria for a standard manual wheelchair and meets one of the following criteria:

      1) Weighs more than three hundred (300) pounds, or

      2) Body measurements do not conform to a standard wheelchair.

   b) Documentation must include:

      1) Specific weight and measurements causing the beneficiary to be unable to function with a standard manual wheelchair, and

      2) Specific measurements causing the beneficiary to be unable to function with a standard manual wheelchair.

3. A high strength lightweight manual wheelchair is covered with appropriate documentation and medical necessity justification.

4. A lightweight manual wheelchair:

   a) Is covered if a beneficiary meets all of the following criteria:

1) Meets the criteria for a standard manual wheelchair,

2) Cannot self-propel in a standard manual wheelchair using arms and/or legs, and

3) Is able to and does self-propel in a lightweight manual wheelchair.

b) Documentation must reflect the specific cause or condition that hinders the beneficiary from being able to function with a standard manual wheelchair.

5. An ultra-light manual wheelchair is covered with the appropriate documentation of medical necessity.

6. The Division of Medicaid defines a custom manual wheelchair as one uniquely constructed or substantially modified for a specific beneficiary. Custom manual wheelchairs must be ordered by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist.

D. Standard motorized/power wheelchairs with added accessories do not qualify as an individualized beneficiary specific custom motorized/power wheelchair. The Division of Medicaid covers standard motorized/power wheelchairs when all the following criteria are met:

1. Ordered by a physician, physician assistant, or nurse practitioner experienced in evaluating specialized needs for the purpose of prescribing motorized/power wheelchairs after a face-to-face examination of the beneficiary.

2. Medically necessary with comprehensive documentation including, but not limited to:

a) That a manual wheelchair cannot meet the beneficiary's needs,

b) The beneficiary requires the motorized/power wheelchair for six (6) months or longer.

c) The beneficiary must:

1) Be bed/chair confined and have documented severe abnormal upper extremity dysfunction or weakness.

2) Expect to have physical improvements or the reduction of the possibility of further physical deterioration, from the use of a motorized/power wheelchair or be for the necessary treatment of a medical condition.

3) Have a poor prognosis for being able to self-propel a functional distance in the future.

4) Not exceed the weight capacity of the motorized/power wheelchair being requested.

5) Have sufficient eye/hand perceptual capabilities to operate the prescribed motorized/power wheelchair safely.

6) Have sufficient cognitive skills to understand directions, such as left, right, front, and back, and be able to maneuver the motorized/power wheelchair in these directions independently.

7) Be independently able to move away from potentially dangerous or harmful situations when seated in the motorized/power wheelchair.

8) Demonstrate the ability to start, stop, and guide the prescribed motorized/power wheelchair within a reasonably confined area.

9) Be in an environment conducive to the use of the prescribed motorized/power wheelchair.

   (a) The environment should have sufficient floor surfaces and sufficient door, hallway, and room dimensions for the prescribed motorized/power wheelchair unit to turn and enter/exit, as well as necessary ramps to enter/exit the residence.

   (b) The environmental evaluation must be documented and signed by the beneficiary/caregiver and supplier for the prescribed motorized/power wheelchair.

   (c) If the residential environment cannot accommodate the prescribed motorized/power wheelchair, the wheelchair is not covered.

10) Or the caregiver must be capable of maintaining the motorized/power wheelchair or be capable of having the motorized/power wheelchair repaired and maintained.

11) Have appropriate covered transportation for the prescribed motorized/power wheelchair.

3. The ordering practitioner must document:

   a) The face-to-face examination in a detailed narrative note in the beneficiary's chart and must clearly indicate that the reason for the visit was a mobility examination.

   b) Whether or not the beneficiary currently possesses a motorized/power wheelchair not previously purchased by the Medicaid program.

c) And provide a certificate of medical necessity with comprehensive documentation that describes the medical reason(s) why a motorized/power wheelchair is medically necessary such that no other type of wheelchair can be utilized including, but not limited to:

1) The diagnosis/co-morbidities and conditions relating to the need for a motorized/power wheelchair.

2) Description and history of limitation/functional deficits.

3) Description of physical and cognitive abilities to utilize equipment.

4) History of previous interventions/past use of mobility devices.

5) Description of existing equipment, age and specifically why it is not meeting the beneficiary's needs.

6) Explanation as to why a less costly mobility device is unable to meet the beneficiary's needs.

7) Description of the beneficiary's ability to safely tolerate/utilize the prescribed motorized/power wheelchair.

8) The type of chair and each individual attachment required by the beneficiary.

4. An initial evaluation documented by a physical therapist (PT) or occupational therapist (OT), not employed by the DME supplier or the manufacturer, within three (3) months of the written prescription date to determine individualized needs of the beneficiary which includes whether the beneficiary currently possesses a motorized/power wheelchair not previously purchased by the Medicaid program.

5. An agreement documented by both the prescribing physician and the PT or OT performing the initial evaluation that the motorized/power wheelchair being ordered is appropriate to meet the needs of the beneficiary.

6. A subsequent evaluation documented after the delivery of the motorized/power wheelchair by a PT or OT, not employed by the DME provider or the manufacturer, to determine if the motorized/power wheelchair is appropriate for the resident's needs. The DME provider cannot bill the Division of Medicaid until the PT/OT documentation verifies on the subsequent evaluation that the motorized/power wheelchair is appropriate for the resident's needs.

7. Documentation during the PT/OT initial and subsequent evaluations must include appropriate seating accommodation for beneficiary's height and weight, specifically addressing anticipated growth and weight gain or loss.

8. The DME provider must fully assess the beneficiary's needs and ensure that the motorized/power wheelchair is adequate to meet those needs.

E. The Division of Medicaid defines an individualized, beneficiary specific custom motorized/power wheelchair as one that has been uniquely constructed or substantially modified for a specific beneficiary. Individualized, beneficiary specific custom motorized/power wheelchairs must meet the following criteria:

1. Be ordered by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist.

2. Meet all the requirements in Miss. Admin. Code Part 209, Rule 1.47.D.2– 8.

3. Coverage for a customized electronic interphase device, specialty and/or alternative controls require documentation of an extensive evaluation of each customized feature required for physical status and specification of medical benefit of each customized feature to establish that the beneficiary is unable to manage a motorized/power wheelchair without the assistance of said device.

   a) For a joystick, hand or foot operated, device the beneficiary must demonstrate safe operation of the motorized/power wheelchair with extremity using a joystick. The beneficiary can manipulate the joystick with fingers, hand, arm, or foot.

   b) For a chin control device, the beneficiary must demonstrate safe operation of the motorized/power wheelchair with manipulation of the chin control device. The beneficiary must have a medical condition which prevents the use of their hands/arms but is able to move their chin and safely operate the chair in all circumstances.

   c) For a head control device, the beneficiary must demonstrate safe operation of the motorized/power wheelchair with manipulation of the head control device. The beneficiary must have a medical condition which prevents the use of their hands/arms but is able to move their head freely with control of their head and can safely operate the chair in all circumstances.

4. For an extremity control device, the beneficiary must demonstrate safe operation of the motorized/power wheelchair with manipulation of the extremity control device. The beneficiary must have a medical condition which prevents or limits fine motor skills during the use of their extremities but is able to move their hands/arms/legs to safely operate the chair in all circumstances.

5. For a sip and puff feature, the beneficiary must demonstrate safe operation of the motorized/power wheelchair with manipulation of the sip and puff control. The beneficiary cannot move their body at all and cannot operate any other driver except this one.

F. Standard and custom motorized/power wheelchairs are limited to one (1) per beneficiary every five (5) years based on medical necessity. Reimbursement:

1. Is made only for one (1) wheelchair at a time.

2. Includes all labor charges involved in the assembly of the wheelchair and all covered additions, accessories and modifications.

3. Includes support services such as emergency services, delivery, setup, education and ongoing assistance with use of the wheelchair.

4. Is made only after the PT or OT subsequent evaluation is completed.

G. Standard and custom motorized/power wheelchairs are not covered if the use of the standard and custom motorized/power wheelchair primarily benefits the beneficiary in their pursuit of leisure or recreational activities. Motorized/power wheelchairs are not covered for the convenience of the caregiver, ambulatory beneficiaries and non-compliant beneficiaries.

H. The Division of Medicaid does not cover home, environment, and vehicle adaptations, equipment and modifications for motorized/power wheelchair accessibility.

I. The DME provider providing standard and/or custom motorized/power wheelchairs to beneficiaries must have at least one (1) employee with Assistive Technology Professional (ATP) certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) who specializes in wheelchairs and who must be registered with the National Registry of Rehab Technology Suppliers (NRRTS).

1. The NRRTS and RESNA certified personnel must have direct, in-person, face-to-face interaction and involvement in the motorized/power wheelchair selection for the beneficiary.

2. RESNA certifications must be updated every two (2) years.

3. NRRTS certifications must be updated annually.

4. If the certifications are found not to be current, the prior authorization request for the motorized/power wheelchair will be denied.

J. DME providers must provide a two (2) year warranty of the major components for custom motorized/power wheelchairs. [Refer to Part 209, Chapter 1, Rule 1.4.]

1. If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the DME provider is responsible for any repairs, replacement or maintenance that may be required within two (2) years.

2. The warranty begins the date of delivery to the beneficiary.

3. A powered mobility base must have a lifetime warranty on the frame against defects in material and workmanship for the lifetime of the beneficiary.

4. The main electronic controller, motors, gear boxes, and remote joystick must have a two (2) year warranty from the date of delivery.

5. Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects or if the surface does not remain intact due to normal wear.

K. DME suppliers providing custom manual and/or motorized/power wheelchairs, customized electronic interphase devices, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, with a technician available during normal business hours, between eight (8:00) a.m. and five (5:00) p.m. Monday through Friday. Each technician must keep on file records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.

L. The Division of Medicaid covers repairs, including labor and delivery, of DME that is owned by the beneficiary not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.

1. Major repairs and/or replacement of parts require prior authorization from the UM/QIO and must include an estimated cost of the necessary repairs, including labor, and a documentation from the practitioner there is a continued need for the custom manual and/or motorized/power wheelchair.

2. An explanation of time involved for repairs and/or replacement of parts must be submitted to the UM/QIO.

3. Manufacturer time guides must be followed for repairs and/or replacement of parts.

4. The Division of Medicaid defines repair time as point of service and does not include travel time to point of service.

5. No payment is made for repairs or replacement if it is determined that intentional abuse, or misuse, of the wheelchair or components has occurred, which includes damage incurred due to inappropriate covered transportation for the prescribed motorized/power wheelchair.

6. Reimbursement will be made for up to one (1) month for a rental of a wheelchair while the beneficiary's wheelchair is being repaired.

M. The Division of Medicaid does not cover a travel wheelchair that is lightweight and foldable.

Source: Social Security Act § 1834; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/02/2015. Revised eff. 01/01/2013.

Rule 1.48: Wheelchair Accessories

A. Medicaid covers manual and motorized/power wheelchair accessories and options for all beneficiaries when ordered by a physician, nurse practitioner or physician assistant, is medically necessary and prior authorized and for purchase only as follows:

1. Medical necessity is met and adequate documentation of the beneficiary's condition and needs are provided.

2. The beneficiary must already have a wheelchair that meets coverage criteria and the beneficiary's condition must be such that, without the use of a wheelchair, he/she would otherwise be bed or chair confined.

3. The amputee adapter, pair, is covered for a beneficiary with an amputation of one (1) or both lower extremities. This device mounted on the wheelchair to bring the center of gravity forward on the chair to prevent tipping over.

4. A detachable armrest is covered to allow the beneficiary to perform side transfers independently or with assistance.

5. A swing away armrest is covered to allow the beneficiary to perform side transfers independently or with assistance.

6. A mobile arm support is covered for a beneficiary to assist with ADL's or to provide support to position and/or increase function to a weak or diseased upper extremity.

7. An arm trough is covered to support beneficiaries with spasticity or decreased strength or tone in an upper extremity.

8. The anti-roll back device is covered when the beneficiary has little or no assistance and meets the criteria for a manual chair.

9. A fully reclining back is covered when one (1) of the following applies:

   a) The beneficiary is quadriplegic.

   b) The beneficiary has a fixed hip angle that prevents sitting at a ninety-degree angle.

   c) The beneficiary has trunk or lower extremity casting/bracing that requires the reclining back for positioning.

   d) The beneficiary needs to rest in a recumbent position two (2) or more times during the day and transfer between bed and chair is difficult.

10. Reinforced back and seat upholstery is covered when one (1) of the following applies:

    a) The beneficiary is morbidly obese and requires a more stable base.

    b) The beneficiary requires the extra reinforcement due to excessive movement disorders.

11. A solid back insert, planar back, single density foam, attached with straps is covered when one (1) of the following applies:

    a) The beneficiary is using a sling seating system when the back is slung and requires increased support.

    b) The beneficiary requires allowance for growth in a sling system up to one and one half inches (1½") in growing room to the thigh area. The removable back is used until the beneficiary grows and then it is removed to allow for additional growth. This allows the therapist to order a standard wheelchair with growth potential for the beneficiary.

12. A calf pad is covered if the criteria for elevating leg rests are met.

13. A cylinder tank carrier is covered for beneficiaries with constant or intermittent oxygen needs.

14. High mount, flip up footrests are covered when the beneficiary has a lower leg, knee to foot, measurement that prevents them from using the manufactured mounting.

15. A footrest, lower extension tubes, each is covered when one (1) of the following applies:

    a) The beneficiary is growing and will need the adjustability of lowering the footrests for growth.

    b) The beneficiary has a leg length difference and needs the footrest to be mounted at different heights.

16. Footplate, adjustable angle, is covered when one (1) of the following applies:

    a) The beneficiary has a fixed dorsiflexion or plantar flexion contracture.

    b) The beneficiary has the tendency to develop pressure problems on the plantar surface of the foot.

17. Heel loops, are covered when one (1) of the following applies:

    a) The beneficiary is seated in a tilt-in-space wheelchair.

b) The beneficiary has poor lower extremity muscular function and needs the support of the heel loop to keep the foot in place on the footrest.

c) The beneficiary needs the added support of a heel loop to assist in positioning of the lower extremities. This would be used for mild positioning only.

d) The heel loop with ankle strap is covered when one (1) of the following applies:

1) The beneficiary cannot control the movement of his/her lower extremities to position the foot and ankle.

2) The beneficiary is seated in a tilt-in-space wheelchair.

3) The beneficiary cannot maintain adequate positioning of the foot and ankle without an ankle strap.

4) The beneficiary has large feet or moves his/her feet excessively.

18. A hook on headrest extension, used to provide support for the head and neck, is covered if one (1) of the following applies:

a) The beneficiary has decreased to poor head/neck control and is seated in a sling seating system.

b) The beneficiary requires the use of a headrest for safety during transportation.

c) The beneficiary has frequent seizures and the headrest is used for support during or after the seizure.

d) The beneficiary has a reclining back wheelchair and requires support for the head and neck.

19. An IV hanger is covered for those beneficiaries who require continuous/intermittent IV's or tube feedings.

20. A leg strap is covered when one (1) of the following applies:

a) The beneficiary is seated in a tilt-in-space wheelchair and the strap is needed to prevent the lower extremity(ies) from falling backwards into the wheelchair.

b) The beneficiary has increased or excessive extensor tone in the lower extremities and the strap is needed in front of the lower extremities to prevent them from extending forward.

c) The beneficiary has muscle spasms of the lower extremities and requires the strap to help keep the feet positioned on the footplates.

21. The leg strap, H style, is covered if one (1) of the following applies:

    a) The beneficiary requires the added reinforcement not supplied by the single leg strap.

    b) The beneficiary has movement disorders and requires the added reinforcement of the H strap configuration.

22. Low pressure and positioning equalization pads, including one inch (1") to four inch (4") cushions for wheelchairs, are covered when one (1) or more of the following applies:

    a) The beneficiary has a history of pressure sores or decubitus ulcers.

    b) The beneficiary has a pelvic obliquity.

    c) The beneficiary is very thin and is subject to pressure problems secondary to decreased adipose tissue at the bony prominences.

    d) The beneficiary cannot move his/her trunk and/or lower extremities due to a spinal cord injury whether from birth or through an accident.

    e) The beneficiary has decreased or no sensation in the trunk and/or lower extremities.

23. A one (1) arm drive attachment is covered when both of the following apply:

    a) The beneficiary has functional use of only one (1) upper extremity.

    b) There is sufficient cognition, dexterity and endurance to use this item.

24. Shoe holders are covered when the beneficiary requires the added support of a hard surface to position the foot.

25. The safety belt/pelvic strap that is in addition to the standard safety belt is covered when medically necessary to help maintain a neutral position of the pelvis when seated in the wheelchair or for those beneficiaries with an increased extensor tone.

26. The toe loop is covered when the beneficiary requires the cover of the forefoot to keep the foot positioned on the footplate.

27. A wheelchair tray is covered when medically necessary to assist with positioning of the trunk and upper extremities.

28. The wheel lock extension pair is covered when one (1) of the following applies:

a) The beneficiary does not have functional use of one (1) upper extremity. This allows the beneficiary to reach and lock both wheels independently without falling from the wheelchair.

b) The beneficiary has decreased strength and needs the extra height of the locks to achieve a greater lever arm for independent use of the wheel locks.

B. Non-covered accessories:

1. The following items are included in the base rate of the wheelchair for all beneficiaries and are not reimbursed separately:

a) Arms of the wheelchair,

b) Footrests, also known as footplates,

c) Large size footplates on a heavy duty wheelchair for beneficiaries who meet the criteria for that type chair,

d) Leg rests,

e) Elevating leg rests,

f) Standard safety belts,

g) The manual wheel lock assembly,

h) The automatic wheel lock assembly, a device fitted to the wheelchair which automatically locks the wheels when fifty percent (50%) or more of the beneficiary's body weight shifts forward. When one (1) of the following criteria exists, these locks are considered an essential part of the wheelchair and are included in the base rate of the wheelchair.

1) The beneficiary has significant upper extremity disability or weakness and he/she cannot operate manual locks.

2) The beneficiary does not have the cognitive awareness to consistently use manual locks.

2. Crutch and cane holders mounted to the back post of the wheelchair used to transport the cane or crutch of the beneficiary while in the wheelchair are considered not medically necessary and are not covered.

C. Any other accessory medically necessary is considered for coverage on an individual basis with appropriate documentation.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(17); Social Security Act § 1834

History: Revised – 01/01/2013

Rule 1.49: Wheelchairs, Drivers and Seating, Custom

Refer to Part 209, Chapter 1, Rule 1.47 Wheelchairs

History: Revised – 01/01/2013

Rule 1.50: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Rule 1.51: Humidifier/Vaporizer

A. Medicaid defines a humidifier, heated or non-heated, as a device used to increase the moisture content of the air.

B. Medicaid covers humidifiers for all beneficiaries when ordered by a physician, nurse practitioner, or physician assistant, medically necessary and prior authorized for rental up to the purchase amount or for purchase.

C. Room Humidifiers and Vaporizers

1. Medicaid defines a room humidifier as a mechanical device used to increase the moisture content of the air in a room with a cool mist. Medicaid defines a steam vaporizer as a mechanical device that creates moisture in the air by heating the water into a hot mist. Medicaid defines a warm mist humidifier as a type of steam vaporizer that cools the moist steam before it is released into the room.

2. Room humidifiers and vaporizers are covered for beneficiaries who have a chronic diagnosis(es) indicating a respiratory condition in which ease of breathing could be facilitated by increasing the moisture content of the air. The diagnosis may include, but are not limited to:

   a) Chronic bronchitis,

   b) Asthmatic bronchitis,

   c) Chronic Asthma,

   d) Bronchopulmonary dysplasia, or

e) Chronic airway obstruction.

3. Documentation must be provided that the patient or caregiver is able to use and care for the equipment.

4. Humidifiers are not covered for acute upper respiratory infections, a chronic cough or colds unrelated to another diagnosis.

D. Medicaid defines a heat and moisture exchanger (HME), or an artificial nose, as a passive acting humidifier that collects expired heat and moisture and returns it during the following inspiration. The HME is covered when the beneficiary has:

1. An existing tracheostomy, and

2. Documentation that supplemental, direct humidification is required for the beneficiary's tracheostomy.

E. High-Flow or Water Reservoir Humidifiers

1. High-Flow, water reservoir, heated or non-heated humidifiers include, but are not limited to pass-over, wick, and bubble types. High-flow and water reservoir humidifiers are used to provide supplemental heat and humidity and are covered as follows:

a) The use of high-flow, water reservoir humidifiers to increase moisture to the airway of a beneficiary with a tracheostomy is covered when the beneficiary has an existing tracheostomy and documentation is present that the beneficiary requires supplemental, direct humidification to the tracheostomy.

b) A high-flow, water reservoir humidifier is covered for C-PAP and Bi-PAP devices if criteria for coverage of the C-PAP or BI-PAP device are satisfied and documentation is present that the beneficiary requires supplemental humidification.

c) A high-flow, water reservoir humidifier is covered in conjunction with ventilators if criteria for coverage of the ventilator are satisfied and documentation is present that the beneficiary requires supplemental humidification.

2. Humidifiers are included in the rental or purchase price of that equipment when used in conjunction with oxygen or IPPB treatments.

Source: Miss. Code Ann. § 43-13-121

History: 01/01/2013

Rule 1.52: Pressure Reducing Support Surface

A. Medicaid defines pressure reducing support surfaces as surfaces designed for beneficiaries

with limited or no mobility who are bed confined most or all of the day and prone to developing pressure ulcers.

B. Medicaid covers pressure reducing support surfaces for all eligible beneficiaries when ordered by a physician, nurse practitioner, or physician assistant, is medically necessary and prior authorized for rental up to purchase amount or purchase.

C. Beneficiaries requiring pressure reducing support surfaces must have a care plan, established by the beneficiary's physician or home care nurse, documented in the beneficiary's medical record, which includes all of the following:

1. Education of the beneficiary and caregiver on the prevention and/or management of pressure ulcers.

2. Regular assessment by a nurse, physician, or other licensed health care practitioner.

3. Appropriate turning and positioning.

4. Appropriate wound care for a stage II, III or IV ulcer.

5. Appropriate management of moisture/incontinence.

6. Nutritional assessment and intervention consistent with the overall plan of care.

D. Medicaid defines a pressure pad for a mattress as a non-powered pressure reducing mattress overlay designed to be placed on top of a standard hospital or home mattress which includes a gel mattress overlay, an air mattress overlay, a water mattress overlay and a foam mattress overlay with a waterproof cover.

1. Medicaid covers a pressure pad when one (1) or more of the following apply:

a) The beneficiary is completely immobile and cannot make changes in body position without assistance.

b) The beneficiary has limited mobility and cannot independently make changes in body position significant enough to alleviate pressure.

c) The beneficiary has any stage of a pressure ulcer on the trunk or pelvis.

d) The beneficiary is essentially bedbound with an impaired nutritional status, fecal or urinary incontinence, altered sensory perception, or compromised circulatory status.

2. A replacement pad for use with a medically necessary power alternating pressure device owned by the beneficiary is covered if the beneficiary meets one (1) or more of the criteria in Rule 1.52, D.1.a-d.

3. A foam overlay or mattress, such as an egg crate without a waterproof cover, is not

considered durable and is not covered under the DME program.

E. Powered Pressure Reducing Overlays and Mattresses

1. Medicaid defines a powered pressure reducing overlay as a low air loss, powered flotation device without low air loss, or alternating pressure with an air pump or blower providing either sequential inflation or deflation of the air cells or a low interface pressure throughout the overlay designed to reduce friction and shear and are to be placed on top of a standard hospital or home mattress.

2. Medicaid defines a powered pressure reducing mattress as a mattress with alternating pressure, low air loss, or powered flotation without low air loss. An air pump or blower provides both sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress. The surface is designed to reduce friction and shear and can be placed directly on a hospital bed frame.

3. Powered pressure reducing overlays and mattresses are covered when one (1) or more of the following applies:

   a) The beneficiary has multiple stage II pressure ulcers, defined as partial thickness skin loss involving epidermis and/or dermis, on the truck or pelvis.

   b) The beneficiary has been on a comprehensive ulcer treatment program and the ulcers have worsened or remained the same for one (1) month.

   c) Large or multiple stage III pressure ulcers, defined as full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia, or stage IV pressure ulcers, defined as full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures, on the trunk or pelvis.

   d) Myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis within the previous sixty (60) days.

Source: Miss. Code Ann. § 43-13-121

History: 01/01/2013

Part 209 Chapter 2: Medical Supplies

Rule 2.1: General Provider Information

A. The Division of Medicaid defines medical supplies as medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a beneficiary to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease and are appropriate for use in the beneficiary's home.

B. Certification or prior authorization is not required for covered medical supplies except for diapers and underpads. Providers must submit the required documentation with their claim to the fiscal agent for manual pricing.

C. All medical supplies, including those required for operation of DME, must be prescribed by a licensed, qualified physician, nurse practitioner, or physician assistant.

   1. A Medical Supply Certificate of Medical Necessity (CMN) form must be completed by the DME provider.

   2. The Medical Supply CMN form must be signed by the ordering physician, nurse practitioner, or physician assistant within thirty (30) days of the date of delivery which can be used as the physician prescription.

   3. The Medical Supply CMN form must be retained by the DME provider in the beneficiary's medical record and is subject to review by the Division of Medicaid

   4. The DME provider must provide a copy of the Medical Supply CMN form to the ordering physician, nurse practitioner, or physician assistant for their records.

D. The DME provider is responsible for compliance with all the Division of Medicaid rules, including, but not limited to:

   1. Use of the appropriate procedure code for the billed item(s),

   2. Dispensing of the appropriate medically necessary quantities of supplies,

   3. Ensuring accurate billing, and

   4. Maintaining all documentation to show compliance with Miss. Admin. Code Part 209.

E. The provider must only dispense medical supplies in quantities to meet the beneficiary's needs for one (1) calendar month.

   1. The beneficiary must request the supplies each month.

   2. Supplies cannot be shipped on an automatic basis.

F. A prescription and/or Medical Supply CMN form must be completed and signed by the ordering physician, nurse practitioner, or physician assistant every twelve (12) months.

   1. The prescription and/or Medical Supply CMN form is considered current up to twelve (12) months from the date it was signed by the physician, nurse practitioner, or physician assistant.

2. Medical supplies will be considered non-covered if there is no current prescription and/or Medical Supply CMN form in the beneficiary's medical record.

Source: 42 U.S.C. 1395m; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: Revised eff. 07/01/2015.

Rule 2.2: Covered Medical Supplies

The Division of Medicaid covers the following medical supplies when they are medically necessary and considered standard care for the treatment of a beneficiary's medical condition and dispensed in quantities that meet a beneficiary's medical needs without excessive utilization. [Refer to Miss. Admin. Code Part 207 for coverage of medical supplies in a long-term care facility.]

A. Alcohol preps, swabs, wipes and bottle are covered for quantity or number of pints appropriate for the plan of care for all beneficiaries for injection site cleanings, for self-administration, or care giver administration of intramuscular or subcutaneous injections ordered by a practitioner.

B. Apnea monitor supplies for beneficiaries who have an apnea monitor.

   1. Electrodes,

   2. Lead wires, and

   3. Battery pack.

C. Diabetic supplies for all beneficiaries who meet the criteria for:.

   1. Blood glucose monitors:

      a) Test strips,

      b) Lancets,

      c) Insulin syringes,

      d) Control solutions,

      e) Replacement battery,

      f) Spring lancet device,

      g) Autoclix lancets (spring), and

      h) Urine test or reagent strips.

2. Continuous glucose monitoring systems (CGMS):

    a) Disposable sensors,

    b) Receiver,

    c) Transmitter, and

    d) Replacement batteries.

D. Dressing supplies for all beneficiaries.

1. 4x4 non-sterile gauze pads,

2. 4x4 sterile gauze pads, including drain sponges,

3. Tape,

4. Sterile normal saline solution, 1000 ml, and

5. Gloves, sterile and non-sterile.

E. Biofeedback/Electromyography (EMG) supplies for all beneficiaries who meet criteria for biofeedback/EMG.

1. Lead wires, and

2. Electrodes.

F. Enteral Feeding supplies for all beneficiaries who meet criteria for enteral feeding pump.

1. 4x4 non-sterile gauze,

2. 4x4 sterile gauze, including drain sponges,

3. Tape,

4. Sterile solution, 1000ml,

5. Gloves, sterile and non-sterile,

6. Feeding bag(s),

7. Feeding syringe, and

8. Sterile water, 1000ml.

G. Elbow and heel protectors for all beneficiaries when one (1) of the following criteria is met:

1. The beneficiary is bed/chair confined and has a history of decubitus ulcers on a heel or elbow.

2. The patient is bed/chair confined and currently has a decubitus ulcer on a heel or elbow.

3. The beneficiary exhibits signs of redness or discomfort at bony prominences or other areas of potential breakdown

H. Hydrogen peroxide for all beneficiaries who have a tracheostomy and a wound.

I. Insulin pen needles or pre-filled insulin syringe needles for all beneficiaries receiving a pre-filled insulin injection device through the pharmacy program. Needles are covered through the medical supply program only if one (1) of the following criteria is met:

1. The patient has very poor eyesight and is unable to read the markings on a standard insulin syringe.

2. The patient has a condition of the hands that will not allow them to manipulate a vial and syringe to draw up their insulin.

J. Insulin pump supplies for all beneficiaries who meet criteria for insulin pump.

1. Cartridges,

2. Infusion sets with cannula,

3. Skin cleanser,

4. Skin prep,

5. Alcohol prep,

6. Adhesive remover,

7. Replacement batteries, and

8. Gloves, sterile.

K. Intravenous (IV) Pump, also referred to as an Infusion Pump, and supplies for all beneficiaries who meet criteria for an IV pump.

1. Cassette appropriate for pump type, and

2. Replacement batteries.

L. IV Supplies for all beneficiaries who meet criteria for an IV pump or an IV pole.

1. Central line supplies,
2. Administration set,
3. Tubing and clamp,
4. Extension set,
5. IV start kit,
6. Butterfly needles, all sizes,
7. IV catheters, all sizes,
8. Non-coring needles,
9. 2x2 gauze, sterile,
10. Tape, all types,
11. Syringe, any size without needles,
12. Syringe, any type with needle,
13. INT,
14. Flush kit,
15. Iodine prep,
16. Alcohol preps,
17. Dial-a-flow,
18. Sterile normal saline for injection - 2ml, 2.5ml, 3ml, 5ml, 10ml, 20ml, 30ml, and 50ml supplied in bottles, ampules or vials, and
19. Gloves, sterile.

M. Nebulizer supplies for all beneficiaries when criteria for nebulizer are met.

1. Administration set, disposable, non-filtered,

2. Administration set, non-disposable, non-filtered,

3. Administration set, filtered,

4. Aerosol mask, and

5. Tubing.

N. Neuromuscular Electrical Stimulator (NMES) supplies for all beneficiaries who meet criteria for neuromuscular electrical stimulator.

1. Electrodes, and

2. Lead wires.

O. Ostomy supplies for all beneficiaries who have a surgically established opening, or stoma to divert urine, feces, or illegal contents outside the body.

P. Oxygen and oxygen related supplies are covered for all beneficiaries who meet criteria for oxygen therapy.

1. E cylinders, including delivery,

2. H or K Cylinders, including delivery,

3. Tubing,

4. Face masks,

5. Nasal cannulas, and

6. Regulators.

Q. Pulse oximeter supplies, which include an oxygen probe, are covered for all beneficiaries who meet criteria for pulse oximeter monitoring.

R. A sling for all beneficiaries who have an injury or diagnosis which requires support or immobilization of an upper extremity to control pain, restrict motion, prevent further deformity, or protect the limb following trauma or surgery. The request for coverage must be supported by the beneficiary's diagnosis, the goals for use of the sling, and the expected duration of use.

S. Suction pump supplies (respiratory or gastric) for all beneficiaries who meet criteria for a suction pump.

1. Respiratory suction supplies include:

    a) Catheter kit, sterile,

    b) Suction catheter, 8-15 FR,

    c) Yankauer type respiratory suction,

    d) Respiratory suction tubing,

    e) Canister, disposable, and

    f) Gloves, any type.

2. Gastric suction supplies include:

    a) Gastric suction catheter kit,

    b) Gastric suction catheter, 8-15 FR,

    c) Gastric suction whistle tip, with valve,

    d) Gastric suction tubing,

    e) Canister, disposable,

    f) Gloves, any type, and

    g) Gastric suction tube.

T. Supplies for maintenance of drug infusion catheter, per week, for all beneficiaries who meet criteria for an IV pump.

1. Catheter insertion devices,

2. Dressing for catheter site,

3. Flush solutions not directly related to drug infusion,

4. Cannulas,

5. Needles,

6. Infusion supplies, excluding the insulin reservoir, and

7. Gloves, sterile.

U. Supplies for external drug infusion pump, per cassette or bag, for all beneficiaries who meet criteria for an IV pump.

1. Cassettes,

2. Bags,

3. Diluting solution,

4. Tubing,

5. Other administration supplies,

6. Port charges, not used for syringe-type reservoir,

7. Gloves, sterile.

V. Syringes and needles are covered for self-administration of intramuscular and/or subcutaneous injectable medication for all beneficiaries that are performing the administration of injections in the home. The Division of Medicaid does not cover for caregivers to be hospice, home health, respite and/or other provider types.

W. Transcutaneous Electrical Nerve Stimulator (TENS) supplies for all beneficiaries who meet criteria for Transcutaneous Electric Nerve Stimulator.

1. Electrodes, and

2. Lead wires.

X. Tracheostomy supplies for all beneficiaries who have a tracheostomy with documentation of the specific respiratory condition.

1. Trach mask or collar,

2. Trach or laryngectomy tube,

3. Trach, inner cannula,

4. Replacement tracheal suction catheter, any type,

5. Trach care kit, for new trach,

6. Trach care kit, for established trach,

7. Suction catheter kit, sterile,

8. Sterile water, 1000 ml,

9. Sterile normal saline for instillation, supplied in 2ml, 2.5ml, 3ml, 5ml, 10ml, 20ml, 30ml, and 50 ml bottle, ampule, or vial.

10. Trach ties,

11. Trach cleaning brush,

12. Heat and Moisture Exchangers (HME),

13. Trach shower protector,

14. Tracheostomy/laryngectomy, tube plug/stop,

15. Tracheostoma filter,

16. Gauze, and

17. Gloves, sterile.

Y. Urinary catheters

1. Urinary catheters are covered for all beneficiaries when one (1) of the following criteria is met:

   a) Beneficiary must have an acute condition which requires intermittent catheterization for measuring residual, instilling medication, or other medically necessary indication,

   b) Beneficiary has an acute condition which requires the short-term use of an indwelling catheter,

   c) Beneficiary has a chronic condition which incontinence is exacerbating pressure sores that will not heal,

   d) Beneficiary has a condition that requires accurate measurement of intake and output on a short-term basis, or

   e) Beneficiary has urinary retention that cannot be relieved by medication.

2. Supplies include:

   a) Insertion tray,

b) Irrigation tray, with bulb or piston syringe,

c) Irrigation syringe, bulb or piston,

d) Sterile solution for irrigation,

e) Female external collection device,

f) Indwelling catheter, foley, two-way,

g) Indwelling catheter, three-way,

h) Male external catheter, with or without adhesive,

i) Intermittent catheter, straight tip,

j) Bedside drainage bag,

k) Leg bag with or without strap,

l) Gloves, sterile.

3. Medicaid requires the beneficiary and/or caregiver to be capable of performing the catheterization procedure and report results and have been instructed in the procedure and properly demonstrated the ability to perform the procedure.

4. Medicaid covers condom catheters for beneficiaries with paraplegia, neurogenic bladder, or other medically necessary indications when requested with appropriate documentation.

Z. The Division of Medicaid covers supplies for manual and electric breast pumps.

Source: 42 U.S.C. 1395m; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: Added Miss. Admin. Code Part 209, Rule 2.2.C.2. eff. 07/01/2015; Revised Miss. Admin, Code Part 209, Rule 2.2.O eff. 01/02/2015; Added Miss. Admin. Code Part 209, Rule 2.2.Z., eff. 05/01/2014; Revised eff. 01/01/2013.

Rule 2.3: Non-Covered Medical Supplies

Oral Hygiene supplies that include tooth brushes, dental floss, toothpaste, toothettes, lemon glycerin swabs and other non-specific oral hygiene items.

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

History: Removed Miss. Admin. Code Part 209, Rule 2.3.B., eff. 05/01/2014.

Rule 2.4: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.5: Diapers and Underpads

A. Diapers and underpads are covered for purchase only when prior authorized for beneficiaries ages three (3) and above when ordered by a physician, nurse practitioner, physician assistant and all the following criteria is met:

    1. Documentation of medical necessity is required for all incontinence supplies.

        a) The beneficiary must meet at least two (2) of the following:

        b) Unable to control bowel or bladder functions.

        c) Unable to utilize regular toilet facilities due to a documented medical condition.

        d) Unable to physically turn self or reposition self.

        e) Unable to transfer self from bed to chair or wheelchair without assistance.

    2. The clinical documentation for incontinence supplies must include a diagnosis of incontinence.

        a) The physician must maintain documentation of the medical necessity for all incontinence supplies in the beneficiary's medical record.

        b) Only one (1) type of incontinence product is covered for any authorized period.

    3. The DME supplier must maintain a signed practitioner's order in the beneficiary's record.

        a) The order must include a start and stop date, and a detailed list of the incontinence supplies ordered.

        b) The practitioner's order must be renewed every six (6) months.

        c) The DME supplier must have a current practitioner's order to initiate or continue the provision of incontinence supplies to a beneficiary.

d) In addition to the signed practitioner's order, the DME supplier must maintain documentation of the specific quantity and description including the brand, type, and size of the incontinence supplies provided.

4. The DME supplier must maintain documentation of proof of delivery of incontinence supplies. Documentation must include the date of delivery, address of delivery, and signature of the beneficiary, caregiver, or family member who received the supplies.

B. Diapers or underpads are covered at a maximum quantity of six (6) per day.

1. In extenuating circumstances, where there is full documentation that justifies the medical necessity for more than six (6) per day, individual consideration will be given to the specific request.

2. Either diapers or underpads are covered during one authorized period but not at the same time.

C. Diapers or underpads may only be dispensed for a one (1) month supply at a time and may not be shipped on a regular basis regardless of need.

D. Providers must dispense size, waist and weight appropriate diapers based on the beneficiaries current weight. Should the DME provider need to change the size of the diaper due to a change in the beneficiary's size, the DME provider must submit a new Plan of Care.

E. For those cases where there is full documentation justifying the need for the diapers or underpads for beneficiaries whose medical condition is not expected to improve, recertification will only be required every twelve (12) months.

Source: 42 U.S.C. 1395m; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: Revised eff.01/01/2013.

Administrative Code

Title 23: Medicaid
Part 210
Ambulatory Surgical Centers

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Title 23: Division of Medicaid

Part 210: Ambulatory Surgical Centers

Part 210 Chapter 1: General

Rule 1.1: General

A. Medicaid considers an Ambulatory Surgical Center (ASC) a publicly, or privately, owned institution not considered a part of a hospital, in accordance with its function.

B. Ambulatory surgical centers must be operated by its own organized medical and administrative staff primarily for the purpose of providing elective surgical treatment for "outpatients" whose recovery under normal and routine circumstances will not require "inpatient" care.

C. The facility cannot include the offices of private physicians or dentists, whether practicing individually or in groups, but does include facilities engaged in such outpatient surgery, whether using the name "ambulatory surgical" facility or a similar or different name.

D. A facility considered to be operated by a hospital or hospital holding, leasing, or management company, whether for-profit or non-profit, must be a separate, identifiable entity which is physically, administratively and financially independent and distinct from other operations of any hospital.

E. Once licensed and certified as such, the "facility" will not be allowed to revert to the position as a component part of any hospital without securing a Certificate of Need to do so.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 416

Rule 1.2: Definitions

A. Add-on codes are defined as procedures performed in addition to the primary service/procedure and are never reported as a stand-alone code. Add-on codes describe additional intra-service work associated with the primary procedure.

B. Ambulatory surgery is defined as surgical procedure(s) that are more complex than office procedures, under local anesthesia, but less complex than procedures requiring prolonged postoperative monitoring and hospital care to ensure safe recovery and desirable results.

C. Bilateral procedures are defined as exact procedures identified by the same procedure codes which are performed on anatomically bilateral sides of the body during the same operative session.

D. Endoscopic procedure is defined as the performance of a procedure on interior organs and cavities of the body through an endoscope. An endoscope is a flexible fiber optic instrument used to visual the interior of a body cavity or organ.

E. Incidental procedure is a procedure carried out at the same time as a primary procedure, but is clinically integral to the performance of the primary procedure or requires little additional physician resources.

F. Multiple surgeries are defined as separate procedures performed by the same physician on the same patient at the same operative setting.

G. Mutually exclusive procedures are defined as separate billing for two (2) or more procedures that are usually not performed for the same patient on the same date of service.

H. Unbundled procedures are defined as the use of two (2) or more procedure codes to describe a procedure or event when a single procedure code exists that comprehensively describes the surgery performed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 416

Rule 1.3: Provider Enrollment Requirements

Ambulatory surgical centers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements listed below:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

B. Written confirmation from the IRS confirming the providers tax identification number and legal business name, and

C. Copy of Medicare certification letter:

1. EOMB not acceptable, and

2. Must be from Medicare Intermediary.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129; 42 CFR § 416

Rule 1.4: Covered Services

A. The Ambulatory Surgical Center (ASC) must have procedures for obtaining routine and emergency laboratory and radiology services from Medicare-approved facilities. The ASC, when contracting for those lab, x-ray and hospital services which directly relate to the surgical procedure, must be billed by the provider performing these services.

B. ASC services must be Medicare-approved items and services furnished by an ASC in connection with a covered surgical procedure furnished to a Medicaid beneficiary.

C. ASC services do not include items and services for which payment may be made under other provisions, such as physician services, lab, x-ray or diagnostic procedures, other than those directly related to performance of the surgical procedure.

D. Under the current ASC facility services payment system, the ASC payment rate includes all the costs incurred by the ASC in providing facility services in connection with performing a specific procedure, like surgical supplies, equipment, and nursing services.

E. Medicaid covers the cost of corneal tissue used in corneal transplant cases. The reimbursement will be one hundred percent (100%) of the cost reflected on the invoice from the donor supplier excluding transportation fees. Transportation fees are not covered under the Medicaid program. This rule is applicable only to Ambulatory Surgical Centers.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 416

Rule 1.5: Non-Covered Procedures

Non-covered services and procedures as outlined in Part 200, Chapter 2, Rule 2.2 performed in an Ambulatory Surgical Center are subject to Medicaid rules for reimbursement.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 416

Rule 1.6: Reimbursement

A. Mississippi Medicaid ASC rates are set at eighty percent (80%) of the current Medicare Ambulatory Surgical Center Payment System rate set by the Center for Medicare and Medicaid Services (CMS).

B. Reimbursement is in accordance with the Medicaid ASC Procedure Schedule or usual and customary charges, whichever is less.

C. Payment for Multiple Procedures: Rules for payment of multiple procedures, as outlined in Part 203, Chapter 4 will be applied.

D. Surgical or other procedures canceled due to scheduling conflicts of the operating suite or physician, beneficiary request, or other reason not related to medical necessity, must not be billed; and no payment will be made for the procedure. Services provided, prior to the procedure, may be billed and will be covered subject to rules for those services.

E. For surgical or other procedures canceled or terminated before completion due to changes in the beneficiary's medical condition that threaten his/her well-being, only the services that were actually performed may be billed and will be covered subject to rules for those services. Clear documentation regarding the medical necessity for cancellation or termination of the procedure must be provided.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 416

Rule 1.7: Documentation Requirements

The physician and ASC must maintain auditable records that will substantiate the services provided. The ASC must maintain a medical record for each patient. Medical records must include at least the following:

A. Patient identification,

B. Significant medical history and results of physical examination,

C. Pre-operative diagnostic studies, entered before surgery, if performed,

D. Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body,

E. Any allergies and abnormal drug reactions,

F. Entries related to anesthesia administration,

G. Documentation of properly executed informed patient consent, and

H. Discharge diagnosis and instructions.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 416

Rule 1.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 212
Rural Health Clinics

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Title 23: Division of Medicaid

Part 212: Rural Health Clinics

Part 212 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

A. To participate as a Rural Health Clinic (RHC) in the Medicaid program, an organization must be approved by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) as an RHC.

B. RHC providers must comply with the requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the specific provider type requirements outlined below:

1. National Provider Identifier (NPI), verification from the National Plan and Provider Enumeration System (NPPES),

2. A copy of the interim rate notice or current rate letter from CMS,

3. Copy of the nurse practitioner's protocol and license to practice. If the nurse practitioner is not enrolled with the Division of Medicaid as a provider, the nurse practitioner must complete a provider application and obtain an individual provider number, and

4. Clinical Laboratory Improvement Amendments (CLIA) Information form and current CLIA certificate, if applicable.

C. Medicaid payments may not be made to any organization prior to the date of approval and execution of a valid Medicaid provider agreement.

D. The effective date of the Medicaid provider enrollment will be:

1. The date of Medicare certification if the provider requests enrollment in the Medicaid program within one hundred twenty (120) days from the date the Medicare Tie-in Notice was issued to the provider, or

2. The first day of the month in which the Division of Medicaid receives the provider's completed enrollment packet if the provider requests enrollment after one hundred twenty (120) days of the issuance of the Medicare Tie-in Notice.

Source: 42 CFR § 440.20 (b); 42 CFR Part 455, Subpart E; 42 CFR Part 491; Miss. Code Ann. § 43-13-121.

History: Revised eff. 07/01/2014. Updated Miss. Admin. Code Part 212, Rule 1.1A. 05/01/13 to include 04/01/2012 compilation omission.

Rule 1.2: Service Limits

A. The Division of Medicaid limits reimbursement to a RHC to no more than four (4) encounters per beneficiary per day, provided that each encounter represents a different provider type, as the Division of Medicaid only reimburses for one (1) medically necessary encounter per beneficiary per day for each of the following provider types:

   1. A physician, physician assistant, nurse practitioner, or nurse midwife,

   2. A dentist,

   3. An optometrist, or

   4. A clinical psychologist or clinical social worker.

B. An exception to Miss. Admin. Code Part 212, Rule 1.2.A. is when the beneficiary suffers an injury or illness requiring additional diagnosis or treatment subsequent to the first encounter.

Source: 42 CFR § 440.230; Miss. Code Ann. § 43-13-121; SPA 2013-033.

History: Revised to correspond with SPA 2013-033 (eff. 11/01/2013) eff. 06/01/2015.

Rule 1.3: Covered and Non-Covered Services

A. The Division of Medicaid defines an RHC encounter as a face-to-face visit for the provision of services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers.

   1. An RHC's encounter rate covers the beneficiary's visit to the RHC, which is inclusive of all services and supplies and drugs and biologicals which are not usually self-administered by the beneficiary, furnished as an incident to a professional service.

   2. The RHC cannot refer the beneficiary to another provider that will bill the Division of Medicaid for the covered service, supply, drug or biological which is included in the RHC's encounter.

   3. Drugs are included in the encounter rate, if purchased at a discounted price through a discount agreement.

B. The Division of Medicaid covers ambulatory services performed by an RHC employee or contractual worker for an RHC beneficiary at multiple sites, including, but not limited to:

   1. The RHC,

2. A skilled nursing facility,

3. A nursing facility, or

4. Other institution used as a beneficiary's home.

C. An RHC must provide the following six (6) laboratory services on site. These services are included in the encounter rate:

1. Chemical examinations of urine by stick or tablet method or both, including urine ketones,

2. Hemoglobin or hematocrit,

3. Blood glucose,

4. Examination of stool specimens for occult blood,

5. Pregnancy tests, and

6. Primary culturing for transmittal to a certified laboratory.

D. If the RHC performs only the six (6) tests listed in Miss. Admin. Code Part 212, Rule 1.3.C., a waiver certificate from the regional Clinical Laboratory Improvement Amendments (CLIA) office must be obtained. If an RHC provides other laboratory tests on site, it must comply with CLIA requirements for the laboratory services actually provided.

E. The Division of Medicaid reimburses an outside laboratory for laboratory services not listed in Miss. Admin. Code Part 212, Rule 1.3.C. outside the encounter rate.

F. The Division of Medicaid does not cover:

1. RHC services when performed in an inpatient or outpatient hospital setting.

2. The cost of a subdermal implant as a separate service.

Source: OBRA (1990) § 4161; 42 CFR § 440.20 (b) - (c), Part 491; Miss. Code Ann. § 43-13-121; SPA 2013-033.

History: Revised eff. 06/01/2015.

Rule 1.4: Reimbursement Methodology

A. The Division of Medicaid uses the Prospective Payment System (PPS) method and an alternate payment methodology of reimbursement for RHCs which include:

1. A PPS rate per encounter as described below:

   a) For services provided on and after January 1, 2001, during calendar year 2001, payment for services shall be calculated, on a per visit basis, in an amount equal to one hundred percent (100%) of the average of the RHC's reasonable costs of providing the Division of Medicaid covered services during fiscal years 1999 and 2000. If an RHC first enrolls during fiscal year 2000, the rate will only be computed from the fiscal year 2000 Medicaid cost report. The PPS baseline calculation shall include the cost of all Medicaid covered services including other ambulatory services that were previously paid under a fee-for-service basis. This rate will be adjusted to take into account any increase or decrease in the scope of services furnished by the RHC during fiscal year 2001.

   b) Payment rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

   c) Beginning in calendar year 2002, and for each calendar year thereafter, the RHC is entitled to the payment amount, on a per visit basis, to which the RHC was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services for that calendar year, and adjusted to take into account any increase or decrease in the scope of services furnished by the RHC during that calendar year. The rate will be retroactively adjusted to reflect the MEI.

   d) New clinics that qualify for the RHC program after January 1, 2001, will be reimbursed the initial PPS rate which will be based on the rates established for other RHCs located in the same or adjacent area with a similar caseload. In the absence of comparable RHC, the rate for the new provider will be based on projected costs. The clinic's Medicare final settlement cost report for the initial cost report period year will be used to calculate a PPS base rate that is equal to one hundred (100%) of the clinic's reasonable costs of providing Medicaid covered services. If the initial cost report period represents a full year of RHC services, this final settlement rate will be considered the base rate. If the initial RHC cost report period does not represent a full year, then the rate from the first full year cost report will be used as the clinic's base rate. For each subsequent calendar year, the payment rate will be equal to the rate established in the preceding calendar year, increased by the percentage increase in the MEI for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year. If a clinic's base year cost report is amended, the clinic's PPS base rate will be adjusted based on the Medicare final settlement amended cost report. The clinic's original PPS base rate and the rates for each subsequent fiscal year will be recalculated per the payment methodology outlined above. Claims payments will be adjusted retroactive to the effective date of the original rate.

2. An alternate payment methodology, effective November 1, 2013, which is an additional fee for certain services provided outside the Division of Medicaid's regularly scheduled office hours.

   a) The Division of Medicaid defines regularly scheduled office hours as the hours between 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding Saturday, Sunday and federal and state holidays, referred to in Miss. Admin. Code, Part 212, Rule 1.4.A.2 as "office hours".

   b) The Division of Medicaid permits RHCs to set regularly scheduled office hours outside of the Division of Medicaid's definition of office hours, referred to in Miss. Admin. Code, Part 212, Rule 1.4.A.2. as "RHC established office hours".

   c) The RHC must maintain records indicating RHC established office hours and any changes including:

      1) The date of the change,

      2) The RHC established office hours prior to the change, and

      3) The new RHC established office hours.

   d) The Division of Medicaid reimburses a fee in addition to the encounter rate when the encounter:

      1) Occurs during the RHC established office hours which are set outside of the Division of Medicaid's office hours, or

      2) Occurs outside of office hours or the RHC established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or RHC established office hours.

   e) The Division of Medicaid reimburses only the appropriate encounter rate for an encounter scheduled during office hours or RHC established office hours but not occurring until after office hours or RHC established office hours.

B. All services provided in an inpatient hospital setting, outpatient hospital setting, or a hospital's emergency room will be reimbursed on a fee-for-service basis. If a physician employed by an RHC provides physician services at an inpatient, outpatient, or emergency room hospital setting, the services must be billed under the individual physician's Medicaid provider number and payment will be made directly to the physician. The financial arrangement between the physician and the RHC must be handled through an agreement.

C. An RHC must request an adjustment to its PPS rate whenever there is a documented change in the scope of services. The adjustment will be granted only if the change in scope of

services results in at least a five percent (5%) increase or decrease in the clinic's PPS rate for the calendar year in which the change in scope of service took place.

1. The Division of Medicaid defines a change in the scope of service as a change in the type, intensity, duration and/or amount of services including:

   a) The addition of a new service, including, but not limited to dental, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), optometry, obstetrics/gynecology (OB/GYN), laboratory, radiology, pharmacy, outreach, case management, transportation, which were not previously provided by the RHC, and/or

   b) The elimination of an existing service provided by the RHC.

2. A change in the scope of service does not mean:

   a) The addition or reduction of staff members to or from an existing service and/or

   b) An increase or decrease in the number of encounters.

3. A change in the cost of a service is not considered in and of itself a change in the scope of service.

4. It is the responsibility of the RHC to notify the Division of Medicaid of any change in the scope of service(s) and provide required documentation to support the rate change. Such required documentation should include, at minimum, a detailed working trial balance demonstrating the increase or decrease in the RHC's PPS rate as a result of the change in scope of service(s). The Division of Medicaid may require the RHC to provide such documentation in a format acceptable to the Division of Medicaid, including providing such documentation upon the Division of Medicaid's pre-approved forms. The Division of Medicaid may also request additional information as it sees fit in order to sufficiently determine whether any change in scope of service(s) has occurred.

D. Cost Reports

1. All RHCs must submit to the Division of Medicaid a copy of their Medicare cost report for information purposes using the appropriate Medicare forms postmarked on or before the last day of the fifth (5th) month following the close of its Medicare cost-reporting year. All filing requirements shall be the same as for Title XVIII. When the due date of the cost report falls on a weekend or State of Mississippi or federal holiday, the cost report is due on the following business day. Extensions of time for filing cost reports will not be granted by the Division of Medicaid except for those supported by written notification of the extension granted by Title XVIII. Cost reports must be prepared in accordance with the State Plan for reimbursement of RHCs. The RHC's cost report should include information on all satellite RHCs.

2. If the Medicare cost report is not received within thirty (30) days of the due date, payment of claims will be suspended until receipt of the required report. This penalty can only be waived by the Executive Director of the Division of Medicaid.

3. An RHC that does not file a Medicare cost report within six (6) calendar months after the close of its Medicare cost reporting year may be subject to cancellation of its provider agreement at the Division of Medicaid's discretion.

Source: OBRA (1990) § 4161; 42 CFR §§ 440.20 (b) - (c), 447.371, Part 491; Miss. Code Ann. § 43-13-121; SPA 2013-033.

History: Revised to correspond with SPA 2013-033 (eff. 11/01/13) eff. 06/01/2015.

Rule 1.5: Documentation Requirements

The Division of Medicaid requires RHCs to maintain auditable records that will substantiate the services provided. At a minimum, the records must contain the following on each patient:

A. Date of service,

B. Beneficiary's presenting complaint,

C. Provider's findings,

D. Treatment rendered, and

E. Provider's signature.

Source: 42 CFR § 440.20 (b) - (c), Part 491; Miss. Code Ann. § 43-13-121.

Rule 1.6: Co-Mingling

A. The Division of Medicaid does not allow co-mingling which is defined as the simultaneous operation of an RHC and another physician practice where the two (2) practices share:

   1. Hours of operation,

   2. Use of the space,

   3. Professional staff,

   4. Equipment,

   5. Supplies, and

   6. Other resources.

B. Physicians and non-physician practitioners cannot operate a private Medicare or Medicaid practice during RHC hours of operation using the RHC's resources.

Source: 42 CFR Part 491; Miss. Code Ann. § 43-13-121.

Rule 1.7: Pregnancy Related Eligibles

The Division of Medicaid covers women who are eligible for Medicaid only because of pregnancy for full Medicaid benefits during the course of their pregnancy and for sixty (60) days following delivery including any remaining days in the month in which the sixtieth (60th) day occurs.

Source: 42 CFR §§ 435.116, 440.20 (b) - (c), Part 491; Miss. Code Ann. § 43-13-121; SPA 13-0019.

History: Revised to correspond with SPA 13-0019 (eff. 01/01/2014) eff. 06/01/2015.

Rule 1.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 211
Federally Qualified Health Centers (FQHC)

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Title 23: Division of Medicaid

Part 211: Federally Qualified Health Centers

Part 211 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

A. To participate as a Federally Qualified Health Center (FQHC) or FQHC look-alike in the Medicaid program, an organization must be approved by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) as an FQHC or FQHC look-alike.

B. FQHC or FQHC look-alike providers must comply with the requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the specific provider type requirements outlined below:

National Provider Identifier (NPI), verification from the National Plan and Provider Enumeration System (NPPES),

2. Written confirmation from the IRS confirming provider's tax identification number and noted Legal Business Name, and

3. Medicare Cost Report.

C. Medicaid payments may not be made to any organization prior to the date of approval and execution of a valid Medicaid provider agreement.

D. The effective date of the Medicaid provider enrollment will be:

1. The date of Medicare certification if the provider requests enrollment in the Medicaid program within one hundred twenty (120) days from the date the Medicare Tie-in Notice was issued to the provider, or

2. The first day of the month in which the Division of Medicaid receives the provider's completed enrollment packet if the provider requests enrollment after one hundred twenty (120) days of the issuance of the Medicare Tie-in Notice.

Source: 42 USC § 1396a; 42 CFR Part 491; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129.

History: Revised eff. 06/01/2015. Revised eff. 07/01/2014.

Rule 1.2: Service Limits

A. The Division of Medicaid limits reimbursement to an FQHC and FQHC look-alike to no more than four (4) encounters per beneficiary per day, provided that each encounter represents a different provider type, as the Division of Medicaid only reimburses for one (1) medically necessary encounter per beneficiary per day for each of the following provider types:

1. A physician, physician assistant, nurse practitioner, or nurse midwife,

2. A dentist,

3. An optometrist, or

4. A clinical psychologist or clinical social worker.

B. An exception to Miss. Admin. Code Part 211, Rule 1.2.A. is when the beneficiary suffers an injury or illness requiring additional diagnosis or treatment subsequent to the first encounter.

Source: 42 CFR § 440.230; Miss. Code Ann. § 43-13-121; SPA 2013-032.

History: Revised to correspond with SPA 2013-032 (eff. 11/01/2013) eff. 06/01/2015.

Rule 1.3: Covered Services and Non-Covered Services

The Division of Medicaid defines an FQHC or FQHC look-alike encounter as a face-to-face visit for the provision of services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers.

1. An FQHC's or FQHC look-alike's encounter rate covers the beneficiary's visit to the FQHC or FQHC look-alike, which is inclusive of all services and supplies and drugs and biologicals which are not usually self-administered by the beneficiary, furnished as an incident to a professional service.

2. The FQHC or FQHC look-alike cannot refer the beneficiary to another provider that will bill the Division of Medicaid for the covered service, supply, drug or biological which is included in the FQHC's or FQHC look-alike's encounter.

3. Drugs are included in the encounter rate, if purchased at a discounted price through a discount agreement.

B. The Division of Medicaid covers ambulatory services performed by an FQHC or FQHC look-alike employee or contractual worker for an FQHC or an FQHC look-alike beneficiary at multiple sites, including, but not limited to:

1. The FQHC or FQHC look-alike,

2. A skilled nursing facility,

3. A nursing facility, or

4. Other institution used as a beneficiary's home.

C. The Division of Medicaid covers an outside laboratory for lab services outside the encounter rate.

D. The Division of Medicaid does not cover:

1. FQHC or FQHC look-alike services when performed in an inpatient or outpatient hospital setting.

2. The cost of a subdermal implant as a separate service.

Source: 42 CFR Part 491; Miss. Code Ann. 43-13-121.

History: Revised eff. 06/01/2015.

Rule 1.4: Pregnancy-Related Eligibles

The Division of Medicaid covers women who are eligible for Medicaid only because of pregnancy for full Medicaid benefits during the course of their pregnancy and for sixty (60) days following delivery including any remaining days in the month in which the sixtieth (60th) day occurs.

Source: 42 CFR § 435.116, Part 491; Miss. Code Ann. § 43-13-121; SPA 13-0019.

History: Revised to correspond with SPA 13-0019 (eff. 01/01/2014) eff. 06/01/2015.

Rule 1.5: Reimbursement Methodology

A. The Division of Medicaid uses the Prospective Payment System (PPS) method and an alternate payment methodology of reimbursement for Federally Qualified Health Centers (FQHCs) and FQHC look-alikes which include:

1. A PPS rate per encounter as described below:

a) For services provided on and after January 1, 2001, during calendar year 2001, payment for services shall be calculated, on a per visit basis, in an amount equal to one hundred percent (100%) of the average of the FQHC's or FQHC look-alike's reasonable costs of providing Medicaid covered services during fiscal years 1999 and 2000. The average rate will be computed from the FQHC or FQHC look-alike Medicaid cost reports by applying a forty percent (40%) weight to fiscal year 1999 and a sixty percent (60%) weight to fiscal year 2000 and adding those rates together. If an FQHC or FQHC look-alike first qualifies during fiscal year 2000, the rate will

only be computed from the fiscal year 2000 Medicaid cost report. The PPS baseline calculation shall include the cost of all Medicaid covered services including other ambulatory services that were previously paid under a fee-for-service basis. This rate will be adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC or FQHC look-alike during fiscal year 2001.

b) Payment rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

c) Beginning in calendar year 2002, and for each calendar year thereafter, the FQHC or FQHC look-alike is entitled to the payment amount, on a per visit basis, to which the FQHC or FQHC look-alike was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services for that calendar year, and adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC or FQHC look-alike during that calendar year. The rate will be retroactively adjusted to reflect the MEI.

d) New centers that qualify for the FQHC or FQHC look-alike program after January 1, 2001, will be reimbursed the initial PPS rate which will be based on the rates established for other FQHCs and FQHC look-alikes located in the same or adjacent area with a similar caseload. In the absence of a comparable FQHC or FQHC look-alike, the rate for the new provider will be based on projected costs. After the FQHC's or FQHC look-alike's initial year, a Medicaid cost report must be filed in accordance with the State Plan. The cost report will be desk reviewed and a rate will be calculated in an amount equal to one hundred percent (100%) of the FQHC's or FQHC look-alike's reasonable costs of providing Medicaid covered services. The FQHC or FQHC look-alike may be subject to a retroactive adjustment based on the difference between projected and actual allowable costs. Claims payments will be adjusted retroactive to the effective date of the original rate. For each subsequent calendar year, the payment rate will be equal to the rate established in the preceding calendar year, increased by the percentage increase in the MEI for primary care services that is published in the Federal Register in the 4th quarter of the preceding calendar year.

2. An alternate payment methodology, effective November 1, 2013, which is an additional fee for certain services provided outside the Division of Medicaid's regularly scheduled office hours.

a) The Division of Medicaid defines regularly scheduled office hours as the hours between 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding Saturday, Sunday and federal and state holidays, referred to in Miss. Admin. Code, Part 211, Rule 1.5.A.2. as "office hours".

b) The Division of Medicaid permits FQHCs and FQHC look-alikes to set regularly scheduled office hours outside of the Division of Medicaid's definition of office hours, referred to in Miss. Admin. Code, Part 211, Rule 1.5.A.2. as "FQHC or FQHC

look-alike established office hours".

c) The FQHCs and FQHC look-alikes must maintain records indicating FQHC and FQHC look-alike established office hours and any changes including:

1) The date of the change,

2) The FQHC and FQHC look-alike established office hours prior to the change, and

3) The new FQHC and FQHC look-alike established office hours.

d) The Division of Medicaid reimburses a fee in addition to the encounter rate when the encounter:

1) Occurs during the FQHC or FQHC look-alike established office hours which are set outside of the Division of Medicaid's definition of office hours, or

2) Occurs outside of office hours or the FQHC or FQHC look-alike established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or provider established office hours.

e) The Division of Medicaid reimburses only the appropriate encounter rate for an encounter scheduled during office hours or FQHC and FQHC look-alike established office hours but not occurring until after office hours or FQHC and FQHC look-alike established office hours.

3. An additional fee per completed transmission, for telehealth services provided by the FQHC and FQHC look-alike acting as the originating site, which meets the requirements in Miss. Admin. Code Part 225, Chapter 1, effective January 1, 2015.

B. All services provided in an inpatient hospital setting, outpatient hospital setting or a hospital's emergency room will be reimbursed on a fee-for-service basis. If a physician employed by an FQHC or FQHC look-alike provides physician services at an inpatient, outpatient, or emergency room hospital setting, the services must be billed under the individual physician's Medicaid provider number and payment will be made directly to the physician. The financial arrangement between the physician and the FQHC or FQHC look-alike must be handled through an agreement.

C. An FQHC or FQHC look-alike must request an adjustment to its PPS rate whenever there is a documented change in the scope of services. The adjustment will be granted only if the change in scope of services results in at least a five percent (5%) increase or decrease in the center's PPS rate for the calendar year in which the change in scope of service took place.

1. The Division of Medicaid defines a change in the scope of service as a change in the type, intensity, duration and/or amount of service including:

a) The addition of a new service, including, but not limited to, dental, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), optometry, obstetrics/gynecology (OB/GYN), laboratory, radiology, pharmacy, outreach, case management, transportation, which were not previously provided by the FQHC or FQHC look-alike, and/or

b) The elimination of an existing service provided by the FQHC or FQHC look-alike.

2. A change in the scope of service does not mean:

   a) The addition or reduction of staff members to or from an existing service, and/or

   b) An increase or decrease in the number of encounters.

3. A change in the cost of a service is not considered in and of itself a change in the scope of service.

4. It is the responsibility of the FQHC or FQHC look-alike to notify the Division of Medicaid of any change in the scope of service and provide required documentation to support the rate change. Such required documentation should include, at minimum, a detailed working trial balance demonstrating the increase or decrease in the FQHC's or FQHC look-alike's PPS rate as a result of the change in scope of service. The Division of Medicaid may require the FQHC or FQHC look-alike to provide such documentation in a format acceptable to the Division of Medicaid, including providing such documentation upon the Division of Medicaid's pre-approved forms. The Division of Medicaid may also request additional information as it sees fit in order to sufficiently determine whether any change in scope of service has occurred.

D. Cost Reports

1. All FQHCs and FQHC look-alikes must submit to the Division of Medicaid a copy of their Medicare cost report for information purposes using the appropriate Medicare forms postmarked on or before the last day of the fifth (5th) month following the close of its Medicare cost reporting year. All filing requirements must be the same as for Title XVIII. When the due date of the cost report falls on a weekend or State of Mississippi or federal holiday, the cost report is due on the following business day. Extensions of time for filing cost reports will not be granted by the Division of Medicaid except for those supported by written notification of the extension granted by Title XVIII. Cost reports must be prepared in accordance with the policy for reimbursement of FQHCs and FQHC look-alikes. The FQHC's or FQHC look-alike's cost report must include information on all satellite FQHCs or FQHC look-alikes.

2. If the Medicare cost report is not received within thirty (30) days of the due date, payment of claims will be suspended until receipt of the required report. This penalty can only be waived by the Executive Director of the Division of Medicaid.

3. An FQHC or FQHC look-alike that does not file a Medicare cost report within six (6) calendar months after the close of its Medicare cost reporting year may be subject to cancellation of its provider agreement at the Division of Medicaid's discretion.

Source: 42 CFR Part 491; Miss. Code Ann. § 43-13-121; SPA 2013-032; SPA 15-003.

History: Added Miss. Admin. Code Part 212, Rule 1.5.A.3. to correspond with SPA 15-003 (eff. 01/01/2015) eff. 12/01/2015; Revised to correspond with SPA 2013-032 (eff. 11/01/2013) eff. 06/01/2015.

Rule 1.6: Documentation Requirements

The Division of Medicaid requires FQHCs and FQHC look-alikes to maintain auditable records that substantiate the services provided. At a minimum, the records must contain the following on each beneficiary:

A. Date of service,

B. Beneficiary's presenting complaint,

C. Provider's findings,

D. Treatment rendered, and

E. Provider's signature.

Source: 42 CFR Part 491; Miss. Code Ann. § 43-13-121.

History: Revised eff. 06/01/2015.

Rule 1.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

MISSISSIPPI DIVISION OF
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Title 23: Medicaid
Part 212
Rural Health Clinics

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Title 23: Division of Medicaid

Part 212: Rural Health Clinics

Part 212 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

A. To participate as a Rural Health Clinic (RHC) in the Medicaid program, an organization must be approved by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) as an RHC.

B. RHC providers must comply with the requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the specific provider type requirements outlined below:

1. National Provider Identifier (NPI), verification from the National Plan and Provider Enumeration System (NPPES),

2. A copy of the interim rate notice or current rate letter from CMS,

3. Copy of the nurse practitioner's protocol and license to practice. If the nurse practitioner is not enrolled with the Division of Medicaid as a provider, the nurse practitioner must complete a provider application and obtain an individual provider number, and

4. Clinical Laboratory Improvement Amendments (CLIA) Information form and current CLIA certificate, if applicable.

C. Medicaid payments may not be made to any organization prior to the date of approval and execution of a valid Medicaid provider agreement.

D. The effective date of the Medicaid provider enrollment will be:

1. The date of Medicare certification if the provider requests enrollment in the Medicaid program within one hundred twenty (120) days from the date the Medicare Tie-in Notice was issued to the provider, or

2. The first day of the month in which the Division of Medicaid receives the provider's completed enrollment packet if the provider requests enrollment after one hundred twenty (120) days of the issuance of the Medicare Tie-in Notice.

Source: 42 CFR § 440.20 (b); 42 CFR Part 455, Subpart E; 42 CFR Part 491; Miss. Code Ann. § 43-13-121.

History: Revised eff. 07/01/2014. Updated Miss. Admin. Code Part 212, Rule 1.1A. 05/01/13 to include 04/01/2012 compilation omission.

Rule 1.2: Service Limits

A. The Division of Medicaid limits reimbursement to a RHC to no more than four (4) encounters per beneficiary per day, provided that each encounter represents a different provider type, as the Division of Medicaid only reimburses for one (1) medically necessary encounter per beneficiary per day for each of the following provider types:

   1. A physician, physician assistant, nurse practitioner, or nurse midwife,

   2. A dentist,

   3. An optometrist, or

   4. A clinical psychologist or clinical social worker.

B. An exception to Miss. Admin. Code Part 212, Rule 1.2.A. is when the beneficiary suffers an injury or illness requiring additional diagnosis or treatment subsequent to the first encounter.

Source: 42 CFR § 440.230; Miss. Code Ann. § 43-13-121; SPA 2013-033.

History: Revised to correspond with SPA 2013-033 (eff. 11/01/2013) eff. 06/01/2015.

Rule 1.3: Covered and Non-Covered Services

A. The Division of Medicaid defines an RHC encounter as a face-to-face visit for the provision of services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers.

   1. An RHC's encounter rate covers the beneficiary's visit to the RHC, which is inclusive of all services and supplies and drugs and biologicals which are not usually self-administered by the beneficiary, furnished as an incident to a professional service.

   2. The RHC cannot refer the beneficiary to another provider that will bill the Division of Medicaid for the covered service, supply, drug or biological which is included in the RHC's encounter.

   3. Drugs are included in the encounter rate, if purchased at a discounted price through a discount agreement.

B. The Division of Medicaid covers ambulatory services performed by an RHC employee or contractual worker for an RHC beneficiary at multiple sites, including, but not limited to:

   1. The RHC,

   2. A skilled nursing facility,

   3. A nursing facility, or

4. Other institution used as a beneficiary's home.

C. An RHC must provide the following six (6) laboratory services on site. These services are included in the encounter rate:

1. Chemical examinations of urine by stick or tablet method or both, including urine ketones,

2. Hemoglobin or hematocrit,

3. Blood glucose,

4. Examination of stool specimens for occult blood,

5. Pregnancy tests, and

6. Primary culturing for transmittal to a certified laboratory.

D. If the RHC performs only the six (6) tests listed in Miss. Admin. Code Part 212, Rule 1.3.C., a waiver certificate from the regional Clinical Laboratory Improvement Amendments (CLIA) office must be obtained. If an RHC provides other laboratory tests on site, it must comply with CLIA requirements for the laboratory services actually provided.

E. The Division of Medicaid reimburses an outside laboratory for laboratory services not listed in Miss. Admin. Code Part 212, Rule 1.3.C. outside the encounter rate.

F. The Division of Medicaid does not cover:

1. RHC services when performed in an inpatient or outpatient hospital setting.

2. The cost of a subdermal implant as a separate service.

Source: OBRA (1990) § 4161; 42 CFR § 440.20 (b) - (c), Part 491; Miss. Code Ann. § 43-13-121; SPA 2013-033.

History: Revised eff. 06/01/2015.

Rule 1.4: Reimbursement Methodology

A. The Division of Medicaid uses the Prospective Payment System (PPS) method and an alternate payment methodology of reimbursement for Rural Health Centers (RHCs) which include:

1. A PPS rate per encounter as described below:

a) For services provided on and after January 1, 2001, during calendar year 2001, payment for services shall be calculated, on a per visit basis, in an amount equal to one hundred percent (100%) of the average of the RHC's reasonable costs of providing the Division of Medicaid covered services during fiscal years 1999 and 2000. If an RHC first enrolls during fiscal year 2000, the rate will only be computed from the fiscal year 2000 Medicaid cost report. The PPS baseline calculation shall include the cost of all Medicaid covered services including other ambulatory services that were previously paid under a fee-for-service basis. This rate will be adjusted to take into account any increase or decrease in the scope of services furnished by the RHC during fiscal year 2001.

b) Payment rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

c) Beginning in calendar year 2002, and for each calendar year thereafter, the RHC is entitled to the payment amount, on a per visit basis, to which the RHC was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services for that calendar year, and adjusted to take into account any increase or decrease in the scope of services furnished by the RHC during that calendar year. The rate will be retroactively adjusted to reflect the MEI.

d) New clinics that qualify for the RHC program after January 1, 2001, will be reimbursed the initial PPS rate which will be based on the rates established for other RHCs located in the same or adjacent area with a similar caseload. In the absence of comparable RHC, the rate for the new provider will be based on projected costs. The clinic's Medicare final settlement cost report for the initial cost report period year will be used to calculate a PPS base rate that is equal to one hundred percent (100%) of the clinic's reasonable costs of providing Medicaid covered services. If the initial cost report period represents a full year of RHC services, this final settlement rate will be considered the base rate. If the initial RHC cost report period does not represent a full year, then the rate from the first full year cost report will be used as the clinic's base rate. For each subsequent calendar year, the payment rate will be equal to the rate established in the preceding calendar year, increased by the percentage increase in the MEI for primary care services that is published in the Federal Register in the fourth (4th) quarter of the preceding calendar year. If a clinic's base year cost report is amended, the clinic's PPS base rate will be adjusted based on the Medicare final settlement amended cost report. The clinic's original PPS base rate and the rates for each subsequent fiscal year will be recalculated per the payment methodology outlined above. Claims payments will be adjusted retroactive to the effective date of the original rate.

2. An alternate payment methodology, effective November 1, 2013, which is an additional fee for certain services provided outside the Division of Medicaid's regularly scheduled office hours.

a) The Division of Medicaid defines regularly scheduled office hours as the hours

between 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding Saturday, Sunday and federal and state holidays, referred to in Miss. Admin. Code, Part 212, Rule 1.4.A.2 as "office hours".

b) The Division of Medicaid permits RHCs to set regularly scheduled office hours outside of the Division of Medicaid's definition of office hours, referred to in Miss. Admin. Code, Part 212, Rule 1.4.A.2. as "RHC established office hours".

c) The RHC must maintain records indicating RHC established office hours and any changes including:

1) The date of the change,

2) The RHC established office hours prior to the change, and

3) The new RHC established office hours.

d) The Division of Medicaid reimburses a fee in addition to the encounter rate when the encounter:

1) Occurs during the RHC established office hours which are set outside of the Division of Medicaid's office hours, or

2) Occurs outside of office hours or the RHC established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or RHC established office hours.

e) The Division of Medicaid reimburses only the appropriate encounter rate for an encounter scheduled during office hours or RHC established office hours but not occurring until after office hours or RHC established office hours.

3. An additional fee per completed transmission, for telehealth services provided by the RHC acting as the originating site, which meets the requirements in Miss. Admin. Code Part 225, Chapter 1, effective January 1, 2015.

B. All services provided in an inpatient hospital setting, outpatient hospital setting, or a hospital's emergency room will be reimbursed on a fee-for-service basis. If a physician employed by an RHC provides physician services at an inpatient, outpatient, or emergency room hospital setting, the services must be billed under the individual physician's Medicaid provider number and payment will be made directly to the physician. The financial arrangement between the physician and the RHC must be handled through an agreement.

C. An RHC must request an adjustment to its PPS rate whenever there is a documented change in the scope of services. The adjustment will be granted only if the change in scope of services results in at least a five percent (5%) increase or decrease in the clinic's PPS rate for

the calendar year in which the change in scope of service took place.

1. The Division of Medicaid defines a change in the scope of service as a change in the type, intensity, duration and/or amount of services including:

   a) The addition of a new service, including, but not limited to dental, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), optometry, obstetrics/gynecology (OB/GYN), laboratory, radiology, pharmacy, outreach, case management, transportation, which were not previously provided by the RHC, and/or

   b) The elimination of an existing service provided by the RHC.

2. A change in the scope of service does not mean:

   a) The addition or reduction of staff members to or from an existing service and/or

   b) An increase or decrease in the number of encounters.

3. A change in the cost of a service is not considered in and of itself a change in the scope of service.

4. It is the responsibility of the RHC to notify the Division of Medicaid of any change in the scope of service(s) and provide required documentation to support the rate change. Such required documentation should include, at minimum, a detailed working trial balance demonstrating the increase or decrease in the RHC's PPS rate as a result of the change in scope of service(s). The Division of Medicaid may require the RHC to provide such documentation in a format acceptable to the Division of Medicaid, including providing such documentation upon the Division of Medicaid's pre-approved forms. The Division of Medicaid may also request additional information as it sees fit in order to sufficiently determine whether any change in scope of service(s) has occurred.

D. Cost Reports

1. All RHCs must submit to the Division of Medicaid a copy of their Medicare cost report for information purposes using the appropriate Medicare forms postmarked on or before the last day of the fifth (5th) month following the close of its Medicare cost-reporting year. All filing requirements shall be the same as for Title XVIII. When the due date of the cost report falls on a weekend or State of Mississippi or federal holiday, the cost report is due on the following business day. Extensions of time for filing cost reports will not be granted by the Division of Medicaid except for those supported by written notification of the extension granted by Title XVIII. Cost reports must be prepared in accordance with the State Plan for reimbursement of RHCs. The RHC's cost report should include information on all satellite RHCs.

2. If the Medicare cost report is not received within thirty (30) days of the due date, payment of claims will be suspended until receipt of the required report. This penalty can only be waived by the Executive Director of the Division of Medicaid.

3. An RHC that does not file a Medicare cost report within six (6) calendar months after the close of its Medicare cost reporting year may be subject to cancellation of its provider agreement at the Division of Medicaid's discretion.

Source: OBRA (1990) § 4161; 42 CFR §§ 440.20 (b) - (c), 447.371, Part 491; Miss. Code Ann. § 43-13-121; SPA 2013-033; SPA 15-003.

History: Added Miss. Admin. Code Part 212, Rule 1.4.A.3. to correspond with SPA 15-003 (eff. 01/01/2015) eff. 12/01/2015; Revised to correspond with SPA 2013-033 (eff. 11/01/13) eff. 06/01/2015.

Rule 1.5: Documentation Requirements

The Division of Medicaid requires RHCs to maintain auditable records that will substantiate the services provided. At a minimum, the records must contain the following on each patient:

A. Date of service,

B. Beneficiary's presenting complaint,

C. Provider's findings,

D. Treatment rendered, and

E. Provider's signature.

Source: 42 CFR § 440.20 (b) - (c), Part 491; Miss. Code Ann. § 43-13-121.

Rule 1.6: Co-Mingling

A. The Division of Medicaid does not allow co-mingling which is defined as the simultaneous operation of an RHC and another physician practice where the two (2) practices share:

1. Hours of operation,

2. Use of the space,

3. Professional staff,

4. Equipment,

5. Supplies, and

6. Other resources.

B. Physicians and non-physician practitioners cannot operate a private Medicare or Medicaid practice during RHC hours of operation using the RHC's resources.

Source: 42 CFR Part 491; Miss. Code Ann. § 43-13-121.

Rule 1.7: Pregnancy Related Eligibles

The Division of Medicaid covers women who are eligible for Medicaid only because of pregnancy for full Medicaid benefits during the course of their pregnancy and for sixty (60) days following delivery including any remaining days in the month in which the sixtieth (60th) day occurs.

Source: 42 CFR §§ 435.116, 440.20 (b) - (c), Part 491; Miss. Code Ann. § 43-13-121; SPA 13-0019.

History: Revised to correspond with SPA 13-0019 (eff. 01/01/2014) eff. 06/01/2015.

Rule 1.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 213
Therapy Services

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Title 23: Division of Medicaid

Part 213: Therapy Services

Part 213 Chapter 1: Physical Therapy

Rule 1.1: Provider Enrollment Requirements for Physical Therapist

Providers of physical therapy must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the provider specific requirements outlined below:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System **(**NPPES),

B. Copy of licensure card or letter from the appropriate board stating current certification and must be from state of servicing location, and

C. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E

Rule 1.2: Definitions

A. Medicaid defines physical therapy services as medically prescribed services designed to develop, improve or restore neuro-muscular or sensory-motor function, relieve pain, or control postural deviations. Services are concerned with the prevention of disability, and rehabilitation for congenital or acquired disabilities, resulting from or secondary to injury or disease.

B. Medicaid defines a physical therapist as an individual who meets the state and federal licensing and/or certification requirements to perform physical therapy services.

C. Medicaid defines a physical therapy assistant as an individual who meets state and federal licensing and/or certification requirements to assist in the practice of physical therapy services under the supervision of a licensed physical therapist.

D. Medicaid defines a physical therapy aide as an individual who assists the physical therapist and the physical therapist assist in the practice of physical therapy. The physical therapy aide performs services under the supervision of the licensed physical therapist or licensed physical therapist assistant.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110

Rule 1.3: Covered Physical Therapy Services

A. The Division of Medicaid covers physical therapy services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity to treat a beneficiary's illness, condition, or injury and the following requirements are met:

    1. The services require the knowledge, skill and judgment of a state-licensed physical therapist.

    2. The Certificate of Medical Necessity (CMN) for the initial referral/order is completed by the prescribing provider prior to the physical therapy evaluation.

    3. The plan of care (POC) is developed by a state-licensed physical therapist.

    4. The prescribing provider approves the initial/revised POC with a signature and date:

        a) Before the initiation of treatment or change in treatment, or

        b) Within thirty (30) calendar days of the verbal order for the initial treatment plan or change in treatment.

    5. The services are rendered as individualized therapy consistent with the symptomatology/diagnosis and do not exceed the beneficiary's needs.

    6. The services do not duplicate another provider's services including those services provided in a school-based setting.

B. The Division of Medicaid reimburses for covered physical therapy services provided by:

    1. A state-licensed physical therapist.

    2. A state-licensed physical therapist assisted by a state-licensed physical therapist assistant under direct, on-site supervision by a state-licensed physical therapist.

        a) The Division of Medicaid defines direct, onsite supervision as face-to-face oversight by a state-licensed physical therapist at regular intervals, as prescribed in regulations adopted by the Mississippi State Board of Physical Therapy and does not include:

            1) Contacts by telephone,

            2) Contacts by pager,

            3) Video conferencing, and/or

4) Any method not approved by the Division of Medicaid.

b) The initial evaluation, POC, and discharge summary must be completed by a state-licensed physical therapist.

3. A state-licensed physical therapist assisted by a physical therapy student who is enrolled in an accredited physical therapy program while completing the clinical requirements necessary for graduation under direct, on-site supervision of a state-licensed physical therapist, referred to as student assisted physical therapy services.

   a) The Division of Medicaid defines direct, on-site supervision of a physical therapy student as the face-to-face oversight by a state-licensed physical therapist.

   b) The state-licensed physical therapist must be physically present and engaged in student oversight during the entirety of a physical therapy session such that the state-licensed physical therapist is considered to be providing the physical therapy service.

C. The state-licensed physical therapist cannot supervise at the same time during the work day more than:

   1. One (1) physical therapy student,

   2. A total of four (4) state-licensed physical therapist assistants, or

   3. One (1) physical therapy student and three (3) state-licensed physical therapist assistants.

Source: 42 CFR §§ 410.60-61, 440.110; Miss. Code Ann. §§ 43-13-121, 73-23-31, et seq.

History: Revised eff. 01/01/2016.

Rule 1.4: Non-Covered Physical Therapy Services

The Division of Medicaid does not cover or reimburse for physical therapy services in the outpatient setting when:

A. Services are not certified/ordered by a physician, physician assistant, or nurse practitioner,

B. The plan of care (POC) has not been approved, signed, and dated by the physician, physician assistant, or nurse practitioner within established timeframes [Refer to Miss. Admin. Code Part 213, Rule 1.3.A.4.],

C. Services do not meet medical necessity criteria,

D. Services do not require the knowledge, skill, and judgment of a state-licensed physical therapist,

E. Documentation supports that the beneficiary has attained the physical therapy goals or has reached the point where no further significant improvement can be expected,

F. Documentation supports that the beneficiary has not reached physical therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the physical therapy regimen,

G. The beneficiary can perform services independently or with the assistance of unskilled personnel or family members,

H. Services duplicate other concurrent therapy,

I. Services are for maintenance and/or palliative therapy which maintains function and generally does not involve complex procedures or the professional skill, judgment, or supervision of a state-licensed physical therapist,

J. Conditions could be reasonably expected to improve spontaneously without therapy,

K. Services are ordered daily or multiple times per day from the initiation of therapy through discharge,

L. Services are normally considered part of nursing care,

M. Services are provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),

N. Services are billed as separate fees for self-care/home-management training,

O. Services are related solely to employment opportunities or the purpose is vocationally based,

P. Services are for general wellness, exercise, and/or recreational programs,

Q. Services are provided by physical therapy aides,

R. Services are delivered in a group therapy or co-therapy session,

S. Services are investigational or experimental,

T. Services consist of acupuncture or biofeedback,

U. Services are outside the scope/and or authority of the state-licensed physical therapist's specialty and/or area of practice,

V. The provider has not met the prior authorization/pre-certification requirements,

W. Services are provided in the home setting, or

X. Services are not specifically listed as covered by the Division of Medicaid.

Source: 42 CFR § 410.60; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

Rule 1.5: Reserved

Rule 1.6: Prior Authorization/Precertification

A. Medicaid requires prior authorization/precertification for certain outpatient therapy services.

   1. Prior authorization/precertification for therapy services is conducted through the Utilization Management and Quality Improvement Organization (UM/QIO).

   2. Failure to obtain prior authorization/precertification will result in denial of payment to the providers billing for services.

   3. The UM/QIO must determine medical necessity for the types of therapy services and the number of units reasonably necessary to treat the beneficiary's condition. The frequency of visits provided by the therapist must match the Plan of Care signed by the physician.

B. Prior Authorization/Precertification for outpatient therapy services is only required for certain codes when the services fall into one (1) of the following categories:

   1. Therapy services provided to beneficiaries in individual therapist offices or in therapy clinics,

   2. Therapy services provided to adult beneficiaries in the outpatient department of hospitals,

   3. Therapy services provided to beneficiaries in physician offices/clinics,

   4. Therapy services provided to beneficiaries in nursing facilities,

   5. Therapy services covered under regular benefits and provided to beneficiaries also enrolled in a Home and Community-Based Services (HCBS) waiver program,

   6. Therapy services provided to beneficiaries covered under both Medicare and Medicaid, if Medicare benefits have exhausted, or

   7. Therapy services billed by school providers.

C. Prior Authorization/Precertification is not required, when the services fall into one (1) of the following categories:

   1. Therapy services provided to beneficiaries in an ICF/MR,

2. Therapy services provided to beneficiaries in a Private Nursing Facility for the Severely Disabled (PNFSD),

3. Therapy services provided to beneficiaries enrolled in a hospice program, or

4. Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not exhausted,

D. Medicaid will cover the initial evaluation and first (1st) therapy session on the same day if the following criteria are met:

1. Medicaid covers urgent physical therapy which is defined as the delivery of therapy services resulting from the sudden onset of a medical condition or injury requiring immediate care and manifesting itself by acute symptoms of sufficient severity such that the absence of therapy could result in immediate hospitalization, moderate impairment to bodily function, serious dysfunction of a bodily organ or part, or other serious medical consequences.

2. Medicaid covers same day/non-urgent outpatient physical therapy services which is defined as the delivery of therapy services that do not meet the definition of urgent, but completion of services on the same day as the evaluation significantly impacts the beneficiary's treatment.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Prescribing Provider Orders and Responsibilities

Medicaid covers therapy services that are medically necessary, as certified by the prescribing provider.

A. The prescribing provider must complete a Certificate of Medical Necessity for Initial Referral/Orders and submit it to the therapist prior to the therapy evaluation. Medicaid defines prescribing provider as a state-licensed physician, nurse practitioner, or physician assistant who refers the beneficiary for therapy services.

B. Therapy services must be furnished according to a written plan of care (POC).

1. The POC must be approved by the prescribing provider before treatment is begun.

a) An approved POC does not mean that the prescribing provider has signed the POC prior to implementation, but only has agreed to it.

b) Medicaid covers for the review to be done in person, by telephone, or facsimile.

2. The POC must be developed by a therapist in the discipline.

3. A separate POC is required for each type of therapy ordered by the prescribing provider.

4. Medicaid requires that the POC must, at a minimum, include the following:

   a) Beneficiary demographic information,

   b) Name of the prescribing provider,

   c) Dates of service,

   d) Diagnosis/symptomatology/conditions and related diagnosis codes,

   e) Specific diagnostic and treatment procedures/modalities and related procedure codes,

   f) Reason for referral,

   g) Frequency of therapeutic encounters,

   h) Units/minutes required per visit,

   i) Duration of therapy,

   j) Precautions,

   k) Short and long term goals that are specific, measurable, and age appropriate,

   l) Home program,

   m) Discharge plan, and

   n) Therapist's signature including name, title, and the date of the therapy session.

5. Medicaid requires the POC to be developed to cover a period of treatment not to exceed six (6) months.

   a) The projected period of treatment must be indicated on the initial POC and must be updated with each subsequent revised POC.

   b) A POC for a projected period of treatment beyond six (6) months is not covered by Medicaid.

6. Medicaid requires a revised POC in the following situations:

   a) The projected period of treatment is complete and additional services are required,

   b) A significant change in the beneficiary's condition and the proposed treatment plan

requires that:

1) A therapy provider propose a revised POC to the prescribing provider, or

2) The prescribing provider requests a revision to the POC. Information and documentation submitted to the UM/QIO indicates that the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates.

7. All therapy plans of care, both initial and revised, must be authenticated by the prescribing provider's signature and date signed. The prescribing provider must sign the POC before initiation of treatment or within thirty (30) calendar days of the verbal order approving the treatment plan. Medicaid accepts the signature on the revised POC as a new order.

8. The prescribing provider may make changes to the POC established by the therapist, but the therapist cannot unilaterally alter the POC established by the prescribing provider.

C. Medicaid requires the prescribing provider to participate in the delivery of care by communicating with the treating therapist and by assessing the effectiveness of the prescribed care. The prescribing provider must have a face-to-face visit with the beneficiary at least every six (6) months with the encounter documented.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.60

Rule 1.8: Evaluation and Re-Evaluation

A. Medicaid requires a Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider, and it must be received by the therapist prior to performing the initial evaluation.

B. Medicaid requires a comprehensive evaluation of the beneficiary's medical condition, disability, and level of functioning before therapy is initiated. A comprehensive evaluation must be performed to determine the need for treatment and, when treatment is indicated, to develop the treatment plan.

1. Medicaid requires the evaluation must be written and must demonstrate the beneficiary's need for skilled therapy based on functional diagnosis, prognosis, and positive prognostic indicators.

2. The evaluation must form the basis for therapy treatment goals, and the therapist must have an expectation that the patient can achieve the established goals.

3. Initial evaluations should, at a minimum contain, the following information:

a) Beneficiary demographic information,

b) Name of the prescribing provider,

c) Date of the evaluation,

d) Diagnosis/functional condition or limitation being treated and onset date,

e) Applicable medical history including mechanism of injury, diagnostic imaging/testing, recent hospitalizations including dates, medications, comorbidities, either complicating or precautionary information,

f) Prior therapy history for same diagnosis/condition and response to therapy,

g) Level of function, prior and current

h) Clinical status including cognitive function, sensation/proprioception, edema, vision/hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance by sitting and standing, transfer ability, ambulation on level and elevated surfaces, gait analysis, assistive/adaptive devices which are currently in use or required, activity tolerance, presence of wounds including description and incision status, assessment of the beneficiary's ability to perform activities of daily living and potential for rehabilitation, age appropriate information on all children such as chronological age/corrected age, motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy,

i) Special/standardized tests including the name, scores/results, and dates administered,

j) Social history including effects of the disability on the beneficiary and the family, architectural/safety considerations present in the living environment, identification of the primary caregiver, caregiver's ability/inability to assist with therapy,

k) Discharge plan including requirements to return to home, school, and/or job,

l) Impression/interpretation of findings, and

m) Physical therapist's signature, including name, title, and date of service.

C. Medicaid covers re-evaluations based on medical necessity.

1. All re-evaluations must be precertified through the UM/QIO.

2. Documentation must reflect a significant change in the beneficiary's condition or functional status. Medicaid defines significant change as a measurable and substantial increase or decrease in the beneficiary's present functional level compared to the level documented at the beginning of treatment.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: Beneficiary Non-Compliance

Medicaid does not cover therapy services when documentation supports that the beneficiary:

A. Has not reached therapy goals and is unable to participate and/or benefit from skilled intervention,

B. Refuses to participate, or

C. Is otherwise noncompliant with the therapy regimen. Medicaid defines noncompliance as failure to follow therapeutic recommendations which may include any or all of the following:

1. Failure to attend scheduled therapy sessions, which is defined by Medicaid as cancellation or 'no show' to three (3) consecutive therapy sessions and/or missing half or more of the scheduled visits without documentation of valid reasons such as personal illness/hospitalization or illness/death in the family,

2. Failure to perform home exercise program as instructed by the therapist,

3. Failure to fully participate in therapy sessions,

4. Failure of the parent/caregiver to attend therapy sessions with beneficiary who is incapable of carrying out the home program without assistance,

5. Failure to properly use special equipment or adaptive devices, or

6. Failure of parent/caregiver/beneficiary to otherwise comply with therapy regimen as documented in the medical record.

Source: Miss. Code Ann. § 43-13-121

Rule 1.10: Maintenance Therapy

Medicaid defines maintenance therapy as activities that preserve the patient's present level of function and prevent regression of that function. Maintenance programs do not require the professional skills of a licensed therapy provider, are not considered medically necessary, and are not covered by Medicaid. Such services include but are not limited to the following:

A. Services related to the general welfare of the beneficiary such as exercises to promote fitness and flexibility, training or conditioning, and holistic treatments,

B. Repetitive services that are performed to maintain function, maintain gait, maintain strength and endurance that do not require the professional skills of a licensed therapy provider,

C. Therapy after the beneficiary has achieved goals outlined in the Plan of Care or where there is no meaningful progress, or

D. Exercises and range of motion exercises not related to the restoration of a specific loss of function.

Source: Miss. Code Ann. § 43-13-121

Rule 1.11: Documentation

Provider records must be documented and maintained in accordance with requirements set forth in Part 200, Chapter 1, Rule 1.3 in addition to the provider specific requirements outlined below:

A. Servicing providers must maintain documentation including, but not limited to, the following:

1. Beneficiary demographic information,

2. A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,

3. Signed consent for treatment, if applicable,

4. The original copies of all Outpatient Therapy Evaluation/Re-Evaluation specific to the therapy requested,

5. The original copies of all Outpatient Therapy Plan of Care specific to the therapy requested,

6. The original copies of all tests performed or a list of all tests, test results, and the written evaluation reports,

7. Specific documentation for timed procedure codes. If a treatment log is used, it must be retained as part of the beneficiary's medical record,

8. Progress Notes:

a) If the beneficiary is receiving therapy one (1) or more times per week, progress notes must be documented at least weekly,

b) If treatment intervals exceed weekly, progress notes must be documented following each therapy session,

c) Progress notes should include:

1) Date/time of service,

2) Specific treatment modalities/procedures performed,

3) Beneficiary's response to treatment,

4) Functional progress,

5) Problems interfering with progress,

6) Education/teaching activities and results,

7) Conferences,

8) Progress toward discharge goals/home program activities, and

9) The signature and title of the therapist providing the service(s).

d) If treatment times are documented in the Progress Notes in lieu of a Treatment Log, all requirements for timed codes must be met as follows:

1) Medicaid defines timed codes as procedure codes that reference a time per unit. Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service. Medicaid considers the following activities as not part of the total treatment time:

i) Pre and post-delivery services. The beneficiary must be in the treatment area and prepared to start treatment,

ii) Time the beneficiary spends not being treated, and

iii) Time waiting for equipment or for treatment to begin.

2) Medicaid defines untimed codes as procedure codes that are not defined by a specific time frame. Medicaid does not require documentation of the treatment time for untimed codes. Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

9. Discharge Summary, if applicable, and

10. A copy of the completed prior approval form with prior approval authorization, if applicable.

B. Prescribing providers must maintain documentation including, but not limited to, the following:

1. Date(s) of service,

2. Beneficiary demographic information,

3. Signed consent for treatment, if applicable,

4. Medical history /chief complaint,

5. Diagnosis,

6. Specific name/type of all diagnostic studies and results/findings of the studies,

7. Treatment rendered and response to treatment,

8. Medications prescribed including name, strength, dosage, and route,

9. Orders that are signed and dated for all medications, treatments, and procedures rendered,

10. Discharge planning and beneficiary instructions,

11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders,

12. Evidence that the beneficiary was seen face-to-face and evaluated/re-evaluated every six (6) months at a minimum, and

13. Copies of the rendering provider's therapist's documentation as follows:

a) Initial therapy evaluation and all re-evaluations,

b) Initial plan of care and all revisions,

c) Written evaluation reports for all tests, and

d) Discharge summary, if applicable.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 1.12: Dual Eligibles

A. Medicaid covers therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The therapy services must be pre-certified through the UM/QIO.

B. Beneficiaries cannot receive services under both programs simultaneously.

Source: Miss. Code Ann. § 43-13-121

Rule 1.13: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 213 Chapter 2: Occupational Therapy

Rule 2.1: Provider Enrollment Requirements for Occupational Therapist

Providers of occupational therapy must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the provider specific requirements outlined below:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System **(**NPPES),

B. Copy of licensure card or letter from the appropriate board stating current certification and must be from state of servicing location, and

C. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E

Rule 2.2: Definitions

A. Medicaid defines occupational therapy services as medically prescribed services that address developmental and/or functional needs related to the performance of self-help skills, adaptive behavior, and/or sensory, motor and postural development. Services include therapeutic goal-directed activities and/or exercises used to improve mobility and Activities of Daily Living (ADL) functions when such functions have been impaired due to congenital and/or developmental abnormalities, illness or injury.

B. Medicaid defines an occupational therapist as an individual who meets the state and federal licensing and/or certification requirements to perform occupational therapy services.

C. Medicaid defines an occupational therapy assistant as an individual who meets the state and federal licensing and/or certification requirements to assist in the practice of occupational therapy services under the supervision of a licensed occupational therapist.

D. Medicaid defines an occupational therapy aide as an unlicensed individual who assists the occupational therapist and the occupational therapy assistant in the practice of occupational

therapy. The occupational therapy aide performs services under the supervision of the licensed occupational therapist or licensed occupational therapy assistant.

E. Medicaid defines direct supervision as a state licensed therapist physically being on the premises where services are rendered and is available for immediate assistance during the entire time services are rendered**.** The licensed therapist may not supervise more than two (2) assistants at a time. Medicaid does not cover contacts by telephone, pager, video conferencing, etc. as any type of or substitution for direct supervision.

F. Medicaid defines prescribing provider as a state licensed physician, nurse practitioner, or physician assistant who refers a beneficiary for therapy services.

G. Medicaid defines maintenance therapy as activities that preserve the patient's present level of function and prevent regression of that function.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110; 410.59

Rule 2.3 Covered Occupational Therapy Services

A. The Division of Medicaid covers occupational therapy services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity to treat a beneficiary's illness, condition, or injury and the following requirements are met:

1. The services require the knowledge, skill and judgment of a state-licensed occupational therapist.

2. The Certificate of Medical Necessity (CMN) for initial referral/order is completed by the prescribing provider prior to the occupational therapy evaluation.

3. The plan of care (POC) is developed by a state-licensed occupational therapist.

4. The prescribing provider approves the initial/revised POC with a signature and date:

   a) Before the initiation of treatment or change in treatment, or

   b) Within thirty (30) calendar days of the verbal order for the initial treatment plan or change in treatment.

5. The services are rendered as individualized therapy, consistent with the symptomatology/diagnosis and do not exceed the beneficiary's needs.

6. The services do not duplicate another provider's services including those services provided in a school-based setting.

B. The Division of Medicaid reimburses for covered occupational therapy services provided by:

1. A state-licensed occupational therapist.

2. A state-licensed occupational therapist assisted by a state-licensed occupational therapist assistant under direct, on-site supervision by a state-licensed occupational therapist.

   a) The Division of Medicaid defines direct, onsite supervision as face-to-face oversight by a state-licensed occupational therapist at regular intervals, as prescribed by the standards of the Accreditation Council of Occupational Therapy Education (ACOTE) and does not include:

      1) Contacts by telephone,

      2) Contacts by pager,

      3) Video conferencing, and/or

      4) Any method not approved by the Division of Medicaid.

   b) The initial evaluation, POC, and discharge summary must be completed by a state-licensed occupational therapist.

3. A state-licensed occupational therapist assisted by an occupational therapy student who is enrolled in an accredited occupational therapy program while completing the clinical requirements necessary for graduation under direct, on-site supervision of a state-licensed occupational therapist, referred to as student assisted occupational therapy services.

   a) The Division of Medicaid defines direct, on-site supervision of an occupational therapy student as the face-to-face oversight by a state-licensed occupational therapist.

   b) The state-licensed occupational therapist must be physically present and engaged in student oversight during the entirety of a therapy session such that the state-licensed occupational therapist is considered to be providing the occupational therapy service.

C. The state-licensed occupational therapist cannot supervise at the same time during the work day more than:

1. One (1) occupational therapy student,

2. A total of four (4) state-licensed occupational therapist assistants, or

3. One (1) occupational therapy student and three (3) state-licensed occupational therapist assistants.

Source: 42 CFR § 410. 59, 410.61; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

Rule 2.4: Non-Covered Occupational Therapy Services

The Division of Medicaid does not cover or reimburse for occupational therapy services in the outpatient setting when:

A. Services are not certified/ordered by a physician, physician assistant, or nurse practitioner,

B. The plan of care (POC) has not been approved, signed, and dated by the physician, physician assistant, or nurse practitioner within established timeframes [Refer to Miss. Admin. Code Part 213, Rule 2.3.A.4],

C. Services do not meet medical necessity criteria,

D. Services do not require the knowledge, skills, and judgment of a state-licensed occupational therapist,

E. Documentation supports that the beneficiary has attained the occupational therapy goals or has reached the point where no further significant improvement can be expected,

F. Documentation supports that the beneficiary has not reached occupational therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the occupational therapy regimen,

G. The beneficiary can perform services independently or with the assistance of unskilled personnel or family members,

H. Services duplicate other concurrent therapy,

I. Services are for maintenance and/or palliative therapy which maintains function and generally does not involve complex procedures or the professional skill, judgment, or supervision of a state-licensed occupational therapist,

J. Conditions could be reasonably expected to improve spontaneously without therapy,

K. Services are ordered daily or multiple times per day from the initiation of therapy through discharge,

L. Services are normally considered part of nursing care,

M. Services are provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),

N. Services are billed as separate fees for self-care/home-management training,

O. Services are related solely to employment opportunities or the purpose is vocationally based,

P. Services are for general wellness, exercise, and/or recreational programs,

Q. Services are provided by occupational therapy aides,

R. Services are delivered in a group therapy or co-therapy session,

S. Services are investigational or experimental,

T. Services consist of acupuncture or biofeedback,

U. Services are outside the scope/and or authority of the state-licensed occupational therapist's specialty and/or area of practice,

V. The provider has not met the prior authorization/pre-certification requirements,

W. Services are provided in the home setting, or

X. Services are not specifically listed as covered by the Division of Medicaid.

Source: 42 CFR § 410.59; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

Rule 2.5: Prior Authorization/ Precertification

A. The UM/QIO will determine medical necessity, the types of therapy services, and the number of units reasonably necessary to treat the beneficiary's condition. The frequency of visits provided by the therapist must match the Plan of Care signed by the prescribing provider.

B. Prior Authorization/Pre-certification for outpatient therapy services is only required for certain procedure codes when the services fall into one (1) of the following categories:

1. Therapy services provided to beneficiaries, adult and/or children in individual therapist offices or in therapy clinics,

2. Therapy services provided to beneficiaries, adult and/or children, in the outpatient department of hospitals,

3. Therapy services provided to beneficiaries, adult and/or children, in physician offices/clinics,

4. Therapy services provided to beneficiaries in nursing facilities,

5. Therapy services covered under regular State Plan benefits and provided to beneficiaries also enrolled in a Home and Community-Based Services (HCBS) waiver program, and

6. Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have been exhausted.

C. Exclusions to Prior Authorization/Precertification

1. Prior Authorization/Precertification is not required, regardless of procedure codes used, when the services fall into one (1) of the following categories:

   a) Therapy services provided to beneficiaries in an ICF/MR,

   b) Therapy services provided to beneficiaries in a Private Nursing Facility for the Severely Disabled (PNFSD),

   c) Therapy services provided to beneficiaries enrolled in a hospice program, or

   d) Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted.

D. Prior Authorization/Pre-certification Request - Processes related to certification and recertification of therapy services must be handled in accordance with the procedures set forth by the UM/QIO. Medicaid does not cover the initial evaluation and the first therapy session on the same day. The UM/QIO is authorized to accept retrospective requests for urgent services and same day/non-urgent services as defined and outlined in Part 213, Chapter 1.

Source: Miss. Code Ann. § 43-13-121

Rule 2.6: Prescribing Provider Orders/Responsibilities

A. Medicaid provides benefits for therapy services that are medically necessary, as certified by the prescribing provider.

B. The prescribing provider must complete a Certificate of Medical Necessity for Initial Referral/Orders form and submit it to the therapist prior to therapy evaluation.

C. Therapy services must be furnished according to a written plan of care (POC). The plan of care must be approved by the prescribing provider before treatment is begun. Medicaid defines approval as the prescribing provider has reviewed and agreed with the therapy plan. The review can be done in person, by telephone, or facsimile. An approved plan does not mean that the prescribing provider has signed the plan prior to implementation, only that he/she has agreed to it. The plan of care must be developed by a therapist in the discipline. A separate plan of care is required for each type of therapy ordered by the prescribing provider. The plan must, at a minimum, include the following:

1. Beneficiary demographic information,
2. Name of the prescribing provider,
3. Dates of service,
4. Diagnosis/symptomatology/conditions and related diagnosis codes,
5. Reason for referral,
6. Specific diagnostic and treatment procedures/modalities and related procedure codes,
7. Frequency of therapeutic encounters,
8. Units/minutes required per visit,
9. Duration of therapy,
10. Precautions, if applicable,
11. Short and long term goals that are specific, measurable, and age appropriate,
12. Home program,
13. Discharge plan, and
14. Therapist's signature, name and title, and date.

D. Medicaid requires the POC to cover a period of treatment up to six (6) months. The projected period of treatment must be indicated on the initial POC and must be updated with each subsequent revised POC. Medicaid does not cover a POC for a projected period of treatment beyond six (6) months.

E. Medicaid requires a revised POC in the following situations:

1. The projected period of treatment is complete and additional services are required,

2. A significant change in the beneficiary's condition and the proposed treatment plan requires that a therapy provider propose a revised POC to the prescribing provider, or the prescribing provider requests a revision to the POC. In either case, the therapy provider must submit a revised POC to the UM/QIO for certification prior to rendering services, and

3. Information/documentation submitted to the UM/QIO indicates the POC needs further review/revision by the therapist/prescribing provider at intervals different from the

proposed treatment dates. The therapy provider must submit a revised POC to the UM/QIO for authorization/certification prior to rendering services,

F. All therapy plans of care, initial and revised, must be authenticated, with signature and date, by the prescribing provider. The prescribing provider must sign the POC before initiation of treatment or within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.

G. Medicaid accepts the signature on the revised plan of care as a new order.

H. The prescribing provider may make changes to the plan established by the therapist, but the therapist cannot unilaterally alter the plan of care established by the prescribing provider.

I. The servicing provider, the licensed therapist, is responsible for providing a copy of the initial plan of care and all revisions to the prescribing provider.

J. Medicaid does not cover therapy services when documentation supports that the beneficiary has not reached therapy goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the therapy regimen. Noncompliance is defined as failure to follow therapeutic recommendations which may include any or all of the following:

1. Failure to attend scheduled therapy sessions,

2. Failure to perform home exercise program as instructed by the therapist,

3. Failure to fully participate in therapy sessions,

4. Failure of the parent/caregiver to attend therapy sessions with beneficiary who is incapable of carrying out the home program without assistance, and

5. Failure to properly use special equipment or adaptive devices. Failure of parent/caregiver/beneficiary to otherwise comply with therapy regimen as documented in the medical record.

K. Medicaid requires a mandatory face-to-face visit with the beneficiary by the prescribing provider at least every six (6) months and, requires the encounter is documented.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.59; 42 CFR 410.61

Rule 2.7: Evaluation/Re-Evaluation

A. A Certificate of Medical Necessity for Initial Referral/Orders must be completed by the prescribing provider, and it must be received by the therapist prior to performing the initial evaluation.

B. Before therapy is initiated, a comprehensive evaluation of the beneficiary's medical condition, disability, and level of functioning must be performed to determine the need for treatment and, when treatment is indicated, to develop the treatment plan. The initial evaluation must be completed by a state-licensed therapist. The evaluation must be written and must demonstrate the beneficiary's need for skilled therapy based on functional diagnosis, prognosis, and positive prognostic indicators. The evaluation must form the basis for therapy treatment goals, and the therapist must have an expectation that the patient can achieve the established goals.

C. Initial evaluations should, at a minimum, contain the following information:

1. Beneficiary demographic information,

2. Name of the prescribing provider,

3. Date of the evaluation,

4. Diagnosis/functional condition or limitation being treated and onset date,

5. Applicable medical history: mechanism of injury, diagnostic imaging/testing, recent hospitalizations including dates, medications, co-morbidities, with complicating or precautionary information,

6. Prior therapy history for same diagnosis/condition and response to therapy,

7. Level of function, prior and current,

8. Clinical status including cognitive function, sensation/proprioception, edema, vision/hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance, while sitting and standing, transfer ability, ambulation at level and elevated surfaces, gait analysis, assistive/adaptive devices either currently in use or required, activity tolerance, presence of wounds including description and incision status, assessment of the beneficiary's ability to perform activities of daily living and potential for rehabilitation, age appropriate information on all children by chronological age/corrected age, motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy,

9. Special/standardized tests including the name, scores/results, and dates administered,

10. Social history including effects of the disability on the beneficiary and the family, architectural/safety considerations present in the living environment, identification of the primary caregiver, caregiver's ability/inability to assist with therapy,

11. Discharge plan including requirements to return to home, school, and/or job,

12. Impression/interpretation of findings, and

13. Occupational therapist's signature, with name and title and date.

D. Medicaid covers re-evaluations based on medical necessity. All re-evaluations must be pre-certified through the UM/QIO. Documentation must reflect significant change in the beneficiary's condition or functional status. Significant change is defined as a measurable and substantial increase or decrease in the beneficiary's present functional level compared to the level documented at the beginning of treatment.

E. The components of the re-evaluation and the documentation requirements are the same as the initial evaluation, but are focused on assessing significant changes from the initial evaluation or progress toward treatment goals and making a professional judgment about continued care, modifying goals and/or treatment, or termination of therapy services. Documentation should include improvements and setbacks, as well as, interventions required to treat any medical complications. When expected progress has not been realized and continued therapy is planned, the re-evaluation needs to include valid indications to support the expectation that significant improvement will occur in a reasonable and predictable time frame.

F. In all cases, other than termination of therapy services, re-evaluation findings must be reflected in revisions to the therapy plan of care.

G. The servicing provider, or licensed therapist, is responsible for providing a copy of the initial evaluation and all re-evaluations to the prescribing provider.

Source: Miss. Code Ann. § 43-13-121

Rule 2.8: Maintenance Therapy

A. Maintenance programs do not require the professional skills of a licensed therapy provider, are not considered medically necessary, and are not covered by Medicaid.

B. Maintenance programs must be planned and taught before the end of active therapy treatment so that the beneficiary, family members, or other unskilled caregivers can carry out the program. If the maintenance program is not established until after the rehabilitative program has been completed, the skills of a therapist for development of a maintenance program are not considered medically necessary and are covered.

Source: Miss. Code Ann. § 43-13-121

Rule 2.9: Documentation

A. Therapy providers must document and maintain auditable records that meet the requirement set forth in Part 200, Chapter 1, Rule 1.3 and those outlined:

1. The servicing provider must maintain documentation including, but not limited to, the following:

a) Beneficiary demographic information,

b) A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,

c) Signed consent for treatment, if applicable,

d) The original copies of all Outpatient Therapy Evaluation/Re-Evaluation forms specific to the therapy request,

e) The original copies of all Outpatient Therapy Plan of Care forms specific to the therapy requested,

f) The original copies of all tests performed or a list of all tests and test results, and the written evaluation reports,

g) Specific documentation for timed procedure codes. If a treatment log is used, it must be retained as part of the beneficiary's medical record,

h) Progress Notes:

   1) If the beneficiary is receiving therapy one (1) or more times per week, progress notes must be documented at least weekly. If treatment intervals exceed weekly, progress notes must be documented following each therapy session.

   2) Progress notes should include date/time of service, specific treatment modalities/procedures performed, beneficiary's response to treatment, functional progress, problems interfering with progress, education/teaching activities and results, conferences, progress toward discharge goals/home program activities, and the signature and title of the therapist providing the service(s). If treatment times are documented in the Progress Notes in lieu of a Treatment Log, all requirements for timed codes must be met.

i) Discharge Summary, if applicable, and

j) A copy of the completed prior approval form with prior approval authorization, if applicable.

B. The prescribing provider must maintain documentation including, but not limited to, the following:

   1. Date(s) of service,

   2. Beneficiary demographic information,

3. Signed consent for treatment, if applicable,

4. Medical history/chief complaint,

5. Diagnosis,

6. Specific name/type of all diagnostic studies and results/findings of the studies,

7. Treatment rendered and response to treatment,

8. Medications prescribed including name, strength, dosage, and route,

9. Orders that are signed and dated for all medications, treatments, and procedures rendered,

10. Discharge planning and beneficiary instructions,

11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders, and

12. Evidence that the beneficiary was seen, face-to-face, and evaluated/re-evaluated every six (6) months, at a minimum.

C. In addition, the prescribing provider must retain copies of the rendering provider's/ therapist's documentation as follows:

1. Initial therapy evaluation and all re-evaluations,

2. Initial plan of care and all revisions,

3. Written evaluation reports for all tests, and

4. Discharge summary, if applicable.

D. The servicing provider or licensed therapist is responsible for providing a copy of all required therapy documentation as noted above to the prescribing provider.

E. Timed Codes:

1. Medicaid defines procedure codes that reference a time per unit as 'timed codes.' Providers must bill units of timed codes based upon the total time actually spent in the delivery of the service. The total treatment time, including the actual beginning and ending time of treatment, must be recorded for services described by time codes. All of the times, as well as the description of the treatment modalities/procedures that were provided, must be recorded for each visit. The therapist rendering treatment must sign, with signature and title, and date each entry. Documentation may be recorded in the Progress Notes or on a treatment log. If a treatment log is used, it must be retained as part of the beneficiary's medical record.

2. Activities that are not considered part of the total treatment time include, but are not limited to, the following:

a) Pre and post-delivery services - The beneficiary should be in the treatment area and prepared to start treatment,

b) Time the beneficiary spends not being treated, and

c) Time waiting for equipment or for treatment to begin.

3. Medicaid defines 'Untimed' procedure codes as no specific time frame. Medicaid does not require documentation of the treatment time for untimed codes. Whether the service took ten (10) minutes or two (2) hours to complete, only one (1) unit can be billed because only one (1) service was provided. The name and title of the person supervising the treatment/modality must be recorded for all procedure codes requiring direct supervision.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118, 43-13-129

Rule 2.10: Dual Eligibles

A. Medicaid covers therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The therapy services must be prior authorized/ precertified through the UM/QIO.

B. Beneficiaries may not receive services under both programs simultaneously.

Source: Miss. Code Ann. § 43-13-121

Rule 2.11: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 213 Chapter 3: Outpatient Speech-Language Pathology (Speech Therapy)

Rule 3.1: Provider Enrollment Requirements

Providers of speech therapy must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition the provider type specific requirements outlined below. Therapy providers wishing to enroll as group providers must adhere to the enrollment requirements in Part 200, Chapter 4, Rule 4.9.

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

B. Copy of current licensure card or permit,

C. Copy of current certificate of clinical competence from the American Speech and Hearing Association (ASHA),

D. Documentation from the State Department of Health verifying that they have completed one (1) of the following requirements:

   1. Has completed the equivalent educational requirements and work experience necessary for the certificate, or

   2. Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

E. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110; 42 CFR 455, Subpart E

Rule 3.2: Definitions

A. Medicaid defines speech therapy services as medically prescribed services necessary for the diagnosis and treatment of communication impairment and/or swallowing disorder that has occurred due to disease, trauma or congenital anomaly.

B. Medicaid defines a speech-language pathologist (speech therapist) as an individual who meets the state and federal licensing and/or certification requirements to perform speech-language pathology services.

C. Medicaid defines a speech-language pathology assistant or speech therapy assistant as an individual who meets the state and federal licensing and/or certification requirements to assist in the practice of speech-language pathology services under the supervision of a licensed speech-language pathologist.

D. Medicaid defines a speech-language pathology aide as an unlicensed individual who assists the speech-language pathologist and the speech-language pathology assistant in the practice of speech-language pathology. The speech-language pathology aide performs services under the supervision of the licensed speech-language pathologist.

E. Medicaid defines group therapy as the simultaneous treatment of two (2) or more

beneficiaries.

F. Medicaid defines a prescribing provider as a state licensed physician, nurse practitioner, or physician assistant who refers the beneficiary for therapy services.

G. Medicaid defines maintenance therapy as activities that preserve the beneficiary's present level of function and prevent regression of that function.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110

Rule 3.3: Covered Speech-Language Pathology and Audiology Services

A. The Division of Medicaid covers speech-language pathology and audiology services in the outpatient setting when medically necessary, ordered by a physician, physician assistant or nurse practitioner, for the diagnosis and treatment of a communication impairment and/or swallowing disorder due to disease, trauma, or congenital anomaly and prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity and the following requirements are met:

1. The services require the knowledge, skill and judgment of a state-licensed speech-language pathologist or audiologist.

2. The Certificate of Medical Necessity (CMN) for initial referral/order is completed by the prescribing provider prior to the speech-language pathology or audiology evaluation.

3. The plan of care (POC) is developed by a state-licensed speech-language pathologist or audiologist.

4. The prescribing provider approves the initial/revised POC with a signature and date:

   a) Before the initiation of treatment or change in treatment, or

   b) Within thirty (30) calendar days of the verbal order for the initial treatment plan or change in treatment.

5. The services are rendered as individualized speech language pathology or audiology services consistent with the symptomatology/diagnosis and do not exceed the beneficiary's needs.

6. The services do not duplicate another provider's services including those services provided in a school-based setting.

7. The beneficiary presents with one (1) or more of the following:

   a) Aphagia defined as an inability to swallow,

b) Aphasia defined as an absence/impairment of the ability to communicate through speech, writing, or signs caused by focal damage to the language dominant hemisphere of the brain,

c) Aphonia defined as an inability to produce sounds from the larynx due to excessive muscle tension, paralysis, or disease of the laryngeal nerves,

d) Apraxia defined as an inability to form words to speak despite an ability to use facial and oral muscles to make sounds,

e) Dysarthria defined as defective or difficult speech that involves disturbances in muscular control like weakness, lack of coordination, or paralysis of the speech mechanism, either oral, lingual, respiratory or pharyngeal muscles, resulting from damage to the peripheral or central nervous system,

f) Dysphagia defined as difficulty swallowing,

g) Dysphasia defined as language impairment from neurodevelopmental disorder or brain lesion,

h) Dysphonia defined as difficulty speaking due to impairment of the muscles involving vocal production, and/or

i) Vocal cord dysfunction defined as impairment of vocal cord mobility due to functional or structural abnormalities resulting from organic or neurological diseases.

8. Risk factors have been identified and documented including, but are not limited to:

a) Neurological disorders/dysfunctions, such as hearing loss or cerebral palsy,

b) Surgical procedures, such as partial/comprehensive/radical laryngectomy, repaired cleft palate, or glossectomy,

c) Cognitive impairments that affect communication functions, or

d) Medical conditions resulting in communication disorders that require restorative therapy including, but not limited to:

1) Laryngeal carcinoma requiring partial/total largyngectomy that results in dysphonia or aphonia,

2) Traumatic brain injury that may exhibit inadequate respiratory volume, apraxia, dysphagia, or dysarthria,

3) Progressive/static neurological conditions, such as amyotrophic lateral sclerosis, Parkinson’s disease, myasthenia gravis, multiple sclerosis, or Huntington’s

disease,

4) Intellectual disability with disorders of dysarthria, dysphagia, apraxia, or aphagia, and/or

5) Cerebrovascular disease, such as cerebrovascular accident, presenting with apraxia, aphasia, dysphagia, or dysarthria.

9. The type of service requested includes one (1) or more of the following:

a) Diagnostic and evaluation services:

1) To determine the type, causal factors, severity of speech-language or swallowing disorders, and the extent of service required to restore functions of speech, language, voice fluency, and swallowing, or

2) The beneficiary demonstrates changes in functional speech or remission of a medical condition that previously contradicted speech-language therapy.

b) Therapeutic services defined as services requiring active corrective/restorative therapy, for communication disorders that result from:

1) Laryngeal carcinoma requiring partial/total largyngectomy that results in aphonia so the beneficiary can develop new communication skills through esophageal speech or the use of an electrolarynx,

2) Cerebrovascular disease, such as cerebrovascular accident, presenting with apraxia, aphasia, dysphagia, or dysarthria, or

3) Medical and neurological conditions, like traumatic brain injury, Parkinson's disease, or multiple sclerosis, exhibiting inadequate respiratory volume/control, aphonia, dysphagia, dysarthria, or dysphonia.

B. The Division of Medicaid reimburses for covered speech-language pathology or audiology services provided by:

1. A state-licensed speech-language pathologist or audiologist.

2. A state-licensed speech-language pathologist or audiologist assisted by a state-licensed speech-language pathologist or audiologist assistant under direct, on-site supervision by a state-licensed speech-language pathologist or audiologist.

a) The Division of Medicaid defines direct, onsite supervision as face-to-face oversight by a state-licensed speech-language pathologist or audiologist at regular intervals, congruent with the standards of the American Speech-Language-Hearing Association (ASHA) and does not include:

1) Contacts by telephone,

2) Contacts by pager,

3) Video conferencing, and/or

4) Any method not approved by the Division of Medicaid.

b) The initial evaluation, POC, and discharge summary must be completed by a state-licensed speech-language pathologist or audiologist.

3. A state-licensed speech-language pathologist or audiologist assisted by a speech-language pathology or audiology student who is enrolled in an accredited speech-language pathology or audiology program while completing the clinical requirements necessary for graduation under direct, on-site supervision of a state-licensed speech-language pathologist or audiologist, referred to as student assisted speech-language pathology or audiology services.

a) The Division of Medicaid defines direct, on-site supervision of a speech-language pathology or audiology student as the face-to-face oversight by a state-licensed speech-language pathologist or audiologist.

b) The state-licensed speech-language pathologist or audiologist must be physically present and engaged in student oversight during the entirety of a therapy session such that the state-licensed speech-language pathologist or audiologist is considered to be providing the speech-language pathology or audiology service.

C. The state-licensed speech-language pathologist or audiologist cannot supervise at the same time during the work day more than:

1. One (1) speech-language pathology or audiology student,

2. A total of four (4) state-licensed speech-language pathologist or audiologist assistants, or

3. One (1) speech-language pathology or audiology student and three (3) state-licensed speech-language pathologist or audiologist assistants.

Source: 42 CFR § 410.61-62; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

Rule 3.4: Non-Covered Speech-Language Pathology or Audiology Services

The Division of Medicaid does not cover or reimburse for speech-language pathology or audiology services in the outpatient setting when:

A. Services are not certified/ordered by a physician, physician assistant, or nurse practitioner,

B. The plan of care (POC) has not been approved, signed, and dated by the physician, physician assistant, or nurse practitioner within established timeframes [Refer to Miss. Admin. Code Part 213, Rule 3.3.A.4.],

C. Services do not meet medical necessity criteria,

D. Services do not require the knowledge, skill, and judgment of a state-licensed speech-language pathologist or audiologist,

E. Documentation supports that the beneficiary has attained the speech-language pathology or audiology goals or has reached the point where no further significant improvement can be expected,

F. Documentation supports that the beneficiary has not reached the speech-language pathology or audiology goals and is unable to participate and/or benefit from skilled intervention, refuses to participate, or is otherwise noncompliant with the speech-language pathology or audiology regimen,

G. The beneficiary can perform services independently or with the assistance of unskilled personnel or family members,

H. Services duplicate other concurrent therapy,

I. Services are for maintenance and/or palliative therapy which maintains function and generally does not involve complex procedures or the professional skill, judgment, or supervision of a state-licensed speech-language pathologist or audiologist,

J. Conditions could be reasonably expected to improve spontaneously without therapy,

K. Services are ordered daily, or multiple times per day, from the initiation of therapy through discharge,

L. Services are normally considered part of nursing care,

M. Services are provided through a Comprehensive Outpatient Rehabilitation Facility (CORF),

N. Services are billed as separate fees for self-care/home-management training,

O. Services are related solely to employment opportunities or the purpose is vocationally based,

P. Services are for general wellness, exercise, and/or recreational programs,

Q. Services are provided by speech-language pathology or audiology aides,

R. Services are delivered in a group therapy or co-therapy session,

S. Services are investigational or experimental,

T. Services consist of acupuncture or biofeedback,

U. Services are outside the scope/and or authority of the state-licensed speech-language pathologist's or audiologist's specialty and/or area of practice,

V. The provider has not met the prior authorization/pre-certification requirements,

W. Services are provided in the home setting, or

X. Services are not specifically listed as covered by the Division of Medicaid.

Source: 42 CFR § 410.61-62; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

Rule 3.5: Prior Authorization/Pre-certification

A. Medicaid requires prior authorization/precertification of certain outpatient therapy services. Prior authorization/precertification for therapy services is conducted through the Utilization Management and Quality Improvement Organization (UM/QIO) Failure to obtain prior authorization/precertification will result in denial of payment to the providers billing for services.

B. Prior Authorization/Pre-certification for outpatient therapy services is only required for certain procedure codes when the services fall into one (1) of the following categories:

1. Therapy services provided to beneficiaries, adult and/or children in individual therapist offices or in therapy clinics,

2. Therapy services provided to beneficiaries, adult and/or children in the outpatient department of hospitals,

3. Therapy services provided to beneficiaries, adult and/or children in physician offices/clinics,

4. Therapy services provided to beneficiaries in nursing facilities,

5. Therapy services covered under regular benefits and provided to beneficiaries also enrolled in a Home and Community-Based Services (HCBS) waiver program,

6. Therapy services provided to beneficiaries covered under both Medicare and Medicaid if

Medicare benefits have been exhausted,

7. Therapy services provided to beneficiaries under age twenty-one (21) through the following providers: Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), and State Department of Health, or

8. Therapy services billed by school providers.

C. Prior Authorization/Precertification is not required, regardless of the procedure codes used, when the services fall into one (1) of the following categories:

1. Therapy services provided to beneficiaries in an ICF/MR,

2. Therapy services provided to beneficiaries in a Private Nursing Facility for the Severely Disabled (PNFSD),

3. Therapy services provided to beneficiaries enrolled in a hospice program, or

4. Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted.

D. Prior Authorization/Precertification Request

1. Processes related to certification and recertification of therapy services must be handled in accordance with the procedures set forth by the UM/QIO.

2. Medicaid does not cover the initial evaluation and the first (1st) therapy session on the same day. The UM/QIO is authorized to accept retrospective requests for the following exceptions:

a) Urgent services as defined and outlined in Part 213, Chapter 1, Rule 1.6 D or

b) Same Day/ Non-Urgent Services as defined and outlined in Part 213, Chapter 1, Rule 1.6 D.

Source: Miss. Code Ann. § 43-13-121

Rule 3.6: Prescribing Provider Orders/Responsibilities

A. Medicaid covers therapy services that are medically necessary, as certified by the prescribing provider. Medicaid defines prescribing provider as a state-licensed physician, nurse practitioner, or physician assistant who refers the beneficiary for therapy services.

B. The prescribing provider must complete a Certificate of Medical Necessity for Initial Referral/Orders form and submit it to the therapist prior to therapy evaluation.

C. Therapy services must be furnished according to a written plan of care (POC). The plan of care must be approved by the prescribing provider before treatment is begun. The review can be done in person, by telephone, or facsimile. An approved plan does not mean that the prescribing provider has signed the plan prior to implementation, only that he/she has agreed to it. The plan of care must be developed by a therapist in the discipline. A separate plan of care is required for each type of therapy ordered by the prescribing provider.

D. Medicaid requires the POC must, at a minimum, include the following:

1. Beneficiary demographic information,
2. Name of the prescribing provider,
3. Dates of service,
4. Diagnosis/symptomatology/conditions and related diagnosis codes,
5. Specific diagnostic and treatment procedures/modalities and related procedure codes,
6. Reason for referral,
7. Frequency of therapeutic encounters,
8. Units/minutes required per visit,
9. Duration of therapy,
10. Precautions short and long term goals that are specific, measurable, and age appropriate,
11. Home program,
12. Discharge plan, and
13. Therapist's signature, including the name and title, and date of the therapy session,

E. The plan of care (POC) must be developed to cover a period of treatment not to exceed six (6) months. The projected period of treatment must be indicated on the initial POC and must be updated with each subsequent revised POC. A POC for a projected period of treatment beyond six (6) months is not covered by Medicaid.

F. Medicaid requires a revised POC in the following situations:

1. The projected period of treatment is complete and additional services are required, or
2. A significant change in the beneficiary's condition and the proposed treatment plan requires that:

a) A therapy provider propose a revised POC to the prescribing provider, or

b) The prescribing provider requests a revision to the POC. Information/documentation submitted to the UM/QIO indicates that the POC needs further review/revision by the therapist/prescribing provider at intervals different from the proposed treatment dates.

G. All therapy plans of care, initial and revised, must be authenticated, signed and dated, by the prescribing provider. The prescribing provider must sign the POC before initiation of treatment or within thirty (30) calendar days of the verbal order approving the treatment plan. This applies to both initial and revised plans of care.

H. Medicaid accepts the signature on the revised plan of care as a new order.

I. The prescribing provider may make changes to the plan established by the therapist, but the therapist cannot unilaterally alter the plan of care established by the prescribing provider.

J. Medicaid requires the prescribing provider to participate in the delivery of care by communicating with the treating therapist and by assessing the effectiveness of the prescribed care. It is mandatory that the prescribing provider has a face-to-face visit with the beneficiary at least every six (6) months and that the encounter is documented.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.61; 42 CFR 410.62

Rule 3.7: Evaluation/ Re-Evaluation

A. Medicaid requires a Certificate of Medical Necessity for Initial Referral/Orders must be completed by the prescribing provider, and it must be received by the therapist prior to performing the initial evaluation.

B. Medicaid requires that before therapy is initiated, a comprehensive evaluation of the beneficiary's medical condition, disability, and level of functioning must be performed to determine the need for treatment and, when treatment is indicated, to develop the treatment plan. Medicaid requires the evaluation must be written and must demonstrate the beneficiary's need for skilled therapy based on functional diagnosis, prognosis, and positive prognostic indicators. The evaluation must form the basis for therapy treatment goals, and the therapist must have an expectation that the patient can achieve the established goals.

C. Initial evaluations should, at a minimum, contain the following information:

1. Beneficiary demographic information,

2. Name of the prescribing provider,

3. Date of the evaluation,

4. Diagnosis/functional condition or limitation being treated and onset date,

5. Applicable medical history: mechanism of injury, diagnostic imaging/testing, recent hospitalizations including dates, medications, co-morbidities, complicating or precautionary information,

6. Prior therapy history for same diagnosis/condition and response to therapy,

7. Level of function, prior and current,

8. Clinical status including cognitive function, sensation/proprioception, edema, vision and hearing, posture, active and passive range of motion, strength, pain, coordination, bed mobility, balance by sitting and standing, transfer ability, ambulation on level and elevated surfaces, gait analysis, assistive/adaptive devices currently in use or required, activity tolerance, presence of wounds including description and incision status, assessment of the beneficiary's ability to perform activities of daily living and potential for rehabilitation, age appropriate information on all children chronological age/corrected age, motivation for treatment, other significant physical or mental disabilities/deficiencies that may affect therapy,

9. Special/standardized tests including the name, scores/results, and dates administered,

10. Social history: effects of the disability on the beneficiary and the family, architectural/safety considerations present in the living environment, identification of the primary caregiver, caregiver's ability/inability to assist with therapy,

11. Discharge plan including requirements to return to home, school, and/or job,

12. Impression/interpretation of findings, and

13. Physical therapist's signature including name and title and date of service.

D. Medicaid covers re-evaluations based on medical necessity. All re-evaluations must be pre-certified through the UM/QIO. Documentation must reflect significant change in the beneficiary's condition or functional status. Medicaid defines significant change as a measurable and substantial increase or decrease in the beneficiary's present functional level compared to the level documented at the beginning of treatment.

Source: Miss. Code Ann. § 43-13-121

Rule 3.8: Maintenance Therapy

A. Maintenance programs do not require the professional skills of a licensed therapy provider, are not considered medically necessary, and are not covered by Medicaid. Such services include, but are not limited to, the following:

1. Services related to the general welfare of the beneficiary such as exercises to promote fitness and flexibility, training or conditioning, and holistic treatments,

2. Repetitive services that are performed to maintain function, maintain gait, maintain strength and endurance that do not require the professional skills of a licensed therapy provider,

3. Therapy after the beneficiary has achieved goals outlined in the Plan of Care or where there is no meaningful progress, or

4. Exercises and range of motion exercises not related to the restoration of a specific loss of function.

B. Maintenance programs must be planned and taught before the end of active therapy treatment so that the beneficiary, family members, or other unskilled caregivers can carry out the program. Maintenance programs established after the rehabilitative program are not considered medically necessary and will not be covered.

Source: Miss. Code Ann. § 43-13-121

Rule 3.9: Documentation

A. Speech therapy providers must document and maintain records in accordance with the requirements set forth in Part 200, Chapter 1, Rule 1.3.

B. Required documentation by servicing provider includes, but is not limited to, the following:

1. Beneficiary demographic information,

2. A copy of the Certificate of Medical Necessity for Initial Referral/Orders completed by the prescribing provider,

3. Signed consent for treatment, if applicable,

4. The original copies of all Outpatient Therapy Evaluation/Re-Evaluations specific to the therapy requested,

5. The original copies of all Outpatient Therapy Plan of Care forms specific to the therapy requested,

6. The original copies of all tests performed or a list of all tests and test results, and the written evaluation reports,

7. Specific documentation for timed procedure codes. If a treatment log is used, it must be retained as part of the beneficiary's medical record,

8. Progress Notes:

a) If the beneficiary is receiving therapy one or more times per week, progress notes must be documented at least weekly. If treatment intervals exceed weekly, progress notes must be documented following each therapy session.

b) Progress notes should include date/time of service, specific treatment modalities/procedures performed, beneficiary's response to treatment, functional progress, problems interfering with progress, education/teaching activities and results, conferences, progress toward discharge goals/home program activities, and the signature and title of the therapist providing the service(s). If treatment times are documented in the Progress Notes in lieu of a Treatment Log, all requirements for timed codes must be met. Refer to timed and untimed codes in this Part.

9. Discharge Summary, if applicable, and

10. A copy of the completed prior approval form with prior approval authorization, if applicable.

C. Required documentation by prescribing provider includes, but is not limited to, the following:

1. Date(s) of service,

2. Beneficiary demographic information,

3. Signed consent for treatment, if applicable,

4. Medical history/chief complaint,

5. Diagnosis,

6. Specific name/type of all diagnostic studies and results/findings of the studies,

7. Treatment rendered and response to treatment,

8. Medications prescribed including name, strength, dosage, and route,

9. Orders that are signed and dated for all medications, treatments, and procedures rendered,

10. Discharge planning and beneficiary instructions,

11. Copy of the Certificate of Medical Necessity for Initial Referral/Orders, and

12. Evidence that the beneficiary was seen (face-to-face) and evaluated/re-evaluated every six (6) months at a minimum.

D. In addition, the prescribing provider must retain copies of the rendering provider's/therapist's documentation as follows:

1. Initial therapy evaluation and all re-evaluations,

2. Initial plan of care and all revisions,

3. Written evaluation reports for all tests, and

4. Discharge summary, if applicable.

E. Timed Codes

1. Procedure codes that reference a time per unit are 'timed codes.' Medicaid covers units of timed codes based upon the total time actually spent in the delivery of the service.

2. Medicaid considers the following activities as not part of the total treatment time:

a) Pre and post-delivery services. The beneficiary should be in the treatment area and prepared to start treatment,

b) Time the beneficiary spends not being treated, or

c) Time waiting for equipment or for treatment to begin.

F. Untimed procedure codes are not defined by a specific time frame. Medicaid does not require documentation of the treatment time for untimed codes. Medicaid only covers one (1) unit for untimed codes regardless of the amount of time taken to complete the service.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 3.10: Dual Eligibles

A. Medicaid covers therapy services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The therapy service must be prior authorization/precertified through the UM/QIO.

B. Beneficiaries cannot receive services under both programs simultaneously.

Source: Miss. Code Ann. § 43-13-121

Rule 3.11: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 213 Chapter 4: Administrative Appeals

Rule 4.1: Appeals for Therapy Services

A. Reconsideration Process - The beneficiary, therapy provider, or prescribing provider is afforded the right to appeal a utilization review denial to the UM/QIO through the reconsideration process set forth by the UM/QIO.

B. Administrative Appeal - Disagreement with the UM/QIO reconsideration determination shall be appealed to Medicaid by the beneficiary/legal representative. The beneficiary/legal representative must submit a written request for administrative appeal within thirty (30) calendar days of the UM/QIO reconsideration determination notice.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 42 CFR 441.308

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 214
Pharmacy Services

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Title 23: Division of Medicaid

Part 214: Pharmacy Services

Part 214 Chapter 1: General Pharmacy

Rule 1.1: Provider Enrollment and Pharmacy Participation

A. Pharmacists must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 for all providers in addition to the provider type specific requirements that follow:

   1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

   2. Written confirmation from the IRS confirming the tax identification number and legal business name, and

   3. Copy of current pharmacy permit issued by the Mississippi Board of Pharmacy.

B. Pharmacies participating in the Mississippi Medicaid program must:

   1. Have a MS Board of Pharmacy permit for one of the following specified types of pharmacies:

      a) Retail pharmacy must hold a community pharmacy permit,

      b) Closed-door pharmacy must hold a specialty community pharmacy permit, and

      c) Institutional pharmacy must hold an Institutional I or Institutional II pharmacy permit.

   2. Be physically located within the state of Mississippi or within a thirty (30) mile radius of the state borders except if the servicing pharmacy provider is:

      a) Providing drugs to a Mississippi Medicaid beneficiary who is a resident of a nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF/IID) or psychiatric residential treatment facility (PRTF) or receiving specialized care that is located outside of the thirty (30) mile radius, or

      b) The source of a drug not obtainable from any pharmacy provider within the state of Mississippi within the thirty (30) mile radius.

C. The Division of Medicaid reimburses pharmacy providers only for prescriptions that are received:

   1. Via hand delivery by a beneficiary or his/her representative,

2. Directly via phone, fax, mail or other electronic means such as e-mail or electronic prescribing from a prescribing provider licensed under State law or an agent with medical training under the health professional's direct supervision. [Refer to Miss. Admin. Code, Part 214, Chapter 1, Rule 1.6.]

D. For Change of Ownership Liability refer to Miss. Admin. Code Part 200, Chapter 4, Rule 4.3.

Source: Miss. Code Ann. §§ 43-13-121, 73-21-105, 73-21-106.

Rule 1.2: Pharmacy Services

A. The Division of Medicaid covers the following pharmacy services including, but not limited to:

1. Prescription drug coverage which includes all legend prescription drugs manufactured by a company that has signed a drug rebate agreement with certain specific Centers for Medicare and Medicaid Services (CMS) exceptions.

2. Over-the-counter (OTC) drug coverage which is limited to OTC drugs listed on the OTC Formulary.

3. Immunization coverage which includes certain vaccines. [Refer to Miss. Admin. Code Part 224, Rule 1.7].

B. The Division of Medicaid is not required to cover prescription drugs from manufacturers that do not participate in the federal drug rebate program.

Source: 42 USC §§ 1396b, 1396r-8; Deficit Reduction Act (DRA); Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

Rule 1.3: Drugs Subject to Exclusion or Otherwise Restricted

A. The Division of Medicaid does not cover pharmacy benefits for full benefit, dual eligible individuals who are entitled to receive Medicare benefits under Part A, B, or C, except for drugs in the Medicare excluded categories.

B. Medicaid excluded or otherwise restricted drugs include, but are not limited to:

1. Drugs when used for anorexia, weight loss, or weight gain,

2. Drugs when used to promote fertility,

3. Drugs when used for cosmetic purposes or hair growth,

4. Over-the-counter (OTC) items except those listed on the Division of Medicaid's OTC formulary which are assigned an appropriate National Drug Code (NDC) on their label and are manufactured by a company that has signed a rebate agreement,

5. Drugs when used for the symptomatic relief of cough and colds except for cough and/or cold drugs listed on the OTC formulary and benzonatate,

6. Prescription vitamins and mineral products except for:

   a) Prenatal vitamins,

   b) Folic acid, and

   c) Cyanocobalamin (vitamin B_{12}) injections.

7. Covered outpatient drugs which the manufacturer requires, as condition of sale, that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee,

8. Those drugs designated less than effective by the Federal Drug Administration (FDA) as a result of the Drug Efficacy Study Implementation (DESI) program unless provided through expanded EPSDT services in Miss. Admin. Code Part 223.

9. [Deleted eff. 01/01/2014],

10. [Deleted eff. 01/01/2014],

11. Drugs when used for the treatment of sexual or erectile dysfunction, unless such drugs are used to treat a condition, other than sexual or erectile dysfunction, for which the drugs have been approved by the FDA.

12. Drugs that are investigational or approved drugs used for investigational purposes,

13. Drugs used for off-label indications which are not found in official compendia or generally accepted in peer reviewed literature,

14. Drugs dispensed after the expiration date,

15. Drugs classified as herbal and/or homeopathic products,

16. Moved to Miss. Admin. Code Part 214, Chapter 1, Rule 1.3.C,

17. Drugs produced by manufacturers that do not have signed rebate agreements with the federal government as required by the Omnibus Budget Reconciliation Act

(OBRA) of 1990, unless provided through expanded EPSDT services in Miss. Admin. Code Part 223, and

18. Compounded prescriptions except for hyperalimentation. The Division of Medicaid defines compounded prescriptions as mixtures of two or more ingredients.

C. The Division of Medicaid does not reimburse for the cost of shipping or delivering drugs.

Source: Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2502, 124 Stat. 119 (2010), as amended by Pub. L. 111-152, 124 Stat. 1029 (2010); Social Security Act §§ 1927(d)(2)(7); 1935(d)(1)(2); 42 CFR §§ 423.100, 423.772, 423.906(c); 42 U.S.C. §§ 1396r-8(a), 1396r-8(d); SPA 14-011; Miss. Code Ann. § 43-13-121.

History: Deleted Miss. Admin. Code Part 214, Rule 1.3 B 9 and 10 to correspond with SPA 14-011 (eff. 01/01/2014), moved Miss. Admin. Code, Part 214, Chapter 1, Rule 1.3.B.16 to Miss. Admin. Code, Part 214, Chapter 1, Rule 1.3.C, eff. 07/01/2014; Revised Miss. Admin. Code Part 214, Rule 1.3.B. eff. 01/01/2013.

Rule 1.4: Prior Authorization

A. The Division of Medicaid requires prior authorization of certain covered drugs to ensure use as approved by the Food and Drug Administration (FDA) for specific medical conditions.

   1. Prior authorization of drugs must be obtained from the Division of Medicaid's Pharmacy Prior Authorization Unit or its designee before the drug may be dispensed.

   2. All prior authorization requests must be submitted electronically via web-portal or by facsimile.

   3. Only the Mississippi Medicaid enrolled prescribing provider or a member of the provider's staff may request prior authorization.

   4. Prior authorization requests submitted by agents of drug manufacturers will be denied.

B. The Division of Medicaid reimburses for a seventy-two (72) hour emergency supply of a prescribed drug when a medication is needed without delay and prior authorization is not available and applies to all drugs requiring a prior authorization either because they are:

   1. Non-preferred drugs listed in the Preferred Drug List (PDL), or

   2. A drug affected by clinical or prior authorization edits which would need prescriber prior approval.

Source: 42 USC § 1396r-8(d)(5); Miss. Code Ann. §§ 43-13-117(A)(9), 43-13-121, 73-21-129.

History: Revised Miss. Admin. Code Part 214, Rule 1.4.A.1-B.2 eff. 07/01/2013.

Rule 1.5: Reimbursement

A. Medicaid reimbursement for covered brand name and single source generic drugs is:

1. The lesser of:

   a) The usual and customary charge, or

   b) The Federal Upper Limit (FUL), if applicable, and a dispensing fee of three dollars and ninety one cents ($3.91), or

   c) Average Wholesale Price (AWP) less twelve percent (12%) and a dispensing fee of three dollars and ninety one cents ($3.91), or

   d) Wholesale Net Unit Price/Wholesale Acquisition Cost (WAC) plus nine percent (9%) and a dispensing fee of three dollars and ninety one cents ($3.91). Wholesale Net Unit Price (WNUP) is the published unit price that a manufacturer charges a wholesaler, commonly referred to as the Wholesale Acquisition Cost (WAC).

2. Less the applicable co-payment of three dollars ($3.00).

3. Medicaid defines brand name drugs as single source or innovator multiple source drugs.

4. Medicaid defines single source generic drugs as those drugs going off patent and a single source generic house has exclusivity for a period of time.

B. Medicaid reimbursement methodology for multiple source generic drugs is:

1. The lesser of:

   a) The usual and customary charge, or

   b) The Federal Upper Limit (FUL), if applicable, and a dispensing fee of four dollars and ninety one cents ($4.91); but note, the dispensing fee for prescriptions to beneficiaries in long-term care facilities for multi-source generic drugs is limited to three dollars and ninety one cents ($3.91), or

   c) Average Wholesale Price (AWP) less twenty five percent (25%) and a dispensing fee of four dollars and ninety one cents ($4.91); but note, the dispensing fee for prescriptions to beneficiaries in long-term care facilities for multi-source generic drugs is limited to three dollars and ninety one cents ($3.91).

2. Less the applicable co-payment of three dollars ($3.00).

C. Medicaid reimbursement methodology for covered over-the-counter (OTC) drugs is:

1. The lesser of:

    a) The usual and customary charge, or

    b) The estimated shelf price and a dispensing fee of three dollars and ninety one cents ($3.91).

2. Less the applicable co-payment of three dollars ($3.00).

3. Medicaid defines estimated shelf price as the lowest of the following:

    a) Mississippi Estimated Acquisition Cost (MEAC) for OTC drugs is defined as the Average Wholesale Price (AWP) less twenty five percent (25%), or

    b) Federal Upper Limit (FUL) is the unit price as published by the Centers for Medicare and Medicaid Services (CMS).

D. Medicaid does not reimburse claims at more than the usual and customary charge. Claims must be billed at the usual and customary charge. Medicaid defines usual and customary charge for prescription drugs as the price charged to the general public. Medicaid defines the general public as the patient group accounting for the largest number of non-Medicaid prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through a third party payer.

Source: Miss. Code Ann. § 43-13-121; Section 1902(a)(30)(A) of the Social security Act.; 42 CFR 447.332.; § 73-29-155.

Rule 1.6: Prescription Requirements

A. Pharmacists in the legal employ of the pharmacy provider or under the personal direction of a pharmacist employed by the pharmacy provider must submit claims for services rendered. Prescriptions must be dispensed at the provider's actual physical location of the pharmacy.

B. For purposes of this rule, the Division of Medicaid defines a prescribing provider as an enrolled Mississippi Medicaid provider duly licensed and acting within the scope of practice of his/her profession according to State law.

C. All non-electronic prescriptions must be written on tamper-resistant pads/paper in order to be eligible for reimbursement by the Division of Medicaid.

    1. The tamper-resistant prescription pads/paper requirement applies to all Medicaid prescribing providers including physicians, dentists, optometrists, nurse practitioners and other providers who prescribe outpatient drugs including over-the-counter drugs.

    2. Exemptions to this mandate include:

a) Prescriptions presented by other modes of transmission including facsimile, electronic or e-prescribed, and telephone,

b) Written orders prepared in an institutional setting, including intermediate care facilities and nursing facilities, provided that the beneficiary never has the opportunity to handle the written order and the order is given by licensed staff directly to the dispensing pharmacy, or

c) Transfer of a prescription between two (2) pharmacies, provided that the receiving pharmacy is able to confirm by facsimile or telephone call the authenticity of the tamper-resistant prescription with the original pharmacy.

3. Pharmacy providers must return all funds to the Division of Medicaid for any dispensed prescription which is written hard copy on a non-tamper-resistant pad/paper.

D. The pharmacy provider must ensure the integrity of telephone, electronic and/or faxed prescriptions.

E. All Medicaid beneficiaries are limited to five (5) prescriptions per month, including refills, with no more than two (2) brand name (single source or innovator multiple source drug is less expensive than the generic equivalent) drugs per month for each non-institutionalized Medicaid beneficiary. The Division of Medicaid provides coverage to all Medicaid beneficiaries including full benefit dual eligible beneficiaries. [Refer to Miss. Admin. Code, Part 214, Chapter 1, Rule 1.9 for medically necessary services for EPSDT eligible beneficiaries.]

F. The Division of Medicaid requires that all drugs be prescribed in a full month's supply which may not exceed a thirty one (31) day supply. The following exceptions are allowed:

1. Drugs in therapeutic classes commonly prescribed for less than a month's supply including, but not limited to, antibiotics and analgesics,

2. Drugs that, in the prescribing provider's professional judgment, are not clinically appropriate for the beneficiary to be dispensed in a month's supply,

3. Drug products where the only available package size of the product is one that exceeds the thirty one (31) day supply limit,

4. Certain drugs issued by the Mississippi Department of Health (MSDH) and approved by the Division of Medicaid, including, but not limited to:

a) Contraceptives which may be dispensed in a one (1) year supply, and

b) Tuberculosis (TB) medications which may be dispensed in a three (3) month supply.

5. Six (6) vials, sixty (60) ml each, of insulin may be dispensed at one time,

6. Oral contraceptives may be dispensed in three (3) month supplies,

7. Prenatal vitamins may be dispensed in three (3) month supplies,

8. Those products with cumulative maximum daily and/or monthly units as recommended by the Food and Drug Administration (FDA) and the manufacturer, and/or as recommended by the Drug Utilization Board and approved by the Division of Medicaid,

9. Those products limited by authority of the Division of Medicaid with the potential for misuse, abuse, or diversion for the public safety, well-being and/or health, or

10. A limited listing of maintenance medications, approved by the Division of Medicaid, which may be dispensed in no more than a ninety (90) day supply.

G. In emergency situations, the Division of Medicaid will reimburse for a seventy two (72) hour supply of drugs that require prior authorization. [Refer to Miss. Admin. Code, Part 214, Chapter 1, Rule 1.4.B.]

H. Pharmacy claims must be billed using the National Drug Code (NDC) number of the product dispensed. Pharmacy providers must bill the eleven (11) digit NDC for the drug and package size actually dispensed. This requirement is for all products, regardless of legend or over-the-counter (OTC) status.

I. Pharmacy prescription claims must be billed with the National Provider Identification (NPI) number for the individual prescriber.

1. The NPI number on a pharmacy prescription claim must be for the prescribing provider and not for an entity.

2. The pharmacy is responsible for maintaining current and accurate prescriber identification on file.

3. Access to provider identification information must be available to all pharmacy employees.

4. Non-compliance with Miss. Admin. Code, Part 214, Chapter 1, Rule 1.6.I. may result in termination of point-of-sale (POS) privileges and/or recovery of false claims.

Source: 42 USC §§ 1396b (i) (21) and (23), 1396br-8(a) and (d), 1903(i)(23); Social Security Act, Pub. L. No. 74-271, 49 Stat. 620; U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, 121 Stat. 112; Miss. Code Ann. §§ 43-13-121, 73-21-115.

History: Revised Miss. Admin. Code, Part 214, Chapter 1, Rule 1.6, C.3, G. and I. 07/01/2013; Revised Miss. Admin. Code, Part 214, Chapter 1, Rule 1.6, E. 01/01/2013.

Rule 1.7: Refills/Renewals of Prescription Drugs

A. A written, faxed, e-prescribed, or telephoned prescription may be refilled, in compliance with the prescriber's order, up to a limit of eleven (11) times per year, if compliant with state and/or federal regulations and guidelines. Additionally, the following are applicable:

   1. The absence of an indication to refill by the prescribing provider renders the prescription non-refillable.

   2. Refills are reimbursable only if specifically authorized by the prescribing provider.

   3. The Division of Medicaid does not reimburse prescription refills:

      a) Exceeding the specific number authorized by the prescribing provider.

      b) Dispensed after one (1) year from the date of the original prescription.

      c) With greater frequency than the approximate interval of time that the dosage regimen of the prescription would indicate, unless extenuating circumstances are documented which would justify the shorter interval of time before the refilling of the prescription.

      d) With quantities in excess of the prescribing provider's authorization.

      e) Without an explicit request from a beneficiary or the beneficiary's responsible party, such as a caregiver, for each filling event. The possession, by a provider, of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription.

      f) Until seventy five percent (75%) of the day's supply of the drug has elapsed as indicated on the prescription.

      g) For any controlled substance (Schedule III, IV, and V) until eighty five percent (85%) of the day's supply of the drug has elapsed as indicated on the prescription. Any attempt to refill a prescription through the Point-of-Sale system before the twenty-sixth (26th) day will be automatically denied.

      h) For any Schedule II narcotics.

B. Beneficiaries or providers cannot waive the explicit refill request and enroll beneficiaries in an electronic automatic refill in pharmacies.

C. The Division of Medicaid may permit an early refill of an original claim as long as the monthly service limits have not been exhausted under one (1) of the following

circumstances:

1. The beneficiary's life is at risk,

2. When an acute clinical condition is occurring, which would require extra medication to stop or mitigate further morbidity, or

3. The prescribing provider either increases the dosing frequency or the amount per dose.

   a) The prescribing provider must document the change in dosage or frequency by writing or phoning in a new prescription.

   b) The prescriber(s) who wrote the original prescription must initiate any request for additional medication.

4. If a beneficiary requires an early refill, the prescribing provider must request an exception override of this requirement by seeking approval from Division of Medicaid's Pharmacy Prior Authorization (PA) Unit.

D. The Division of Medicaid does not reimburse for replacement of prescription medications unless the beneficiary can show good cause, which must include documentation such as a police report or insurance claim, that the prescription medications were lost, stolen or otherwise destroyed beyond the beneficiary's control. A replacement may be approved only if the monthly service limit, if applicable, has not been reached.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 11/01/2014.

Rule 1.8: Generic Mandates for Prescription Drugs

Mississippi law requires that the Division of Medicaid does not reimburse for a brand name drug if an equally effective generic equivalent is available and the generic equivalent is the least expensive.

A. Generic drugs classified as non-preferred by the Division of Medicaid require prior authorization.

B. In the absence of a specific request for the brand name drug from the prescribing provider to the pharmacist, the pharmacist must follow standard practice guidelines for the State of Mississippi and fill the prescription with the generic equivalent unless the branded agent is preferred and the generic agent is non-preferred.

C. Prior authorization (PA) is required for any brand name multiple source drug that has a generic equivalent except Narrow Therapeutic Index (NTI) drugs as defined by the Division of Medicaid.

Source: Miss. Code Ann. §§ 43-13-117, 73-21-115, 73-21-117, 73-21-123, 73-21-127, 73-21-129.

Rule 1.9: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Miss. Admin. Code, Part 223, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.10: Preferred Drug List

A. The Division of Medicaid recommends that prescribers use the drugs on the Preferred Drug List (PDL).

    1. The PDL is defined as a list of drugs reviewed and proposed by the Pharmacy and Therapeutics (P&T) Committee, a group of physicians, pharmacists, nurse practitioners, and/or other health care professionals. Final approval of the PDL is the responsibility of the Executive Director of the Division of Medicaid.

    2. The PDL contains a wide range of generic and preferred brand name products approved by the FDA.

    3. A medication becomes a preferred drug based first on safety and efficacy, then on cost-effectiveness.

B. Prior authorizations for non-preferred drugs may be approved for medically accepted indications when criteria have been met.

C. Drugs must be prescribed and dispensed in accordance with medically accepted indications for uses and dosages. No payment will be made under the Medicaid program for services, procedures, supplies or drugs still in clinical trials and/or investigative or experimental in nature.

D. Prior authorizations are reviewed and a determination notice provided within twenty-four (24) hours from receipt of request. If a PA is not available, a seventy-two (72) hour emergency supply must be dispensed. Pharmacists should use his/her professional judgment regarding whether or not there is an immediate need every time the seventy-two (72) hour option is used. The seventy-two (72) hour emergency procedure must not be used for routine and continuous overrides.

E. The PDL is subject to change. [Refer to the Division of Medicaid's website for a current listing of prescription drugs on the PDL.]

Source: Social Security Act § 1927; Miss. Code Ann. § 43-13-121.

History: Effective – 07/01/2012.

Rule 1.11: Smoking Cessation Agents

The Division of Medicaid covers all FDA approved smoking cessation OTC and prescription drugs and nicotine replacement products when used to promote smoking cessation, except dual eligible as Part D will cover.

Source: Miss. Code Ann § 43-13-121.

History: Effective - 01/01/2013.

Rule 1.12: Beneficiary Signature

A. The pharmacy must obtain the signature of the beneficiary or his/her representative signature and their relationship to the beneficiary for each prescription received with the exception of beneficiaries living in long-term care facilities, i.e. nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IID) facilities and/or psychiatric residential treatment facilities (PRTF).

    1. Electronic signatures are acceptable.

    2. One signature per prescription is required.

    3. The pharmacist may sign for a prescription if the beneficiary or his/her representative is not capable of signing. When signing the pharmacist must:

        a) Document the circumstances preventing the beneficiary or his/her representative from signing for the prescription, and

        b) Sign the prescription signature record with his/her own name and the beneficiary's name.

    4. For shipped or delivered prescriptions, the pharmacy must obtain the signature of the beneficiary or his/her representative and their relationship to the beneficiary.

        a) The pharmacy must maintain signatures on-site and in an auditable manner.

        b) The Division of Medicaid will not reimburse for medications lost in transit and/or not received by the beneficiary.

B. Prescription signature records for received prescriptions must include the prescription serial number, date medication is received and the beneficiary or his/her representative's signature and their relationship to the beneficiary.

1. Prescription signature records must be retained for a period of five (5) years for audit purposes.

2. Prescription signature records for shipped prescriptions must be retained for a period of five (5) years and must include the delivery confirmation for audit purposes.

3. Prescription signature records must be maintained on-site and in an auditable manner.

C. The beneficiary or provider cannot waive the receipt signature requirement nor does "signature on file" meet this obligation.

Source: Miss. Code Ann. § 43-12-121.

History: Miss Admin. Code, Part 214, Chapter 1, Rule 1.12 A.-E. added 07/01/13 to include 04/01/12 compilation omission.

Rule 1.13: Retrospective Drug Utilization Review (DUR)

A. The Division of Medicaid utilizes a quality assurance program, Drug Utilization Review (DUR), to:

   1. Promote patient safety by an increased review and awareness of outpatient prescribed drugs including drug appropriateness,

   2. Enhance and improve the quality of pharmaceutical care and patient outcomes by encouraging optimal drug use, and

   3. Educate physicians and pharmacists on appropriate, safe and effective drug therapy.

B. The Division of Medicaid's DUR Board is composed of twelve (12) participating physicians and pharmacists who are active MS Medicaid providers and in good standing with their licensing boards who meet quarterly.

Source: The Omnibus Budget Reconciliation Act (OBRA 90); Miss. Code Ann. § 43-13-107.

History: New Rule eff. 11/01/2014.

Rule 1.14: Participating Federally Qualified Health Center (FQHC) Providers

All drugs, as defined by the Veterans Health Care Act of 1992 Title VI, purchased by an in-house pharmacy of a Federally Qualified Health Center (FQHC) at a discounted price must be reported on the cost report and are reimbursed through the core services encounter rate and not billed through the Pharmacy Program.

Source: The Veterans Health Care Act of 1992 Title VI.

History: New Rule eff. 11/01/2014.

Rule 1.15: 340B Program

Providers participating in the 340B program must adhere to all the provisions in Miss. Admin. Code Part 200, Chapter 4, Rule 4.10.

Source: Sec. 340B of the Public Health Service Act (Pub. L. 102-585), as amended by the Patient Protection and Affordable Care Act (Pub. L. 111-148), Health Care and Education Reconciliation Act (Pub. L. 111-152) and Medicare and Medicaid Extenders Act of 2010 (Pub. L. 111-309); Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 11/01/2014.

Part 214 Chapter 2: Pharmacy Disease Management

Rule 2.1: Provider Enrollment and Pharmacy Participation

A. Pharmacists participating in the Medicaid program and providing disease management services must comply with the requirements outlined in Part 214, Chapter 1, Rule 1.1 in addition to the following requirements:

    1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

    2. Copy of current pharmacist's license or permit,

    3. Current certificate for disease management,

    4. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name on the W-9, and

    5. Credentials from the National Institute for Standards in Pharmacists Credentialing for the specific disease for which care is provided.

B. Pharmacy disease management provider agreements will not be initiated or maintained with any pharmacist whose place of business is physically located more than thirty (30) miles from the borders of Mississippi.

C. Only individual pharmacists can enroll as a pharmacy disease management provider. Pharmacies with multiple individual pharmacy disease management providers may apply for group management services under one (1) group provider number; but each individual pharmacist in the group must maintain his/her own individual provider number. Businesses

such as partnerships and corporations are not allowed to operate as pharmacy disease management providers.

Source: Miss. Code Ann. § 43-13-121, 42 CFR 455, Subpart E.

Rule 2.2: Program Services

A. Pharmacy Disease Management (PDM) services are those provided for Medicaid beneficiaries with specific chronic disease states of diabetes, asthma, hyperlipidemia, anti-coagulation therapy, or other disease states as defined by the Division of Medicaid. It is a patient-centered concept integrating the pharmacist into the health care team with shared responsibility for disease management and therapeutic outcomes.

B. A referral for PDM services is required and services must be provided by a specially credentialed pharmacist. Pharmacy care records including a written referral and all laboratory test results must be transferred from the referring physician to the pharmacist. PDM services performed by the pharmacist must not duplicate services provided by the physician.

C. The pharmacist must be knowledgeable about pharmaceutical products and the design of therapeutic approaches that are safe, effective, and cost-efficient for patient outcomes. He or she is to function in an educational capacity to ensure the patient understands and complies with the proper usage of all drugs prescribed by the physician. It is the responsibility of the pharmacist to:

1. Evaluate the patient,

2. Consult with the physician concerning the suggested/prescribed drug therapy,

3. Counsel the patient regarding compliance, and

4. Provide the patient with educational and informational materials specific to the disease and/or drug.

D. Communication is required between the referring physician and the pharmacist. Pharmacy disease management services follow a protocol developed between the pharmacist and patient's physician.

E. The pharmacist provider must personally render all pharmacy disease management services billed to Medicaid. A relief pharmacist employed for pharmacy disease management services must bill Mississippi Medicaid using his/her own individual Medicaid provider number.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.3: Components of Pharmacy Disease Management

A. The primary components of this service are as follows:

1. Patient evaluation,

2. Compliance assessment,

3. Drug therapy review,

4. Disease state management, according to clinical practice guidelines, and

5. Patient/caregiver education.

B. The pharmacist must provide a separate, distinct area conducive to privacy for a seated, face-to-face consultation with the beneficiary, such as a partitioned booth or a private room. This consultation is used to privately educate the beneficiary.

C. A copy of the pharmacy care records, including the documentation for services, must be shared with the patient's physician and remain on file in the pharmacist's facility and available for audit by the Division of Medicaid.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.4: Eligibility

A. Pharmacy disease management services are not covered for beneficiaries in long term care facilities or for beneficiaries receiving home health services.

B. Neither OBRA-mandated counseling nor JCAHO-mandated institutional discharge counseling qualify as a pharmacy disease management service.

C. Pharmacy disease management services are available to the parent or other responsible guardian when the beneficiary is a minor and/or mentally challenged and living at home.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.5: Reimbursement

A. Pharmacy disease management services are reimbursed on a per encounter basis. When billing for an encounter, pharmacy disease management providers must use the appropriate procedure code. An encounter must be at least fifteen (15) minutes and average thirty (30) minutes.

B. The number of encounters is limited to twelve (12) per beneficiary per fiscal year.

Source: Miss. Code Ann. § 43-12-121.

Rule 2.6: Pharmacy Disease Management Documentation Requirements

In addition to the documentation requirements applicable to all pharmacy providers, pharmacy

disease management providers must maintain additional documentation. The disease management pharmacist must maintain at his/her place of business proof of current certification for the specific disease state for which reimbursement is sought. A pharmaceutical care record, or patient record, must be maintained on each individual beneficiary for whom services are billed. These records must be retained and maintained in a manner conducive to audit, in alphabetical order and for a minimum of five (5) years. At a minimum, the following documents must be maintained, in date order, within each individual beneficiary's pharmaceutical care record:

A. A referral from the beneficiary's physician/nurse practitioner,

B. A copy of the protocol in accordance with the National Clinical Practice Guidelines authorizing pharmacy disease management of the beneficiary,

C. Documentation of all oral and written communication with the beneficiary's physician/nurse,

D. Copies of all laboratory data provided, and

E. All pharmacist notes, including progress reports, pertaining to the care of the beneficiary.

Source: Miss. Code Ann. § 43-13-117, 43-13-118, 43-13-121, 43-13-129.

Administrative Code

Title 23: Medicaid
Part 215
Home Health Services

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Title 23: Division of Medicaid

Part 215: Home Health Services

Part 215 Chapter 1: Home Health Services

Rule 1.1: General

A. The Division of Medicaid covers home health services for a beneficiary that is:

   1. Essentially homebound;

   2. Under the care of a physician; and

   3. In need of home health services on an intermittent basis.

B. The beneficiary's residence shall not include a hospital, skilled nursing facility, or a mental or criminal institution.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 484

Rule 1.2: Provider Enrollment Requirements

Home health providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

B. Written confirmation from the IRS confirming your tax identification number and legal business name.

C. Copy of the Tie-In Notice. The EOMB is not acceptable.

D. Copy of License from the Mississippi State Board of Health, Health Facilities Licensure and Certification. If parent entity is an out of state facility with a servicing location in Mississippi, a copy of the respective State's license is required.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E; 42 CFR § 484

Rule 1.3: Criteria for Coverage

A. The Division of Medicaid covers home health services for beneficiaries who are under the care of an attending physician when the services are prescribed by the beneficiary's attending physician.

1. The attending physician's order is part of a written Plan of Care.

2. The attending physician must review and recertify the written Plan of Care every sixty (60) days.

B. The Division of Medicaid covers home health agency services, like home nursing care services, home health aide services, and on an intermittent basis when:

1. Documentation is present in the beneficiary's medical record which justifies that the services are medically necessary and reasonable for the treatment of the beneficiary's illness, injury, or condition; and

2. The beneficiary's medical condition, illness, or injury requires services that must be delivered at the beneficiary's place of residence rather than at an office, clinic, or other outpatient facility, according to one (1) or more of the following guidelines:

a) The beneficiary's travel to a physician's office, clinic, or other outpatient setting for the needed service would create a medical hardship for the patient due to the beneficiary's specific illness, injury, or disability.

1) The Division of Medicaid defines medical hardship as including, but not limited to:

i) A patient who requires ambulance transportation due to the severity of their medical condition.

ii) A patient in severe pain.

iii) A patient with bilateral upper extremity loss who is unable to open doors, use handrails or perform other activities, and needs help to leave his/her residence.

iv) A patient for whom leaving the home is likely to cause an exacerbation of his/her condition.

v) A patient who experiences shortness of breath that significantly hinders travel.

vi) A diabetic patient who is wheelchair bound due to bilateral lower extremity amputations and makes only infrequent trips from his residence due to medical complications of the amputations.

2) The Division of Medicaid defines conditions that in and of themselves are not considered hardship including, but not limited to:

i) The use portable oxygen.

ii) Walking with a limp.

iii) The use of an assistive device such as a cane, walker, or wheelchair.

iv) A wheelchair-bound patient who regularly drives a specially equipped vehicle to travel outside of the home.

v) The need for routine transportation. Refer to Part 201, Chapter 2.

vi) The need for a child to be supervised by an adult when the child is outside the home.

b) The beneficiary's travel to a physician's office, clinic, or other outpatient setting for needed services is contraindicated by written documentation in the beneficiary's medical record of a fragile or unstable medical condition. The beneficiary's physician must document in writing that the beneficiary's condition is so fragile or unstable that the beneficiary's leaving their home for services is undesirable or detrimental to the beneficiary's health. The Division of Medicaid defines a fragile or unstable medical condition as including, but not limited to:

1) A newborn infant up to six (6) weeks of age who has acute care needs, or who is at medical risk of complications.

2) A beneficiary who has just had a major surgical procedure and has significant postoperative weakness and pain. Because of his/her condition, their physician has documented restriction(s) of the beneficiary to limited activities and allows only brief periods of time out of bed.

3) A beneficiary with severe arteriosclerotic or congestive heart disease who is ordered by his/her physician to avoid all stress and physical activity.

4) A beneficiary with a serious or immunocompromised medical condition whose physician has documented that protection from exposure to infections is medically necessary.

5) A beneficiary who has been released from the hospital less than forty-eight (48) to seventy-two (72) hours after major surgery.

c) The beneficiary's travel to a physician's office, clinic, or other outpatient setting for a needed service would interfere with the effectiveness of the service. The Division of Medicaid defines situations meeting this criteria as including, but not limited to:

1) A beneficiary who needs a service repeated at intervals difficult to accomplish in a physician's office, clinic, or other outpatient setting.

2) A beneficiary who needs regular or unpredictable catheter changes.

3) A beneficiary who has a documented past failure to comply with visits to a physician's office, clinic, or other outpatient setting for the needed services, and has also suffered, or has a high probability of suffering, documented adverse health consequences as a result of their noncompliance, including frequent use of emergency room and hospital admissions. The beneficiary's non-compliance must be documented to be a direct result of their illness, injury, or disability including mental disorders. The Division of Medicaid defines situations meeting this criteria as including, but not limited to:

i) A beneficiary newly diagnosed with End Stage Renal Disease (ESRD) who has been prescribed a specialized diet with significant restrictions.

ii) A beneficiary who has an abdominal wound dehiscence.

iii) A beneficiary who requires use of assistance devices that have been specifically customized for the patient's home environment which requires reinforcement on the use of the assistive devices, including bath chairs and shower grab bars.

C. The place of residence for the purpose of determining home health services is the address at which the beneficiary lives.

1. The Division of Medicaid defines the place of residence as the beneficiary's:

a) Own private home or apartment,

b) Relative's home, or

c) A home for the aged or boarding home.

2. To qualify for home health benefits, the beneficiary cannot be a resident of an institution that meets the basic definition of a hospital or nursing facility.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 484

Rule 1.4: Covered/Non-Covered Services

A. The Division of Medicaid covers twenty-five (25) home health visits per state fiscal year, July 1-June 30.

1. The visits may be a combination of a skilled nurse and/or home health aide**,** or

2. Home health aide visits will be allowed without the requirement for skilled care by a nurse.

B. Medicaid covers the cost of medical supplies reported in the medical supplies cost center of the Medicare cost report, which are directly identifiable supplies furnished to individual patients and for which a separate charge is made, in the payment for the visit.

C. Physical therapy and speech therapy visits are not covered through the home health program for beneficiaries age 21 and over.

D. Medicaid does not cover Durable Medical Equipment (DME), orthotics, or prosthetics supplied through a home health agency.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 484

Rule 1.5: Certification Requirements

A. The Division of Medicaid requires the ordering physician have full responsibility for maintaining auditable records that verify services provided by the home health agency are medically necessary. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3. At a minimum, the records must contain the following for each beneficiary:

   1. Copy of the initial certification,

   2. Copy of all recertifications,

   3. Copy of any new orders, medications, or other treatment changes,

   4. Documentation of all examinations and evaluations which clearly indicate the medical necessity for ordering home health services and the need for continuation of those services,

   5. Copy of the case conference report(s) covering all disciplines,

   6. Copy of any lab, x-ray, or other diagnostic test results,

   7. Copy of discharge summary to include all transfers and hospital stays, and

   8. Documentation of all verbal communications between the home health agency and the physician.

B. It is the responsibility of the home health agency to supply the ordering physician with copies of reports or records as needed for the physician office files.

   1. Practitioners must provide a statement of certification /recertification that shows the medical necessity for home health services, the type of services required, and the period of time home health services will be needed.

   2. The Division of Medicaid requires that an individual requiring a level of care which

would make them eligible for home health benefits be seen by the specializing physician or the primary care physician at least once every sixty (60) days.

3. The practitioner must provide a written recertification statement indicating there is a continuing need for home health services and approximately how long services will be needed.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 42 CFR 424.22; 42 CFR 484

Rule 1.6: Documentation

The Division of Medicaid requires the home health agency to maintain auditable records that substantiates the services provided. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3. At a minimum, the records must contain the following on each beneficiary:

A. Physician referral,

B. Appropriate identifying information,

C. Name of the physician,

D. Original signed copy of the initial certification,

E. Original signed copy of all recertifications,

F. Original signed copy of any new orders, change in orders, medications, medical supplies or other treatment changes,

G. Original copy of case conference report(s) covering all disciplines,

H. Original copy of all lab results and other diagnostic test results,

I. Original copy of discharge summary to include transfers and hospital stays,

J. Documentation of all verbal communications between the home health agency and the physician, and

K. Signed copy of drug, dietary, treatment and activity orders including any new changes.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129; 42 CFR 484.48

Rule 1.7: Home Health Services Provided in Another State

A. The Division of Medicaid must pay for services furnished in another state to the same extent that it would pay for services furnished within the boundaries of Mississippi if the services are furnished to a beneficiary who is a resident of this state, and any of the following

conditions are met:

1. Medical services are needed because of a medical emergency,

2. Medical services are needed and the beneficiary's health would be endangered if she/he were required to travel to her/his state of residence,

3. The Division of Medicaid determines, on the basis of medical advice, the needed medical services or necessary supplementary resources are more readily available in the other state, or

4. It is general practice for beneficiaries in a particular locality to use resources in another state.

B. The Division of Medicaid requires the following guidelines for an out of state home health agency:

1. If the beneficiary has been a resident for more than thirty (30) days in the state where the home health agency operates, the beneficiary would be considered a resident of that state and the Mississippi Division of Medicaid would not reimburse for services provided, or

2. If the beneficiary has not been a resident for more than thirty (30) days in the state where the home health agency operates, the Mississippi Division of Medicaid would reimburse for services.

C. Out-of-state providers are required to request a provider number and meet all home health agency requirements.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 431.52.

Rule 1.8: Dual Eligibles

Beneficiaries eligible for Medicare and Medicaid must not receive home health visits under both programs simultaneously. Refer to Part 200, Chapter 2, Rule 2.3.

A. If Medicare does not cover home health nurse visits, physical therapy visits, or speech therapy visits because skilled services are not being provided, the Division of Medicaid will not cover the services.

B. If Medicare does not cover home health aide visits because a skilled service is not being provided, the Division of Medicaid will cover medically necessary aide visits.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: Reimbursement

A. The Division of Medicaid covers home health agency reimbursement for covered services based on reasonable cost which is determined in accordance with the Mississippi Medicaid Home Health Reimbursement Plan and Title XVIII (Medicare) principles of reimbursement, except when Medicare guidelines are contradictive to directives of the State Plan or Division of Medicaid. In such a situation, the State Plan or Division of Medicaid will prevail.

1. Medicaid cost reporting schedules must be included with the Medicare cost report to compute Medicaid reimbursement.

2. A schedule must be completed to reflect the lower of reasonable costs or customary charge provisions as they apply to Medicaid.

3. In addition to the lower of costs or charge limitations, reimbursement for home health services is limited to and cannot exceed the prevailing costs of providing nursing facility services in the Mississippi Medical Assistance (Medicaid) Program.

B. The Division of Medicaid will reimburse for the initial assessment visit for skilled services, either Home Health Skilled (HHSK), Home Health Physical Therapy (HHPT), and/or Home Health Speech Therapy (HHST), and aide services as listed below:

1. If a beneficiary is assessed for skilled services, without a skilled service performed during the initial assessment visit and is not admitted to the home health program, the initial assessment visit is not approved and must be claimed as an administrative cost.

2. If a beneficiary is assessed for skilled services, with a skilled service performed during the initial assessment visit and is admitted to the home health program for continuation of skilled visits, the initial assessment visit is not an administrative cost and can be billed.

3. If a beneficiary is assessed for skilled services with a skilled service performed during the initial assessment visit only, the home health agency must elect either to:

   a) Claim this as an administrative cost, or

   b) Admit to and discharge the beneficiary from the home health program for this one (1) visit. This is not an administrative cost and can be billed.

4. If a beneficiary is assessed for home health aide services only, without a skilled service performed during the initial assessment visit and is not admitted to the home health program, the initial assessment visit is not approved and must be claimed as an administrative cost.

5. If the beneficiary is assessed for home health aide services only and is admitted to the home health program and a skilled service is performed during the initial assessment visit, the home health agency must elect either to:

   a) Claim the assessment as an administrative cost, or

b) Bill the initial assessment visit as a skilled service.

C. Initial assessment visits must be performed by a registered nurse.

D. If the beneficiary is receiving home health aide services only, a supervisory visit must be made every sixty (60) days by a registered nurse while the home health aide is providing patient care. Supervisory visits are administrative costs and are not directly reimbursable.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 484, Subpart E

Rule 1.10: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 216
Dialysis Services

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Title 23: Division of Medicaid

Part 216: Dialysis Services

Part 216 Chapter 1: Dialysis Services

Rule 1.1: Provider Enrollment Requirements

Freestanding or hospital-based kidney dialysis centers must satisfy all requirements set forth in Miss. Admin. Code, Part 200, Chapter 4, Rule 4.8, in addition to the following provider type specific requirements:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

B. Written confirmation from the IRS confirming the providers tax identification number and legal name, and

C. Copy of dialysis Medicare certification:

1. Explanation of Medicare Benefits (EOMB) is not acceptable, and

2. Must be from a Medicare Administrative Contractor.

Source: 42 CFR 455, Subpart E; Miss. Code Ann. § 43-13-121.

Rule 1.2: Covered Services

A. The Division of Medicaid covers:

1. Hemodialysis,

2. Peritoneal dialysis,

3. Continuous Ambulatory Peritoneal Dialysis (CAPD), and

4. Continuous Cyclic Peritoneal Dialysis (CCPD).

B. Prior authorization is not required for dialysis services.

C. The Division of Medicaid covers:

1. All resources used in providing outpatient dialysis services, including supplies and equipment used to administer dialysis in the ESRD (end stage renal disease) facility or at a beneficiary's home, drugs, biologicals, laboratory tests, and support services under the bundled ESRD PPS (prospective payment system) rate,

2. Professional services,

3. Antibiotics, when used at home by a beneficiary, to treat an infection of the catheter site or peritonitis associated with peritoneal dialysis, and

4. Specified lab tests and injectable drugs not included in the bundled ESRD PPS rate , when medically necessary.

Source: 42 CFR 494; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 14-003 (eff. 01/01/2014) eff. 05/01/2014.

Rule 1.3: Bundled ESRD PPS /Definition of Units

A. The Division of Medicaid reimburses freestanding and hospital-based ESRD facilities the bundled ESRD PPS rate for all resources used in providing outpatient dialysis services, including supplies and equipment used to administer dialysis in the ESRD facility or at a beneficiary's home, drugs, biologicals, laboratory tests and support services.

   1. The facility must furnish all necessary services, equipment, and supplies.

   2. The appropriate revenue codes must be billed for the ESRD PPS rate.

   3. Dialysis services are not reimbursed if there are no corresponding treatment notes.

B. The Division of Medicaid covers three (3) units of hemodialysis per a seven (7) day week.

   1. Hemodialysis is typically furnished three (3) times per week in treatment sessions lasting four (4) to five (5) hours.

   2. One (1) unit is equal to one (1) treatment session.

C. The Division of Medicaid covers one (1) unit for each day, up to thirty-one (31) days, per month for home hemodialysis, peritoneal dialysis, Continuous Ambulatory Peritoneal Dialysis (CAPD) and Continuous Cycling Peritoneal Dialysis (CCPD). The Division of Medicaid defines one (1) unit ~~i~~as one (1) twenty-four (24) hour day.

D. Medical documentation substantiating the medical necessity for additional units is required.

Source: 42 CFR 494; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 14-003 (eff. 01/01/2014) eff. 05/01/2014.

Rule 1.4: Professional Services

A. The Division of Medicaid covers related physician services for ESRD billed with the

appropriate procedure codes which are excluded from the ESRD PPS rate.

1. The physician or qualified health care professional must provide one (1) face-to-face visit with the beneficiary monthly.

2. The medical record must contain the physician or qualified health care professional's documentation substantiating the medical necessity for additional face-to-face visits.

3. Documentation must be legibly written, signed and dated during the face-to-face visit.

4. Documentation by the interdisciplinary team cannot substantiate the medical necessity of the physician or qualified health care professional's face-to-face visit.

B. Physician services are not covered under the facility's provider number.

C. Face-to-face physician visits are not included in the physician services visit limit.

D. Evaluation and management services provided to the beneficiary which are unrelated to dialysis services cannot be performed during the dialysis session and must be reported separately.

Source: 42 CFR § 414.310; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 14-003 (eff. 01/01/2014) eff. 05/01/2014.

Rule 1.5: Documentation Requirements

A. Dialysis providers must maintain auditable records that substantiate the dialysis services provided.

B. The physician or qualified healthcare professional's documentation in the medical record must include, but not limited to, the following:

1. Dates of service,

2. Monthly face-to-face evaluation of the beneficiary's current health status, medical condition, provider findings and appropriateness of the treatment plan,

3. Mode of dialysis and treatment plan,

4. All treatments, medications, biologicals, lab tests and other studies both included and excluded in the ESRD PPS rate, and

5. A legible signature of the physician or qualified healthcare professional with documented credentials to support the service rendered and date of entry.

C. If more than one (1) face-to-face physician or qualified healthcare professional visit is required within a month the:

1. Physician or qualified healthcare professional's documentation must support the medical necessity for the visit.

2. Interdisciplinary team documentation cannot be used to substantiate billing a physician or qualified healthcare professional's face-to-face visit.

D. The dialysis facility's record must include, but not limited to, the following:

1. Dates of service,

2. Current annual evaluation including age and gender-appropriate history and physical examination documented by a physician including all pertinent lab and diagnostic procedures,

3. Individualized treatment notes which must include documentation verifying each face-to-face physician visit,

4. Beneficiary assessment in accordance with 42 CFR § 494.80,

5. Mode of dialysis and treatment plan,

6. All treatments, medications, biologicals, lab tests and other studies both included and excluded in the ESRD PPS rate,

7. A written plan of care prepared and reviewed monthly by an interdisciplinary team that includes the beneficiary's physician and other healthcare professionals, as appropriate, familiar with the beneficiary's condition, and

8. A legible signature of the physician or healthcare professional with documented credentials to support the service rendered and date of entry.

Source: Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 14-003 (eff. 01/01/2014) eff. 05/01/2014.

Rule 1.6: Immunizations

A. Medicaid reimburses dialysis facilities for influenza and pneumonia vaccines when provided by and administered by the dialysis facility to beneficiaries receiving dialysis services.

B. Influenza and pneumonia vaccines are excluded from the ESRD PPS rate.

Source: Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 14-003 (eff. 01/01/2014) eff. 05/01/2014.

Rule 1.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Miss. Admin. Code, Part 223, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

MISSISSIPPI DIVISION OF
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Administrative Code

Title 23: Medicaid
Part 217
Vision Services

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Title 23: Division of Medicaid

Part 217: Vision Services

Part 217 Chapter 1: General

Rule 1.1: Vision Services

Vision service is an optional benefit under the state's Medicaid program and financial assistance is provided as follows:

A. Eyeglasses for all Medicaid beneficiaries who have had surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses are medically indicated within six (6) months of the surgery and is in accordance with rules established by Medicaid, or

B. One (1) pair of eyeglasses every five (5) years and in accordance with rules established by Medicaid. In either instance, the eyeglasses must be prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the beneficiary selects.

C. Eye exams for all eligible beneficiaries are covered.

Source: Miss. Code Ann. § 43-13-121; 43-113-117(11); 42 CFR 441.30

Rule 1.2: Provider Enrollment

A. Providers of vision services, and those who dispense optical items such as eyeglasses and contacts must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

    1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

    2. Copy of licensure card or letter from the appropriate board stating current certification. Card or letter must be from state of servicing location, and

    3. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

B. Written confirmation from the IRS confirming the provider's tax identification number and legal name.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E

Rule 1.3: Reimbursement

A. Medicaid covers vision services under a statewide uniform fixed fee schedule for the professional services of the optometrist or ophthalmologist plus actual acquisition cost for eyeglass frames and lenses. The provider of eyeglasses must bill the actual acquisition cost (AAC) for the frames and lenses. Medicaid will cover the frames and lenses based on the lower of AAC or the maximum fee as determined by Medicaid.

B. Medicaid does not permit providers of optometric services to charge a beneficiary an additional amount for services or supplies, like frames, above the fee established. The provider cannot dispense a more expensive frame than is covered under the Medicaid program and collect the difference from the beneficiary.

C. A beneficiary may purchase non-covered services, like scratch resistant lens coating. Providers cannot bill Medicaid and hold the eyeglasses or contacts until Medicaid pays the provider. Providers may not bill Medicaid for replacement costs associated with provider error or poor workmanship.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Non-Covered Services

A. The Division of Medicaid does not cover vision services including, but not limited to, eye exams, eyeglasses, frames, lenses, and/or contact lenses, for beneficiaries enrolled in the Family Planning Waiver (FPW).

B. The Division of Medicaid does not cover the following including, but not limited to:

1. Eyeglasses solely for protective, fashion, cosmetic, sports, occupational or vocational purposes,

2. More than one (1) pair of eyeglasses every five (5) years,

3. Single vision eyeglasses in addition to multifocal eyeglasses,

4. Progressive bifocals,

5. Sunglasses,

6. Upgraded frames,

7. Eyeglass cases,

8. Engraving,

9. Contact lens supplies and/or solutions,

10. Eyeglass or contact lens insurance,

11. Lens coating, unless specified by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity,

12. Orthoptics,

13. Dispensing fees,

14. Contact lenses, unless specified by a UM/QIO, the Division of Medicaid, or designated entity,

15. Refractive surgery including, but not limited to, Lasik surgery, radial keratotomy, photorefractive keratectomy, and/or astigmatic keratotomy,

16. Services and items requiring prior authorization for which authorization has been either denied or not requested, or

17. Replacement of lenses or frames due to:

    a) Provider error in prescribing, frame selection, or measurement, or

    b) Poor workmanship and/or materials.

Source: 42 CFR §§ 435.116, 441.30; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 13-0019; Healthier Mississippi Waiver.

History: Revised to correspond with SPA 13-0019 (eff. 01/01/14) and Healthier Mississippi Waiver (HMW) Renewal (eff. 07/24/2015) eff. 04/01/2016.

Rule 1.5: Eye Examinations/Refractions

A. Medicaid requires eye examinations/refractions to be performed by an optometrist or an ophthalmologist. Medicaid covers for one (1) refraction every five (5) years. No prior authorization is required. The appropriate procedure code must be billed.

B. Medicaid covers medically necessary diagnostic services that aid in the evaluation, diagnosis, and or treatment of ocular disease or injury for all beneficiaries regardless of age. Coverage is limited to the eye examination. The exam counts toward the twelve (12) office visits. Providers must bill using the appropriate procedure codes for new and established patients.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.30

Rule 1.6: Lacrimal Punctum Plugs

A. Medicaid covers medically necessary insertion of collagen and silicone punctum plugs when there is a documented diagnosis consistent with moderately severe to severe dry eye syndrome. A signed treatment/surgical consent form, specific to plug insertion, is required.

B. Medicaid does not cover the following:

1. Insertion of silicone plugs less than ten (10) days following collagen plug insertion,

2. Insertion of plugs for the treatment of any condition other than dry eye syndrome, contact lens intolerance, refractive correction, glaucoma, or sinus maladies,

3. Repetitive use of temporary or dissolvable collagen plugs when semi-permanent or permanent treatment is indicated,

4. Repetitive use of semi-permanent or non-dissolvable silicone plugs when there is an absence of documentation to support the need, such as plug fell out, and/or when permanent treatment is indicated, or

5. Separate reimbursement for the plug itself or when the cost of the plug is included in payment for the insertion.

C. Medicaid covers up to two (2) collagen or silicone plugs per office visit. In most cases, placement of one (1) plug in each lower punctum is sufficient to alleviate symptoms. Up to two (2) additional plugs may be performed for a total of four (4), but documentation must reflect that the additional plugs were medically necessary. There must be a period of no less than ten (10) days between the insertion of collagen plugs and the insertion of silicone plugs.

D. Providers must use the appropriate procedure code in conjunction with the appropriate and applicable modifier for each plug is placed into a punctum.

E. There may be both a diagnostic occlusion with a temporary dissolvable collagen plug and a therapeutic occlusion with a semi-permanent, non-dissolvable silicone, plug performed on the same beneficiary within a short amount of time. Medicaid does not cover if the length of time between insertion of collagen and silicone plugs is less than ten (10) days.

F. Medicaid requires documentation of the following for insertion of lacrimal punctum plugs:

1. Symptoms, including dryness, scratchiness, itching, redness, burning, foreign body sensation,

2. Comorbidities that might be related to ophthalmic disease,

3. Diagnostic tests and results, including visual acuity exam, slit lamp exam, tear film break-up time (BUT), Schirmer's tear test, and/or staining procedures,

4. Signed treatment/surgical consent form(s) specific to insertion of the plug,

5. Specific treatments rendered, including conservative treatments, and the results, and

6. Operative report(s).

G. Documentation must be sufficient to support the type, either temporary or semi-permanent, and the number of plugs inserted. Documentation must reflect a minimum of ten (10) days between insertion of temporary plugs and the insertion of semi-permanent plugs.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Documentation

Records must be documented and maintained in accordance with Part 200, Chapter 1, Rule 1.3. The vision medical record documentation must contain the following on each beneficiary:

A. Date(s) of service,

B. Demographic information,

C. Current medical history,

D. Examination and/or treatment rendered,

E. Specific name/type of all diagnostic studies, and the result/finding of the studies,

F. Specific order for all lenses, lens coating, and ocular prosthetics, and

G. Provider's signature.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 1.8: Dual Eligibles

A. Medicare covers vision services provided to dual eligible beneficiaries, in accordance with the rules outlined in this Part, for services not covered by Medicare when the reason for the Medicare denial is other than medical necessity.

B. Dual eligible beneficiaries cannot be billed the balance between standard and deluxe frames as the Medicare and Medicaid payment is considered payment in full.

C. Providers must adhere to the rules for Third Party billing outlined in Part 306.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 217 Chapter 2: Contact Lenses

Rule 2.1: Coverage Criteria

A. Medicaid does not cover contact lenses when prescribed for routine correction of refractive errors.

B. Medicaid covers contact lenses prescribed by an ophthalmologist or an optometrist when there is documentation that supports the following criteria:

1. Conventional eyeglasses will not result in acceptable visual correction, and

2. Contact lenses are medically necessary for the treatment of the following diseases or injury to the eye:

a) Keratoconus,

b) Keratoglobus,

c) Irregular cornea astigmatism,

d) Nystagmus,

e) Progressive myopia over 6 diopters, where contact lens will improve visual acuity or retard the progressive myopia and lessen the frequency of prescription changes,

f) Hyperopia over 3.5 diopters, where contact lenses will improve visual acuity,

g) Anisometropia greater than 3 diopters or greater than 2.5, if there is documented intolerance to glasses as a result of anisometropia,

h) Disease or deformity of the nose, skin, or ears that precludes the wearing of eyeglasses,

i) Post-operative cataract surgery, or

j) Treatment as a result of eye surgery, other than cataracts, which must be provided within six (6) months of the surgery to be covered.

C. Corneal bandages when used as lenses are not covered as a separate reimbursement. The cost of the lenses is included in the payment for the physician and/or facility's service. Providers should bill using the appropriate procedure code. Prior authorization is required.

D. Prescriptions must include lens specifications such as power, size, curvature, flexibility, and gas-permeability for contact lenses.

E. Medicaid does not cover for replacement of lost or stolen contact lenses.

F. Prior authorization is required for all contact lenses**.** The request must properly document that one (1) of the diagnoses listed under coverage criteria is involved, and it must reflect that conventional eyeglasses is not an acceptable method of correction.

Source: Miss. Code Ann. § 43-13-121

Rule 2.2: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 217 Chapter 3: Eyeglasses

Rule 3.1: Coverage Criteria

A. Medicaid covers eyeglasses prescribed by an ophthalmologist or optometrist when documentation supports the following:

    1. Eyeglasses are medically necessary,

    2. Eyeglasses are prescribed to significantly improve vision or correct a medical condition, and

    3. Eyeglasses meet eyeglass program specifications for frames and lenses.

B. Coverage benefits/limitations include:

    1. Beneficiaries are allowed one (1) complete pair of eyeglasses every five (5) years. Prior authorization is not required unless manually priced codes are used. This includes eyeglass lenses and frames.

    2. Repairs and replacements are not covered.

C. Prescriptions for eyeglass lenses must include lens specifications such as lens type, power, axis, prism, absorptive power, and impact resistance.

D. Prescriptions for lens coating must include the appropriate diagnosis codes and/or narrative diagnosis.

E. Lenses may be glass or plastic. All lenses must meet FDA impact resistant regulations.

F. Only standard frames with the appropriate code are covered. Deluxe frames are not covered. Eyeglass frames should be durable and constructed to be normally resistant to damage or breakage to minimize the need for replacement.

G. Fitting is a separate service and is covered. Fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of spectacles to the visual axes and anatomical topography.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(1)

Rule 3.2: Lens Coating

A. For purposes of this rule the following definitions will apply:

    1. Antireflective is a coating applied to a lens to reduce the amount of reflected light and glare that reaches the eye.

    2. Mirror coating is applied to a lens that allows the lens to take on the properties of a two-way mirror.

    3. Scratch resistant coating is applied to a lens that helps retard crazing of the lens, thus extending the product life.

    4. Tint is an opaque or transparent color coating applied to a lens. The parts of the light spectrum that are absorbed by the lens are determined by the color of the tint.

    5. Photochromatic coating is applied to a lens that allows the lens to adjust to the amount of available light.

    6. Polarized coating is applied to a lens that filters out reflected light and glare.

    7. UV coating is applied to a lens to filter out ultraviolet light.

B. Medicaid covers tinted lenses, photochromatic lenses, or UV protected lens when medically necessary for the following medical diagnoses:

    1. Other disturbances of aromatic amino-acid metabolism,

2. Degeneration of macula and posterior pole,

3. Pigmentary retinal dystrophy,

4. Cataracts,

5. Keratitis,

6. Corneal opacity and other disorders of cornea,

7. Disorders of conjunctiva,

8. Aphakia,

9. Congenital Aphakia,

10. Aniridia, and

11. Pseudophakos.

C. Non-covered services include:

1. Scratch resistant coating,

2. Antireflective coating,

3. Mirror coating,

4. Polarized coating, and

5. Diagnoses other than those listed under coverage criteria.

D. Prescriptions for lens coating must include the appropriate diagnosis code and/or a narrative diagnosis.

E. A beneficiary may purchase non-covered lens coating services. Charges for non-covered services must not be billed to Medicaid.

F. Documentation must comply with the requirements for maintenance of records set forth in Part 200, Chapter 1, Rule 1.3 in addition to following documentation specific to lenses and lens coating:

1. Orders and prescriptions for eyeglass lenses must include lens specifications such as lens type, power, axis, prism, absorptive factor, and impact resistance.

2. Orders and prescriptions for contact lenses must include lens specifications such as power,

size, curvature, flexibility, and gas permeability.

3. Orders and prescriptions for lens coating must include appropriate diagnosis and/or narrative diagnosis.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 3.3: Cataract/Ocular Surgery

A. Medicaid covers eyeglasses, including the frames and lenses for beneficiaries who have had surgery on the eyeball or ocular muscle. The surgical benefit will be applied, regardless of whether the beneficiary has received eyeglasses during the benefit period, when all of the following criteria are met:

   1. Surgery results in a vision change,

   2. Eyeglasses are medically indicated within six (6) months of the surgery, and

   3. Eyeglasses are prescribed by an optometrist or ophthalmologist.

B. Beneficiaries who undergo multiple surgeries will be eligible for the benefit following each surgery if all criteria is met.

C. Beneficiaries who experience refractive changes after the six (6) month post-surgical period are subject to the eyeglass benefit limitations.

D. Medicaid does not cover refractive surgery including, but not limited to:

   1. Lasik surgery,

   2. Radial keratotomy,

   3. Photorefractive keratectomy, or

   4. Astigmatic keratotomy.

E. Beneficiaries who undergo the procedures listed in Rule 3.3 D above cannot receive the surgical benefit. Beneficiaries who need eyeglasses following any of these surgeries are subject to the eyeglass benefit limitations.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(11)

Rule 3.4: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

MISSISSIPPI DIVISION OF
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Administrative Code

Title 23: Medicaid
Part 218
Hearing Services

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Title 23: Division of Medicaid

Part 218: Hearing Services

Part 218 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

A. State-licensed audiologists and physicians must render services under their license as an audiologist or physician.

B. All providers of Medicaid services must comply with the requirements for enrollment as outlined in Part 200, Chapter 4, Rule 4.8. Physicians must satisfy the additional provider type requirements outlined in Part 203, Chapter 1, Rule 1.1. Audiologist and hearing aid dealers must satisfy the additional provider type requirements listed below:

1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

2. Copy of current license in the state in which the individual furnishes the services,

3. Verification of having met the following requirements:

   a) A master's or doctoral degree in audiology,

   b) Has received a license from a state that requires the following conditions be met for licensure:

      1) Has a Certificate of Clinical Competence in Audiology granted by the American Speech-Language-Hearing Association for licensure, or

      2) Has successfully completed a minimum of three hundred fifty (350) clock-hours of supervised clinical practicum, or is in the process of accumulating that supervised clinical experience under the supervision of a qualified master or doctor-level audiologist; performed at least nine (9) months of full-time audiology services under the supervision of a qualified master or doctoral-level audiologist after obtaining a master's or doctoral degree in audiology, or a related field; and successfully completed a national examination in audiology approved by the Secretary.

   c) In the case of an individual who furnishes audiology services in a State that does not license audiologists, or an individual exempted from State licensure based on practice in a specific institution or setting, the individual must meet one (1) of the conditions in Part 218, Chapter 1, Rule 1.1.3(b).

4. Verification of a social security number using a social security card, driver's license if it

notes the social security number, military ID or a notarized statement signed by the provider noting the social security number, for individual providers. The name noted on verification must match the name noted on the W-9.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 440.110; 42 CFR 455, Subpart E

Rule 1.2: Cochlear Implants

A. Medicaid covers for unilateral cochlear implantation when there is documentation that demonstrates the procedure is medically necessary and would be beneficial in reducing limitations of hearing impairment.

B. The following must be documented by the surgeon and/or audiologist:

1. Severe to profound sensorineural hearing loss in both ears as defined by FDA criteria with a lack of benefit from a well-fitting aid,

2. Cognitive ability to use auditory clues, patient motivation and a willingness to undergo an extended program of rehabilitation,

3. Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system,

4. No contraindications to surgery, and

5. The device must be used in accordance with the FDA approved labeling.

C. Documentation for children twelve (12) months of age to seventeen (17) years of age must include:

1. The onset of hearing impairment must have occurred during the pre-or post-linguistic period, and

2. Bilateral severe to profound sensorineural deafness must be demonstrated by the inability to improve on age-appropriate closed set word identification tasks with amplification, or lack of progress in auditory training.

D. Documentation for adults eighteen (18) years of age and older must include:

1. The onset of hearing impairment must have occurred during the pre-linguistic, peri-linguistic, or post-linguistic period, and

2. Post-linguistic deafened adults must demonstrate current FDA guidelines on test scores on sentence recognition scores from tape-recorded tests in the beneficiary's best listening condition.

E. Medicaid covers bilateral cochlear implantation when there is documentation that demonstrates the procedure is medically necessary and would be beneficial in reducing limitations of hearing impairment. Bilateral cochlear implantation must meet all of the criteria for unilateral cochlear implantation, above, in addition to the following criteria and circumstances.

F. Medicaid covers bilateral cochlear implants under two (2) different circumstances:

1. Simultaneous bilateral cochlear implants, and

2. Subsequent contralateral cochlear implantation in patients who have already received a previous unilateral cochlear implant.

G. Simultaneous bilateral cochlear implants are covered for beneficiaries who:

1. Have significant deafness, caused by meningitis with subsequent risk for early cochlear ossification, and, in the opinion of the treating physician, are appropriate candidates for bilateral cochlear implantation for the syndrome of post-meningitis deafness prior to cochlear ossification, or

2. Pre-lingually deaf children with profound hearing loss, and who, in the opinion of the treating specialist physician, would benefit from the additional neuronal stimulation afforded by simultaneous bilateral cochlear implantation at an early age. Some patients in this category may, in the opinion of the treating specialist physician, benefit from a staged or subsequent contralateral cochlear implantation as opposed to a simultaneous implantation.

H. Subsequent contralateral cochlear implantation are covered for beneficiaries who:

1. Have bilateral profound deafness that have fallen short of communication goals despite prior placement of a unilateral cochlear implant, and in the opinion of the treating specialist physician, would substantially benefit from a subsequent contralateral cochlear implant,

2. Are prelingually deaf children with bilateral profound hearing loss who have had prior unilateral cochlear implantation and who, in the opinion of the treating specialist physician, would substantially benefit from a subsequent contralateral cochlear implant, or

3. Have bilateral auditory neuropathy to the extent such that their cochlear function is structurally normal but who have abnormal findings on auditory brainstem response testing, and, in the opinion of the treating specialist physician, would substantially benefit from a subsequent contralateral cochlear implant.

I. Medicaid does not cover for bilateral cochlear implantation, either as a simultaneous

procedure or a subsequent contralateral implantation if, in the opinion of the treating physician, audiologist, or therapist, the beneficiary has sufficient limited hearing in the lesser affected ear either could either be:

1. Sufficiently augmented by a hearing aid to augment the opposite cochlear implant, or

2. Could later benefit from a future surgical or other medical intervention to improve the hearing in the non-implanted ear.

J. Medicaid covers a subsequent contra-lateral cochlear implant procedure, the testing, services and procedures, to properly evaluate a beneficiary and address the proper post-operative care and therapy for a second cochlear implant, when the beneficiary already has a unilateral cochlear implant.

K. Medicaid does not cover the cost of the cochlear implant device through the Durable Medical Equipment program. The cost of the device is covered by the usual reimbursement methodology for either inpatient or outpatient hospital services and must be billed by the hospital. Medicaid does not cover additional benefits for the device if the surgical procedure is performed in any other outpatient settings.

L. Medicaid covers the repair and/or replacement of the cochlear implant external speech processor and other minor supplies including batteries, cords, battery charger, and headsets through the Durable Medical Equipment (DME) program. Medicaid covers these items for all beneficiaries by DME providers only. Medicaid requires prior approval for repairs or replacements of external implant parts.

M. Medicaid requires documentation by the provider of rehabilitative services supporting medical necessity and must be retained in the beneficiary's medical record.

Source: Miss. Code Ann. § 43-13-121

Rule 1.3: Implantable and Non-Implantable Auditory Osseointegrated Device (AOD)

A. The Division of Medicaid defines an implantable auditory osseointegrated device (AOD) as a surgically implantable hearing system which transmits sound vibrations through a sound processor to the inner ear by direct bone conduction through the skull.

1. The Division of Medicaid covers implantable AODs in accordance with the Food and Drug Administration (FDA) approved labeling in an Ambulatory Surgical Center (ASC) and the outpatient hospital setting for beneficiaries five (5) years of age and older with conductive, mixed, or single-sided sensorineural hearing loss who can benefit from sound amplification, meets FDA approved audiologic criteria for the prescribed implantable AOD, and meets at least one (1) of the following conditions:

a) Congenital, surgical, or acquired malformation(s) of the external ear canal or middle ear,

b) Severe chronic otitis externa or otitis media with persistent otorrhea and documented failure with air conducted hearing aids,

c) Tumors of the external ear canal and/or tympanic cavity,

d) Dermatitis of the external canal, or

e) Other anatomic or medical conditions in which an air conduction hearing aid is contraindicated.

2. The Division of Medicaid does not cover implantable AODs for beneficiaries:

a) Under five (5) years of age,

b) With bilateral sensorineural hearing loss, or

c) With insufficient bone volume or bone quality to support implant placement.

B. The Division of Medicaid defines a non-implantable AOD as a sound processor attached to the skull using a hard or soft headband in which sound vibrations are transmitted transcutaneously through the bones of the skull to the inner ear.

1. The Division of Medicaid covers non-implantable AODs in accordance with the FDA approved labeling when prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designee for beneficiaries with conductive, mixed, or single-sided sensorineural hearing loss who can benefit from sound amplification, meets FDA approved audiologic criteria for the prescribed non-implantable AOD and meets at least one (1) of the conditions listed in Miss. Admin. Code Part 218, Rule 1.3.A.1.a)-e).

2. The Division of Medicaid does not cover the following:

a) Non-implantable AODs for bilateral sensorineural hearing loss,

b) Replacement of lost or stolen processors, or

c) Non-medically necessary accessories.

C. The Division of Medicaid covers batteries, repairs, and external replacement parts for implantable and non-implantable AODs as outlined in Miss. Admin. Code Part 209, Rule 1.24.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 12/01/2015.

Rule 1.4: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

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MEDICAID

Administrative Code

Title 23: Medicaid
Part 219
Laboratory

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Title 23: Division of Medicaid

Part 219: Laboratory Services

Part 219 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

Independent laboratory providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

B. Written confirmation from the IRS confirming the tax identification number and legal name, and

C. CLIA certificate and completed Certification form, if applicable.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E; Social Security Act § 1902(a)(9)(c).

Rule 1.2: Independent Laboratory Services

The Division of Medicaid does not reimburse independent laboratories for lab procedures performed for beneficiaries during an inpatient hospital stay. The All Patient Refined Diagnosis-Related Group (APR-DRG) payment that the hospital receives is considered to cover all services provided during the inpatient hospital stay. The hospital is responsible for reimbursement to independent laboratories.

Source: SPA 2012-008; Miss. Code Ann. §§ 43-13 117, 121.

History: Revised Miss. Admin. Code Part 219, Rule 1.2 to correspond with SPA 2012-008 (eff. 10/01/2012) eff. 05/01/2014.

Rule 1.3: Routine Venipuncture

Medicaid covers routine venipuncture performed for the purpose of obtaining a blood sample for laboratory testing as follows:

A. Routine venipuncture must be billed with appropriate procedure code.

B. Physicians, nurse practitioners, physician assistants, hospitals, and independent laboratories are covered one (l) for routine venipuncture only if the blood sample is drawn and all of it is referred to a separate, non-affiliated laboratory. If all or part of the sample is retained for a test to be performed in the facility where the venipuncture was performed, the physicians,

nurse practitioners, physician assistants, hospitals, and independent laboratories are not covered for the venipuncture.

C. EPSDT screening providers are covered for routine venipuncture when performed for lead screening and/or RPR screening only if the blood sample is drawn and all of it is referred to a separate, non-affiliated laboratory. If all or part of the sample is retained for a test to be performed in the facility where the venipuncture was performed, the provider is not covered for the venipuncture.

D. The Mississippi State Department of Health (MSDH), Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) providers who are reimbursed an encounter rate are not covered separately for performance of routine venipuncture during the same encounter.

E. Finger/heel/ear sticks that are performed for the purpose of collecting blood specimens or obtaining blood specimens via a partially or completely implantable venous access device are not covered.

F. Dialysis facilities will not be reimbursed outside the composite rate.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Independent Diagnostic Testing Facilities and Other Independent Mobile Diagnostic Units

A. Medicaid only covers Independent Diagnostic Testing Facilities (IDTF), or other independent mobile diagnostic units, including portable x-ray providers, for services provided to dual-eligible beneficiaries. Outpatient testing and diagnostic services are covered when ordered by the beneficiary's physician and billed by an approved Medicaid provider, limited to physicians, physician clinics, Federally Qualified Health Centers, Rural Health Clinics, and county health department clinics.

B. An IDTF is defined by the Centers for Medicare and Medicaid Services (CMS) as "a fixed location, a mobile entity, or an individual non-physician practitioner. It is independent of a physician's office or hospital." These providers perform diagnostic tests such as ultrasounds, echocardiograms, pulmonary function tests, neurological and neuromuscular tests, x-rays, cardiac monitoring, and nuclear medicine.

C. Medicaid covers for a physician to contract with an IDTF or other independent mobile diagnostic unit to provide technical services and, assuming that there are no Stark II or other anti-kickback statute violations, allows for a claim to be filed for either the technical component or the complete procedure if the physician also interprets the procedure.

D. The physician contracting with an IDTF or other independent mobile diagnostic unit may not be employed by or own any part of the IDTF or other independent mobile diagnostic unit.

E. IDTFs and other independent mobile diagnostic units may not pay an additional fee to any physician when they perform the technical component of the procedure.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.33.

Rule 1.5: Trofile Assay

A. The "Trofile Assay" is covered for beneficiaries who are HIV-positive and diagnosed with Acquired Immune Deficiency Syndrome (AIDS) who have evidence of viral replication and HIV-1 strain resistance to multiple anti-retroviral agents.

B. Medicaid covers "Trofile Assay" for beneficiaries age sixteen (16) and over with the following restrictions/guidelines:

1. The assay is to be obtained only in anticipation of treatment of HIV/AIDS patients with CCR5 antagonist agents who:

   a) Are "treatment experienced" defined as having been previously treated with anti-retroviral regimen(s),

   b) Have never received Maraviroc/Selzentry or other CCR5-antagonist agents, and

   c) Have been deemed to have "virologic failure," or failed to obtain sufficiently low HIV viral loads despite prior appropriate anti-retroviral therapy.

2. Medicaid covers one (1) assay per beneficiary, per lifetime. Repeated testing or testing in follow-up of therapy with CCR5 agents is not covered.

3. The treating physician has expertise in Infectious Diseases and/or treating HIV patients with anti-retroviral agents; or the treating physician has consulted with an Infectious Disease physician prior to requesting the assay.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.6: Paternity Testing

A. Medicaid defines paternity testing as any laboratory test used to establish the genetic relationship between an alleged father and a child.

B. Medicaid does not cover Paternity testing.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.7: Qualitative Drug Screening

A. Medicaid will cover medically necessary qualitative drug screens for:

1. Suspected drug overdose, and one (1) or more of the following conditions are present:

    a) Unexplained coma,

    b) Unexplained altered mental status,

    c) Severe or unexplained cardiovascular instability, or cardiotoxicity,

    d) Unexplained metabolic or respiratory acidosis,

    e) Unexplained head trauma with neurological signs and symptoms, and/or

    f) Seizures with an undetermined history.

2. Beneficiaries who present with clinical signs/symptoms of substance abuse.

3. High risk pregnancy, only when the documented patient history demonstrates that the procedure is medically necessary. Medicaid does not consider a qualitative drug screen as a routine component of assessment.

4. EPSDT services, only when the documented patient history demonstrates that the procedure is medically necessary. Medicaid does not consider a qualitative drug screen as a routine component of assessment.

5. Beneficiaries who are locked into a Beneficiary Health Management Program to assure compliance.

B. The appropriate procedure chemistry codes must be used for quantitation of drug screens and procedure therapeutic drug assays for therapeutic drug levels. All diagnosis codes must support medical necessity for the drug screen.

C. Non-covered Services:

1. Medicaid does not cover qualitative drug screens for the following:

    a) To screen for the same drug with both a blood and a urine specimen simultaneously,

    b) For medicolegal purposes,

    c) For employment purposes,

    d) For the active treatment of substance abuse, including monitoring for compliance, or

    e) As a component of medical examination for administrative purposes.

D. Documentation Requirements

1. The ordering/referring provider must retain documentation supporting medical necessity in the medical record. All tests must be ordered in writing, and all drugs/drug classes to be screened must be indicated in the order. A copy of the lab results must be retained in the medical record.

2. If the provider rendering the service is other than the ordering/referring provider, the provider rendering the service must maintain hard copy documentation of the ordering/referring provider's order for the test and the lab results. The order must include clinical indication/medical necessity in addition to all drugs/drug classes to be screened.

3. Records must be documented and maintained in accordance with Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129.

Rule 1.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.9: Genetic Testing

A. The Division of Medicaid defines genetic testing as a type of analysis that identifies changes in chromosomes, genes, or proteins that confirms or rules out a suspected genetic condition.

B. The Division of Medicaid covers genetic testing when medically necessary to establish a diagnosis of an inheritable disease only when all of the following are met:

1. The beneficiary displays clinical features, or is at direct risk of inheriting the mutation in question (pre-symptomatic),

2. The result of the test will directly guide the treatment being delivered to the beneficiary, and

3. After history, physical exam, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain.

C. The Division of Medicaid does not cover genetic testing:

1. Of family members of a beneficiary,

2. If considered to be experimental, investigational or unproven,

3. To determine the likelihood of passing on a trait,

4. For the purpose of determining ancestry, or

5. Other purposes not specifically defined that are not diagnostic in nature.

D. Prior authorization is required by the Utilization Management/Quality Improvement Organization (UM/QIO) for medical necessity and appropriateness.

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

History: New Rule eff. 10/01/2014.

Rule 1.10: Tuberculosis (TB) Testing

A. The Division of Medicaid covers the following tuberculosis (TB) tests when a beneficiary has an increased risk for TB infection, as determined by the Centers for Disease Control and Prevention (CDC) and state law, and is administered in compliance with CDC recommendations and guidelines:

1. Mantoux tuberculin skin test (TST), and

2. Interferon-gamma release assays (IGRA).

B. The Division of Medicaid providers must have a documented treatment plan for a beneficiary with a positive tuberculin skin test to include:

1. A medical evaluation, including chest x-ray and clinical assessment, and

2. An evaluation for a course of treatment for latent TB infection.

C. The Division of Medicaid does not cover TB testing for the routine screening of beneficiaries in the absence of specific risk factors for TB.

D. Staff who read TB skin tests must be certified by the Mississippi State Department of Health (MSDH) TB Certification Program.

E. The provider must refer beneficiaries with a positive TB test to the MSDH Tuberculosis Program.

F. The Division of Medicaid providers must document the following:

1. The medical necessity for TB testing,

2. TST information which must include the following:

    a) Manufacturer and lot number of the injected antigen,

    b) Expiration date of solution,

    c) Dose administered,

    d) Injection site,

    e) Signature or initials of the person who administered the TST,

    f) Size of induration in millimeters (mm),

    g) Date and time the test was read,

    h) Reader's signature and initials, and

    i) Any adverse reactions.

3. Referral to the MSDH Tuberculosis Program for beneficiaries with positive TB tests.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

MISSISSIPPI DIVISION OF
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Title 23: Medicaid
Part 220
Radiology Services

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Title 23: Division of Medicaid

Part 220: Radiology

Part 220 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements

A. Radiology providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

   1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

   2. Written confirmation from the IRS confirming the provider's tax identification number and legal name, and

   3. Clinical Laboratory Improvement Amendments (CLIA) certificate and completed Certification form, if applicable.

B. Independent Diagnostic Testing Facility (IDTF) providers can only be enrolled for submission of crossover claims.

   1. IDTF providers cannot be enrolled for submission of straight Medicaid claims.

   2. A copy of the Medicare certification from the Medicare Intermediary is required.

   3. The Explanation of Medicare Benefits (EOMB) is not acceptable.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 455, Subpart E.

Rule 1.2: Prior Authorization

A. Effective July 1, 2013, prior authorization is required by the radiology Utilization Management/Quality Improvement Organization (UM/QIO) for medical necessity and appropriateness of the service for the following advanced imaging procedures:

   1. Computed Tomography (CT) Scans and Computed Tomography Angiography (CTA),

   2. Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA),

   3. Positron Emission Tomography (PET) Scans, and

   4. Nuclear Cardiac Imaging Studies.

B. Prior Authorization for the advanced imaging procedures listed in Rule 1.2.A. is required in all settings except in an:

1. Inpatient hospital,

2. Emergency room, or

3. Outpatient hospital twenty-three (23) hour observation period.

C. The prior authorization request must be submitted by either the ordering or the rendering provider.

1. The provider must submit documentation indicating medical necessity and appropriateness of the service to the radiology UM/QIO, including, but not limited to, the:

   a) Results of a recent clinical evaluation,

   b) Diagnosis or clinical condition which the imaging evaluation is being ordered,

   c) Treatment history related to the stated diagnosis or clinical condition,

   d) Treatment plan related to the stated diagnosis or clinical condition, and

   e) Previous imaging results related to the stated diagnosis or clinical condition.

2. Medical necessity and appropriateness of the service is based on nationally-accepted guidelines and radiology protocols based on peer reviewed literature for urgent, emergent and non-emergent services including, but not limited to, the:

   a) Division of Medicaid's radiology UM/QIO Clinical Decision Support Tool for Advanced Diagnostic Imaging,

   b) American College of Radiology's Appropriateness Criteria,

   c) American Academy of Neurology,

   d) American Academy of Orthopedic Surgeons,

   e) American College of Cardiology,

   f) American Heart Association, and/or

   g) National Comprehensive Cancer Care Network.

D. Prior authorization must be received by the provider before the procedure is rendered except in medically urgent situations.

E. In the event of a medical emergent condition or situation a retrospective review may be requested.

1. The request must be received by the radiology UM/QIO within three (3) business days from the date of service.

2. The Division of Medicaid defines a medical emergent condition or situation as one which:

a) The patient faces immediate risk of loss of life or limb,

b) Could seriously jeopardize the life or health of the beneficiary or their ability to regain maximum function based on a prudent layperson's judgment, or

c) In the opinion of a practitioner with knowledge of the beneficiary's medical condition, would subject the beneficiary to severe pain that cannot be adequately managed without the requested advanced imaging procedure.

Source: Miss. Code Ann. § 43-13-121, 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.2.C. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

Rule 1.3: Radiopharmaceuticals

A. The Division of Medicaid covers radiopharmaceuticals administered for diagnostic or therapeutic purposes separately from the diagnostic procedure or visit.

1. Only the units administered are covered.

2. Radiopharmaceuticals must be approved by the (FDA), used in accordance with FDA approved conditions, and be administered in dosages that meet FDA regulations.

3. Radiopharmaceuticals considered experimental, investigative, or in clinical trial are not covered.

B. The Division of Medicaid covers radiopharmaceuticals administered in a physician office, clinic or independent radiology facility.

C. Radiopharmaceuticals administered in an outpatient hospital setting is reimbursed in accordance with the Division of Medicaid’s outpatient hospital methodology.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.4: Teleradiology [Refer to Part 225, Chapter 3]

History: Moved with Revisions to Miss. Admin. Code Part 225, Chapter 3 eff. 07/01/2015.

Rule 1.5: Port Films

A. Medicaid does not cover the review and interpretation of port films, referred to as the professional component.

B. Medicaid covers the taking of the port film, one (1) unit for every five (5) treatments, referred to as the technical component.

C. Multiple treatments representing two (2) or more treatment sessions furnished on the same day are covered if the medical record contains documentation of a distinct break in therapy sessions and the treatments are of the character usually furnished on different days.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.6: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.7: Computed Tomography (CT) Scans and Computed Tomography Angiography (CTA)

A. Effective July 1, 2013, Computed Tomography (CT) scans and Computed Tomography Angiography (CTA), with or without contrast, must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.

B. The Division of Medicaid does not cover:

1. A limited or follow-up CT scan for any given area of the body during the same encounter as a full diagnostic CT scan,

2. A two (2)-dimensional rendering after a three (3)-dimensional rendering of a CT scan,

3. A CT/SPECT (Single Photon Emission Computed Tomography) nuclear medicine imaging only for:

   a) Localization, or

   b) Attenuation correction purposes,

3. A whole body CT for screening of asymptomatic beneficiaries, or

4. The performance of CT screenings in healthy beneficiaries.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.7.B. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

Rule 1.8: Magnetic Resonance Angiography (MRA) and Magnetic Resonance Imaging (MRI)

A. Effective July 1, 2013, Magnetic Resonance Angiography (MRA) and Magnetic Resonance Imaging MRI), with or without contrast, must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.

B. The Division of Medicaid covers a functional MRI when used as part of a preoperative evaluation for a planned craniotomy and is required for localization of eloquent areas of the brain, such as those responsible for speech, language, motor function, and senses, which might potentially be put at risk during the proposed surgery.

C. The Division of Medicaid does not cover an MRA or MRI for:

1. Screening of asymptomatic beneficiaries,

2. Screening of healthy beneficiaries, or

3. A two (2)-dimensional rendering after a three (3)-dimensional rendering has been performed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.8.B. and C. eff. 01/01/2014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

Rule 1.9: Positron Emission Tomography (PET) Scans

A. Effective July 1, 2013, Positron Emission Tomography (PET) scans must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.

B. The Division of Medicaid covers one (1) fluorodeoxyglucose (FDG) PET scan for solid tumors, myeloma or lymphoma that are biopsy proven or strongly suspected based on other diagnostic testing for the following therapeutic purposes related to the initial treatment strategy to determine:

1. Whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure,

2. Optimal anatomic location for an invasive procedure, or

3. The anatomic extent of a tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor.

C. The Division of Medicaid covers PET scans for initial anti-tumor treatment strategy, formerly “diagnosis” and “staging”, for the following oncologic conditions:

1. Thyroid cancer,

2. Non-small cell, lung cancer,

3. Colorectal cancer,

4. Melanoma,

5. Lymphoma,

6. Head and neck cancer, excluding thyroid and central nervous system,

7. Esophageal cancer,

8. Male and female breast cancer when used in staging distant metastasis,

9. Cervical cancer that is newly diagnosed following conventional imaging that is negative for extra-pelvic metastasis,

10. Ovarian cancer,

11. Testicular cancer,

12. Brain cancer,

13. Pancreatic cancer, or

14. Soft tissue carcinoma,

D. The Division of Medicaid does not cover PET scans for the initial anti-tumor treatment strategy, formerly “diagnosis” and “staging”, for the:

1. Initial diagnosing of breast cancer or the initial staging of axillary nodes,

2. Initial diagnosing of cervical cancer,

3. Evaluation of regional lymph nodes in melanoma, or

4. Diagnosis of adenocarcinoma of the prostate.

E. The Division of Medicaid covers PET scans for subsequent anti-tumor treatment strategy, formerly "restaging" and "monitoring response to treatment", after the completion of the initial treatment course for the following oncologic conditions:

1. Breast cancer,

2. Colorectal cancer,

3. Esophageal cancer,

4. Head and neck (non-CNS/thyroid), excluding thyroid and central nervous system,

5. Lymphoma,

6. Melanoma,

7. Non-small cell lung cancer,

8. Thyroid cancer,

9. Ovarian cancer,

10. Cervical cancer, or

11. Myeloma.

F. The Division of Medicaid covers FDG-PET scans for refractory seizures only for pre-surgical evaluation of localization of a focus of refractory seizure activity.

G. The Division of Medicaid does not cover PET scans for chronic osteomyelitis, infection of hip arthroplasty, and fever of unknown origin.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Revised Rule 1.9. B. – E. and added G. eff. 01/01/02014, Added to correspond with approved SPA 2013-007 (eff. 07/01/2013) eff. 07/01/2013.

Rule 1.10: Nuclear Cardiac Imaging Studies

A. Effective July 1, 2013, nuclear cardiac imaging studies must be prior authorized by the radiology UM/QIO as noted in Rule 1.2.

B. The Division of Medicaid covers the following nuclear cardiac imaging:

1. Perfusion of the heart, either at rest or with pharmacological stress, for the diagnosis and management of beneficiaries with known or suspected coronary artery disease when one (1) of the following criteria are met:

    a) The PET scan, whether at rest alone or at rest with stress, is performed in place of, but not in addition to, a single photon emission computed tomography (SPECT) scan, or

    b) The PET scan, whether at rest alone or at rest with stress, is performed following an inconclusive SPECT scan.

        1) The PET scan must be considered medically necessary to determine what medical or surgical intervention is required to treat the beneficiary.

        2) The Division of Medicaid defines an inconclusive SPECT scan as a test(s) whose results are equivocal, technically uninterpretable, or discordant with a beneficiary's other clinical data documentation in the beneficiary's medical record.

2. For the determination of myocardial viability as a primary or initial diagnostic study prior to revascularization or following an inconclusive SPECT.

    a) A SPECT scan is not covered following an inconclusive PET scan.

    b) Refer to Rule 1.10.B.1.b) 2).

C. The Division of Medicaid does not cover a SPECT/CT (Single Photon Emission Computed Tomography) which involves a SPECT multi-planar imaging (MPI) nuclear medicine scan only for:

    1) Localization,

    2) Accuracy, and

    3) Attenuation correction purposes.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 431.10(e), 440.230(d).

History: Added Rule 1.10.C. eff. 01/01/2014.

Rule 1.11: Documentation

A. Documentation for advanced imaging procedures must:

    1. Include the referring physician, nurse practitioner or physician's assistant documentation of medical necessity and criteria met in Rule 1.2,

    2. Not duplicate other covered diagnostic tests,

3. Be maintained in the referring provider's file,

4. Include documentation the procedure involved only FDA approved drugs and devices and did not involve investigational drugs, as determined by the FDA,

5. Support the referral to the rendering provider, and

6. Be maintained in accordance with Part 200, Chapter 3, Rule 1.3.

B. Providers and facilities are subject to on-site and documentation reviews of technical and professional imaging services and are reimbursed only for procedures, products, and services within the scope of the provider's clinical practice.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 431.10(e).

History: Added Rule 1.11 eff. 01/01/2014.

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 221
Family Planning Services

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Title 23: Division of Medicaid

Part 221: Family Planning and Family Planning Related Services

Chapter 1: Family Planning and Family Planning Related State Plan Services

Rule 1.1: Purpose

The Division of Medicaid covers family planning and family planning related State Plan services and supplies, directly or under arrangements with others, to individuals capable of reproduction, including minors who can be considered to be sexually active, who are eligible under the State Plan and who desire such services and supplies.

Source: 42 USC §1396a; Miss. Code Ann. § 43-13-121.

Rule 1.2: Freedom of Choice

A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services in accordance with Miss. Admin. Code Part 200, Rule 3.6.

B. Beneficiaries have freedom of choice to:

    1. Receive or reject family planning and family planning related services,

    2. Choose family planning and family planning related services providers, and

    3. Choose any method of birth control, including sterilization.

C. Beneficiaries must not be coerced to employ or not to employ any particular method of birth control including sterilization.

D. Providers must ensure that information is given in such a way as to encourage and support freedom of choice.

Source: 42 USC § 1396a; Miss. Code Ann. § 43-13-121.

History: Added Miss. Admin. Code Part 221, Rule 1.2.C., revised eff. 07/01/2015.

Rule 1.3: Beneficiary Cost Sharing

Family planning and family planning related services are exempt from cost sharing (co-pay) requirements in accordance with Miss. Admin. Code Part 200, Rule 3.7.

Source: 42 USC § 1396a; 42 CFR §§ 447.50-447.57; Miss. Code Ann. § 43-13-121.

Rule 1.4: Covered Services

A. Family planning and family planning related services are available for eligible beneficiaries who voluntarily choose to:

1. Prevent pregnancy,

2. Plan the number of pregnancies, or

3. Plan the spacing between pregnancies.

B. Family planning and family planning related services include, but are not limited to:

1. Contraceptive injections purchased by the provider and administered in the provider's office,

2. Prescription contraceptives dispensed through the pharmacy program,

3. Insertion, removal, and removal with reinsertion of a contraceptive intrauterine device,

4. Insertion, removal, and removal with reinsertion of a contraceptive implant,

5. Diaphragm or cervical cap fitting with instructions,

6. Vaginal rings,

7. Voluntary vasectomy and tubal ligation procedures, including tubal sterilization by hysteroscopy if the criteria in Miss. Admin. Code Part 202, Rule 5.3. is met, and

8. Laboratory procedures, including, but not limited to:

   a) Papanicolaou (Pap) smears, and

   b) Screenings for sexually transmitted infections (STIs)/sexually transmitted diseases (STDs).

C. Counseling and education are considered part of the family planning visit and cannot be billed separately.

Source: 42 USC § 1396a; 42 CFR Part 441, Subpart F; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2015; Revised Rule 1.4.B.4. 10/01/2013.

Rule 1.5: Non-Covered Services and Items

Services and items not considered family planning and family planning related services include, but are not limited to:

A. Facilitating services, including, but not limited to, parking and child care while family planning and family planning related services are being obtained,

B. Indirect services including, but not limited to, telephone contacts/consultations,

C. Drugs used to promote fertility,

D. Emergency contraceptives and related services,

E. Over-the-counter drugs and supplies including, but not limited to, pregnancy tests and spermicides,

F. Infertility studies and procedures to enhance fertility including, but not limited to, reversal of sterilization, artificial or intrauterine insemination or in-vitro fertilization,

G. Abortions and related services,

H. Hysterectomy and related services for sterilization purposes,

I. Menopausal or post-menopausal treatment and related services,

J. Removal of an implanted device for a non-Medicaid eligible individual,

K. Natural family planning services,

L. Ultrasound and radiology services,

M. Cancer screening services, except for Pap smears,

N. Services to a beneficiary whose age or physical condition precludes reproduction,

O. Services to a beneficiary known to be pregnant,

P. Reversal of voluntary sterilization, or

Q. Services outside the scope and/or authority of the provider's specialty and/or area of practice.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 07/01/2015.

Rule 1.6: Documentation/Record Maintenance

A. Providers of family planning and family planning related services must comply with the requirements for maintenance of records outlined in Miss. Admin. Code Part 200, Rule 1.3.

B. Documentation of family planning and family planning related services must include, but are not limited to:

1. Signed and dated consent for treatment, if applicable,

2. Signed and dated consent for sterilization, if applicable, as outlined in Miss. Admin. Code Part 202, Rule 5.3.,

3. Date of service and reason for visit,

4. Demographic information, including name, address, Medicaid number, date of birth, sex, and marital status,

5. Comprehensive health history, updated at least annually, including, but not limited to:

   a) Health risk factors,

   b) Personal medical, sexual and contraceptive history,

   c) Plans for having children, and

   d) Obstetrical and gynecological history.

6. Complete family history, updated at least annually,

7. Allergies, including type, reaction, and treatment,

8. Specific name/type of all diagnostic studies, including, but not limited to, laboratory and the result/finding of the studies,

9. Treatments/procedures rendered,

10. Physical findings including vital signs and weight,

11. Documentation of all medications including contraceptives whether administered by the provider, prescribed, or issued via physician/prescriber samples, and must include, but not limited to:

    a) The name,

    b) Strength,

    c) Dose,

d) Route of administration,

e) Site for all injectables, and

f) Manner in which prescription was issued including, but not limited to, in writing, by telephone, electronically or via facsimile.

12. Contraceptive supplies whether administered by the provider, prescribed, or issued via provider/prescriber samples,

13. Contraceptive devices,

14. Contraception counseling,

15. Date, time, and signature for all entries in the beneficiary's record, and

16. Provider's order, which must include the time, date, and signature, for all medications, treatments, and procedures rendered.

Source: 42 CFR Part 441, Subpart F; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129.

History: Revised eff. 07/01/2015.

Rule 1.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Miss. Admin. Code Part 223 without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.8: Reimbursement

A. The Division of Medicaid reimburses for only the provider's actual acquisition cost for physician administered drugs or implantable drug system devices.

B. The Division of Medicaid does not reimburse for provider/prescriber drug samples.

Source: Miss. Code Ann. § 43-13-121.

History: New Rule eff. 07/01/2015.

Chapter 2: 1115(a) Family Planning and Family Planning Related Waiver Services

Rule 2.1: Purpose

A. The Division of Medicaid covers family planning and family planning related waiver services and supplies, referred to as FPW in Miss. Admin. Code Part 221, Chapter 2, for all women and men, ages thirteen (13) through forty-four (44), who are capable of reproduction, who would not otherwise qualify for Medicaid, and with incomes at or below one hundred eighty-five percent (185%) of the federal poverty level, converted to a Modified Adjusted Gross Income (MAGI) equivalent standard through the 1115(a) Family Planning Waiver (FPW) Demonstration.

B. Providers are responsible for verification of covered FPW services and participant eligibility under the 1115(a) FPW Demonstration.

Source: Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 221, Rule 2.1.A. eff. 10/01/2015. Revised to correspond with the Family Planning Waiver renewal (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.2: Eligibility

A. The FPW limits eligibility to individuals age thirteen (13) through forty-four (44) who meet the following criteria:

   1. Individual has a family income at or below one hundred eighty-five percent (185%) of the federal poverty level, converted to a MAGI equivalent.

   2. Female individual is not pregnant and has not had a medical procedure that would prevent pregnancy including, but not limited to, tubal ligation procedures, including tubal sterilization by hysteroscopy,

   3. Male individual has not had a medical procedure that would prevent reproduction, including, but not limited to, a vasectomy,

   4. Individual is uninsured and is not enrolled in Medicare, Medicaid, Children's Health Insurance Program (CHIP) or possesses other health insurance coverage that provides family planning and family planning related services,

   5. Individual is a U.S. citizen or documented immigrant, and

   6. Individual is a Mississippi resident.

B. Individuals eligible for the FPW remain eligible for twelve (12) consecutive months, or for the duration of the program if less than one (1) year and must recertify at the end of each year of eligibility.

C. Women between ages thirteen (13) through forty-four (44) who are eligible for Medicaid maternity services and have reached the end of their sixty (60) day postpartum period are

automatically enrolled in the FPW.

1. A separate application is not required if the individual is uninsured.

2. The individual will be notified by mail of eligibility for services.

D. The participant will lose eligibility when one (1) of the following occurs:

1. Moves from the state of Mississippi,

2. Loses FPW eligibility,

3. Becomes eligible for another Medicaid program, Medicare, or obtains health insurance with family planning and family planning related benefits,

4. Requests closure or termination of FPW services,

5. Has a procedure that prevents reproduction, including, but not limited to, a tubal ligation procedure, including tubal sterilization by hysteroscopy, or a vasectomy,

6. Becomes pregnant,

7. Turns forty-five (45) years of age, or

8. Is deceased.

E. FPW applicants are considered only for eligibility in the FPW; however, an application for full Medicaid benefits may be filed at any time.

Source: 42 USC §§ 1315, 1396; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised Miss. Admin. Code Part 221, Rule 2.2.A.1. eff. 10/01/2015. Revised to correspond with the Family Planning Waiver renewal (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.3: Freedom of Choice

A. Participants have the right to freedom of choice of providers for FPW services in accordance with Miss. Admin. Code Part 200, Rule 3.6.

B. Beneficiaries have freedom of choice to:

1. Receive or reject FPW services,

2. Choose FPW providers, and

3. Choose any method of birth control, including sterilization.

C. Participants must not be coerced to employ or not to employ any particular method of birth control, including sterilization.

D. Providers must ensure that information is given in such a way as to encourage and support freedom of choice.

Source: 42 USC § 1396a; Miss. Code Ann. § 43-13-121.

Rule 2.4: Covered Services

A. FPW services are available for eligible participants who voluntarily choose to:

   1. Prevent pregnancy,

   2. Plan the number of pregnancies, or

   3. Plan the spacing between pregnancies.

B. FPW services are limited to four (4) visits annually between October 1 through September 30 and include:

   1. A one (1) time initial visit defined as the first time a participant receives family planning services from a provider and must include, but is not limited to:

      a) The establishment of a medical record,

      b) An in-depth evaluation including a complete medical history,

      c) A complete physical examination,

      d) Establishment of baseline laboratory data,

      e) FPW services counseling and education which includes contraceptive and sexually transmitted disease prevention, and

      f) Issuance of supplies or prescriptions.

   2. An annual visit defined as the re-evaluation of an established participant the next year following the one (1) time initial evaluation and must include, but is not limited to:

      a) An update to the medical record,

      b) Interim history,

      c) Complete physical examination,

d) Appropriate diagnostic lab tests or procedures,

e) FPW services management, education and counseling, and

f) Renewal or change of FPW services prescriptions or supplies.

3. A follow-up visit is defined as an evaluation of an established participant with a new or existing family planning or family planning related issue, and must include, but is not limited to:

a) An evaluation of the participant's contraceptive program,

b) Renewal or change of the contraceptive prescription or supplies, and

c) Additional opportunities for counseling and education regarding reproductive health and family planning and family planning related issues.

C. FPW only covers the following drugs:

1. Oral contraceptive agents,

2. Topical patches,

3. Self-inserted contraceptive products,

4. Injectable contraceptives dispensed in the pharmacy venue and administered in the provider's office,

5. Contraceptive injections purchased by the provider and administered in the provider's office,

6. Medications for the treatment of a STI/ STD identified or diagnosed during a routine or periodic FPW visit except for human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS) and hepatitis, and

7. Medications and/or treatments for vaginal infections or disorders, other lower genital tract and genital skin infections or disorders, and urinary tract infections when these conditions are identified or diagnosed during a routine or periodic FPW visit.

D. Covered contraceptive devices include:

1. Insertion, removal, and removal with reinsertion of a contraceptive intrauterine device,

2. Insertion, removal, and removal with reinsertion of a contraceptive implant,

3. Diaphragm or cervical cap fitting with instructions, and

4. Vaginal rings.

E. Voluntary vasectomy and tubal ligation procedures, including tubal sterilization by hysteroscopy, if the criteria in Miss. Admin. Code Part 202, Rule 5.3 is met.

F. Laboratory procedures that must be conducted during initial and annual visits include the following:

1. Hemoglobin,

2. Urinalysis,

3. Pap smear as indicated according to the participant's needs,

4. Screenings for STI/STD and HIV/AIDS, and

5. Pregnancy test, as indicated.

Source: 42 USC §§ 1315, 1396; 42 CFR Part 441, Subpart F; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with the Family Planning Waiver renewal (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.5: Non-Covered Services and Items

Services and items not considered FPW services and not reimbursable under the waiver program and include, but are not limited to, the following:

A. Facilitating services including, but not limited to, transportation, parking, and child care while FPW services are being obtained,

B. Indirect services, including, but not limited to, telephone contacts/consultations,

C. Drugs used to promote fertility,

D. Emergency contraceptives and related services,

E. Over-the-counter drugs and supplies including, but not limited to, pregnancy tests and spermicides,

F. Infertility studies and procedures to enhance fertility including, but not limited to, reversal of sterilization, artificial or intrauterine insemination or in-vitro fertilization,

G. Abortions and related services,

H. Hysterectomy and related services for sterilization purposes,

I. Menopausal or post-menopausal treatment and related services,

J. Removal of an implanted device for a non-FPW eligible individual,

K. Natural family planning services,

L. Ultra sounds and radiology services, except for vaginal ultrasounds,

M. Cancer screening services, except for Pap smears,

N. Mammograms,

O. Services to a participant whose age or physical condition precludes reproduction,

P. Services to a participant known to be pregnant,

Q. Reversal of voluntary sterilization,

R. Services outside the scope and/or authority of the provider's specialty and/or area of practice,

S. Inpatient hospital visit,

T. All services provided for the treatment of a medical condition not considered family planning or family planning related,

U. Services for participants who have received a sterilization procedure and have completed all necessary follow-up procedures, and

V. Prescriptions other than contraceptives and medications to treat STI/STD, vaginal infections or disorders, other lower genital tract and genital skin infections or disorders, and urinary tract infections.

Source: 42 USC §§ 1315, 1396; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with the Family Planning Waiver renewal (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.6: Quality Assurance

A. The Quality Assurance Plan:

1. Ensures the provision of comprehensive, accessible, quality and appropriate FPW services,

2. Provides a system for accountability and measuring performance, and

3. Improves care outcomes and quality of life.

B. The Division of Medicaid in conjunction with the Mississippi State Department of Health (MSDH) monitors quality and improvement activities for MSDH clinics to:

1. Ensure standards of care for FPW services utilize evidence-based best practices, and

2. Conduct periodic on-site review of medical records.

C. The Division of Medicaid conducts periodic on-site reviews of medical records to determine that participants have received appropriate medical care and are appropriately referred for needed primary care.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.7: Participant Cost Sharing

FPW services are exempt from cost sharing (co-pay) requirements in accordance with Miss. Admin. Code Part 200, Rule 3.7.

Source: 42 USC § 1396a; 42 CFR §§ 447.50-447.57; Miss. Code Ann. § 43-13-121.

Rule 2.8: Primary Care Referrals

A. Health concerns identified during a FPW visit but not covered by the FPW must be followed up by a primary care provider with an appropriate clinical referral.

B. Providers should refer participants to other social service and healthcare providers as medically indicated including, but not limited to, a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).

C. As a component of the medical record audit, the primary care referral must be documented in the participant's medical record.

Source: Miss. Code Ann. § 43-13-121.

Rule 2.9: Documentation/Record Maintenance

A. Providers of FPW services must comply with the requirements for maintenance of records outlined in Miss. Admin. Code Part 200, Rule 1.3.

B. FPW services documentation must include, but is not limited to:

1. Date of service,

2. Reason for visit,

3. Physical findings including vital signs and weight,

4. Treatments/procedures rendered,

5. Demographic information, including name, address, Medicaid number, date of birth, sex, and marital status,

6. Allergies, including type, reaction and treatment,

7. Comprehensive health history, updated at least annually, including, but not limited to:

   a) Health risk factors,

   b) Personal medical, sexual and contraceptive history,

   c) Plans for having children, and

   d) Obstetrical and gynecological history.

8. Complete family history, updated at least annually,

9. Specific name/type of all diagnostic studies, including, but not limited to, laboratory and the result/finding of the studies,

10. Documentation of all medications including contraceptives, whether administered by the provider, prescribed, or issued via samples and must include:

    a) The name,

    b) Strength,

    c) Dose,

    d) Route of administration,

    e) Site for all injectables, and

    f) Manner in which prescription was issued including, but not limited to, in writing, by telephone, electronically or via facsimile.

11. Contraceptive supplies whether administered by the provider, prescribed, or issued via samples,

12. Contraceptive devices,

13. Contraception counseling,

14. Date, time, and signature for all entries in the participant's record,

15. Provider's order, which must include the time, date, and signature for all medications, treatments and procedures rendered,

16. Signed and dated consent for treatment, as applicable,

17. Primary care referrals, if applicable, and

18. Signed and dated consent for sterilization, if applicable, as outlined in Miss. Admin. Code Part 202, Rule 5.3.

Source: 42 CFR Part 441, Subpart F; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13- 129.

History: Revised to correspond with the Family Planning Waiver renewal (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.10: Reimbursement

A. The Division of Medicaid reimburses for only the provider's actual acquisition cost for physician administered drugs or implantable drug system devices.

B. The Division of Medicaid does not reimburse for provider/prescriber drug samples.

Source: Miss. Code Ann. § 43-13-121.

History: New Rule eff. 07/01/2015.

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 222
Maternity Services

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Title 23: Division of Medicaid

Part 222: Maternity Services

Part 222 Chapter 1: General

Rule 1.1: Maternity Services

A. The Division of Medicaid covers maternity services which include:

1. Antepartum services defined by the Division of Medicaid as the care of a pregnant woman during the time in the maternity cycle that begins with conception and ends with labor.

2. Delivery services defined by the Division of Medicaid as the care involved in labor and delivery.

3. Postpartum services defined by the Division of Medicaid as the care of the mother inclusive of both hospital and office visits following delivery for sixty (60) days including any remaining days in the month in which the sixtieth (60th) day occurs.

B. The Division of Medicaid covers inductions of labor or cesarean sections prior to one (1) week before the treating physician's expected date of delivery when medically necessary due to one (1) of the following medical and/or obstetric conditions including, but not limited to:

1. Non-reassuring fetal status or fetal compromise,

2. Fetal demise in prior pregnancy,

3. Fetal malformation,

4. Intrauterine Growth Restriction (IUGR),

5. Preeclampsia,

6. Eclampsia,

7. Isoimmunization,

8. Placenta previa, accreta, or abruption,

9. Thrombophilia or an occurrence of maternal coagulation defects,

10. Complicated chronic or gestational hypertension,

11. Chorioamnionitis,

12. Premature rupture of membranes,

13. Oligohydramnios,

14. Polyhydramnios,

15. Multiple gestations,

16. Poorly controlled diabetes mellitus (pregestational or gestational),

17. HIV infection,

18. Pulmonary disease,

19. Renal disease,

20. Liver disease,

21. Malignancy,

22. Cardiovascular diseases,

23. Classical or vertical uterine incision from prior cesarean delivery, or

24. Prior myomectomy.

C. The Division of Medicaid does not cover non-medically necessary early elective deliveries, prior to the expected due date including, but not limited to, the following:

1. Maternal request,

2. Convenience of the beneficiary or family,

3. Maternal exhaustion or discomforts,

4. Availability of effective pain management,

5. Provider convenience,

6. Facility scheduling,

7. Suspected macrosomia with documented pulmonary maturity with no other medical indication,

8. Well-controlled diabetes,

9. History of rapid deliveries,

10. Long distance between beneficiary and treating facility, or

11. Adoption.

D. Medical records will be subject to retrospective review. Reimbursement for hospital and professional services related to the delivery will be recouped if determined not to have met criteria for coverage.

E. Antepartum and postpartum office visits do not apply to the physician services limit.

Source: Miss. Code Ann. §§ 43-13-115(8), 43-13-117, 43-13-121.

History: Revised eff. 01/02/2015.

Rule 1.2: [Reserved]

History: Removed eff. 01/02/2015.

Rule 1.3: Maternal Fetal Ultrasound

A. For a fetal biophysical profile, the physician may bill one (1) unit for each fetus being evaluated in cases of multiple gestations.

B. For an ultrasound during hospitalization, Medicaid reimburses the physician submitting a claim for a visit and a review of an ultrasound on the same date of service for the visit only. A physician's interpretation of the results of an ultrasound will be reimbursed as a separate service when prepared with a separate distinctly identifiable signed written report using the appropriate procedure code with the appropriate modifier which indicates professional component only.

C. Medicaid does not cover routine sonography during pregnancy.

D. Medicaid covers medically necessary ultrasounds when all of the following criteria are met:

1. The ultrasound is consistent with the beneficiary's signs, symptoms, and/or condition,

2. Diagnosis cannot be made through clinical evaluation of the beneficiary's signs and symptoms, and

3. The results of the ultrasound can reasonably be expected to influence the beneficiary's treatment plan.

E. For Medicaid reimbursement for any type of obstetrical ultrasound, documentation in the beneficiary's record must justify the medical necessity. This documentation includes, but is not limited to, at least one (1) of the following:

1. Fetal measurements, as applicable to gestational age, such as crown-rump length, biparietal diameter (BPD), occipitofrontal diameter/head circumference (OFD or HC), abdominal circumference (AC), or femur length (FL),

2. Fetal position,

3. Placental location,

4. Amniotic fluid assessment or measurement,

5. Suspected or known fetal anomalies or conditions,

6. Fetal measurements relative to determination of suspected or known intrauterine growth retardation (IUGR), or

7. Presence of multiple gestations.

F. Documentation must reflect the type of obstetrical ultrasound actually performed, limited or complete.

G. The biophysical profile combines ultrasound with a non-stress test to check fetal well-being. The five (5) fetal parameters checked are as follows:

1. Reactive non-stress test,

2. Fetal breathing movement,

3. Fetal body movement,

4. Fetal muscle tone, and

5. Amniotic fluid volume.

H. Documentation must include a report on each of the five (5) parameters listed in Part 222, Chapter 1 Rule 1.3.G.

I. Providers must maintain proper and complete documentation to verify services provided.

1. The provider has full responsibility for maintaining documentation to justify the services provided.

2. Records must be documented and maintained in accordance with requirements set forth in Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Maternity Epidurals

A. Medicaid covers a maternity epidural for all pregnant Medicaid beneficiaries. Medicaid considers maternity epidurals as a medically necessary service for treatment of labor pain and does not consider it an elective procedure.

B. A physician who is participating in the Medicaid program must take all reasonable measures to ensure that maternity patients are instructed and offered an epidural as an available and covered service under Medicaid as part of the patient's prenatal counseling. The patient's options for pain relief medication during childbirth must be explained to her.

C. Anesthesiologists/CRNAs cannot refuse to provide a maternity epidural to a Medicaid beneficiary except when medically contraindicated.

    1. An anesthesiologist/CRNA who is participating in the Medicaid program must make available and offer maternity epidural services to pregnant Medicaid beneficiaries and cannot require a pregnant Medicaid beneficiary to pay for an epidural.

    2. He/she must accept the Medicaid payment as payment in full and cannot require a co-payment for his/her services. Under federal Medicaid law, deductions, cost sharing, or similar charges are not permitted for Medicaid services furnished to pregnant women. Thus, a participating provider's demand for these additional payments would be in violation of the law.

    3. The decision to have an epidural is to be decided between the beneficiary and her anesthesiologist/CRNA in consultation with the obstetrician. No means of coercion, dissuasion, or refusal by an anesthesiologist/CRNA to provide an epidural to a beneficiary in labor shall be utilized in determining this decision.

D. A hospital that accepts a pregnant Medicaid beneficiary for treatment accepts the responsibility for making sure that the beneficiary has access to an epidural.

    1. If an anesthesiologist does not accept a Medicaid patient for treatment, the hospital has the responsibility of assuring the delivery of this service.

    2. A pregnant beneficiary is entitled to receive the service from a provider who has accepted her as a patient without the imposition of deductibles, cost sharing, or similar charges.

Source: Miss. Code Ann. § 43-13-121

Rule 1.5: [Reserved]

History: Removed eff. 01/02/2015.

Rule 1.6: Reimbursement for Delivery and Tubal Ligation

A delivery, cesarean section or vaginal, and a tubal ligation performed at the same setting will be reimbursed at one hundred percent (100%) of the fee schedule for each procedure.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Sterilization

Medicaid reimburses covered sterilization procedures when the criteria for covered sterilization are satisfied in accordance with Part 202, Chapter 1, Rule 1.8.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441, Subpart F

Rule 1.8: Terbutaline Therapy

Terbutaline pump therapy with uterine activity monitoring for beneficiaries who are at risk for preterm labor is not covered by Medicaid.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: 17 Alpha-Hydroxyprogesterone

Medicaid covers the injection of 17 Alpha-Hydroxyprogesteron (17-P) in accordance with Part 203, Chapter 2, Rule 2.6.

Source: Miss. Code Ann. § 43-13-121

Rule 1.10: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 222 Chapter 2: Perinatal High Risk Management and Infant Services

Rule 2.1: Provider Participation

A. The Division of Medicaid covers the multidisciplinary case management program known as the Perinatal High Risk Management/Infant Services System (PHRM/ISS) program, administered by the State Department of Health, for certain Medicaid eligible pregnant/postpartum women and infants.

B. Any physician or clinic licensed to practice in the State of Mississippi or other approved

practitioner actively enrolled as a Mississippi Medicaid provider may provide PHRM/ISS services as a High Risk Case Management Agency.

C. Providers must meet all the following qualifications:

1. Meet applicable state and federal laws governing the participation of providers in the Medicaid program.

2. Meet the criteria established by the Division of Medicaid as a provider of high risk case management agency services.

3. Be enrolled by the Division of Medicaid as an EPSDT provider to provide high risk infant services

4. Must have qualified case managers who meet the qualifications applicable to their specific disciplines.

   a) Medical Discipline: Case manager must be one (1) of the following:

      1) Physician licensed in Mississippi.

      2) Physician assistant licensed in Mississippi.

      3) Nurse practitioner licensed in Mississippi.

      4) Nurse-midwife certified in Mississippi.

      5) Registered nurse licensed in Mississippi with a minimum of one (1) year of experience in community nursing.

   b) Psychosocial Discipline: Social worker with a minimum of one (1) year of experience in health and/or human services, and one (1) of the following:

      1) Masters in Social Work (MSW) social worker licensed in Mississippi.

      2) Bachelor in Social Work (BSW) social worker licensed in Mississippi in consultation with an MSW.

      3) Other Mississippi licensed social worker supervised by an MSW.

   c) Nutritional Discipline: Nutritionist licensed in Mississippi or a registered dietitian, with a minimum of one (1) year of experience in providing nutritional services to pregnant women and infants. The nutritionist/dietitian may only serve as a case manager for enrollees for whom nutritional problems are their primary risk.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(a)

Rule 2.2: Freedom of Choice

A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.

B. The PHRM/ISS case management services will not restrict an individual's free choice of providers. An eligible beneficiary may choose to receive extended or enhanced services through any PHRM/ISS provider.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902(a)(23)

Rule 2.3: High Risk Pregnant Women

A. A maternity medical risk screening is required to determine if a beneficiary is eligible for PHRM services.

    1. A beneficiary qualifies for PHRM services if one (1) or more positive risk factors are identified.

    2. The medical risk screening must be completed by a physician, physician assistant, a nurse practitioner, or a certified nurse-midwife.

    3. Only one (1) medical risk screening is covered during each pregnancy unless the beneficiary changes providers and the new provider is unable to obtain the beneficiary's medical records.

B. The case management agency is responsible for locating, coordinating, and monitoring PHRM services.

C. Enhanced services are provided to the pregnant woman based on health risks identified during the medical risk screening. Services include:

    1. Nutritional assessment/counseling,

    2. Psychosocial assessment/counseling,

    3. Health education must:

        a) Be provided by a registered nurse, nurse practitioner, certified nurse-midwife, physician assistant, nutritionist/dietician and/or social worker, either one-on-one or in a group, during pregnancy and the postpartum period

        b) Not exceed ten (10) times during the pregnancy and postpartum period, and

        c) Include a written plan or curriculum designed to prevent the development of further

complications during pregnancy and provide education that includes:

1) Prenatal care,

2) Danger signs in pregnancy,

3) Labor and delivery,

4) Nutrition,

5) Pregnancy risk reduction, and

6) Reproductive health.

4. Home visits must:

a) Be provided by a registered nurse, nurse practitioner, certified nurse mid-wife, physician assistant, nutritionist/dietitian, and/or social worker during pregnancy as part of the assessment and follow-up,

b) Not exceed a maximum of five (5) visits, with at least one (1) during the postpartum period. A registered nurse must make the postpartum home visit, and

c) Be recorded in the progress notes and on the Patient Tracking Form.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(a)

Rule 2.4: High Risk Infants

A. The Division of Medicaid defines high risk infants as those whose medical status during their first (1st) year of life places them at risk for morbidity or mortality.

B. An infant medical risk screening must be completed by a physician, physician assistant, certified nurse-midwife, or a nurse practitioner to determine if the infant is high risk for mortality or morbidity.

1. An infant is considered high risk if one (1) or more risk factors are indicated.

2. An infant is limited to two (2) medical risk assessments.

C. The case manager will coordinate enhanced services with needed medical services. Children who are eligible for early intervention should be referred immediately to the Mississippi State Department of Health's Early Intervention program First Steps.

D. Enhanced services are provided to high risk infants through the EPSDT program and include:

1. Nutritional assessment/counseling.

2. Psychosocial assessment/counseling.

3. Health Education must:

   a) Be provided to the family of the infant in a one-on-one setting,

   b) Include a written plan or curriculum designed to prevent the development of complications and identifying early signs and symptoms of disease, and

   c) Be provided by a registered nurse, nurse practitioner, certified nurse-midwife, physician assistant, nutritionist/dietitian or social worker.

4. Home visits must:

   a) Be provided at the infant's place of residence as part of the assessment and follow-up,

   b) Be provided by a registered nurse, nurse practitioner, certified nurse-midwife, physician assistant, nutritionist/dietitian, or social worker, and

   c) Be documented in the progress notes and recorded on the Patient Tracking Form.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(a)

Rule 2.5: Plan of Care

A. A plan of care must be developed and implemented for problems identified from the detailed enhanced services assessment.

B. A PHRM/ISS case manager must be assigned.

   1. The case manager must be a physician, physician assistant, registered nurse, nurse practitioner, certified nurse-midwife, social worker, or nutritionist/dietitian.

   2. The nutritionist/dietitian may only serve as the case manager if the enrollee's primary risk is nutritional problems.

C. The case manager along with the PHRM/ISS team members must review the plan of care monthly to determine if the desired outcomes were achieved by the target date. If not, a revised plan of care must be implemented.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(a)

Rule 2.6: Medical Record Documentation Requirements

PHRM/ISS medical record documentation must contain the following on each patient:

A. Signed consent for treatment,

B. Date of service,

C. Demographic information including:

    1. Name,

    2. Address,

    3. Medicaid number,

    4. Date of birth,

    5. Sex, and

    6. Marital status.

D. Past and present medical history,

E. Family history,

F. Allergies including:

    1. Type,

    2. Reaction, and

    3. Treatment.

G. Medications:

    1. Prescribed, and

    2. Over-the-counter.

H. Specific name/type of all diagnostic studies with the results/findings,

I. Physical findings,

J. Signed physician orders, treatments, and procedures rendered,

K. Maternity services including:

1. Initial assessment,
2. Second trimester updates,
3. Hospital postpartum/discharge summary,
4. Emergency room reports, and
5. Specialty referrals.

L. Infant services including:

1. Injuries and hospitalizations,
2. Hospital admission/discharge summary,
3. Emergency room reports,
4. Operations,
5. Major illnesses,
6. Immunizations,
7. Physical examination,
8. EPSDT program services, and
9. Specialty referrals.

Source: Miss. Code Ann. § 43-13-12143-13-117; 43-13-118; 43-13-129

Rule 2.7: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 223
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

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Title 23: Division of Medicaid

Part 223: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Chapter 1: General

Rule 1.1: Program Description

A. The Division of Medicaid has established a program of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) which provides screenings, preventive and comprehensive health services for certain beneficiaries who are eligible for full Medicaid benefits. EPSDT services end on the last day of the beneficiary's twenty-first (21st) birthday month.

B. EPSDT is defined as:

1. Early is assessing health care in early life so that potential disease and disabilities can be prevented or detected in their preliminary states, when they are most effectively treated.

2. Periodic is assessing a child's health at regular, recommended intervals in the child's life to assure continued healthy development.

3. Screening is the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention.

4. Diagnosis is the determination of the nature or cause of conditions identified by the screening.

5. Treatment is the provision of services needed to control, correct or lessen health problems.

C. Providers of EPSDT screenings must be a currently enrolled Mississippi Medicaid provider, have signed an EPSDT specific provider agreement, and must adhere to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule. EPSDT screening providers include, but are not limited to:

1. The Mississippi State Department of Health,

2. Public schools and/or public school districts certified by the Mississippi Department of Education,

3. Federally Qualified Health Centers (FQHC),

4. Rural Health Clinics (RHC),

5. Comprehensive health clinics, and

6. Similar agencies which provide various components of EPSDT screenings.

D. EPSDT diagnostic and treatment services are primarily provided by referral to other enrolled Mississippi Medicaid providers.

Source: 42 U.S.C. § 1396d; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.2: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Provider Enrollment

A. Physicians, physician assistants or nurse practitioners who wish to provide EPSDT screenings must meet the Mississippi Medicaid enrollment requirements, complete and sign an EPSDT specific provider agreement and pass an onsite clinic inspection performed by the Division of Medicaid.

B. Registered nurses employed through the Mississippi Department of Education (MDE), who meet the certification requirement and the established protocols mandated by the Mississippi State Department of Health (MSDH), MDE, Mississippi School Nurse Association, and Mississippi Board of Nursing, may perform EPSDT health assessments following the protocols established by the MSDH. MDE employed registered nurses must have the educational basis and clinical basis needed to perform health assessments. In addition to the certification requirement, claims submitted for these services must be submitted under the school's provider number and the billing provider must have a current letter of referral affiliation on file with the Division of Medicaid.

Source: 42 U.S.C § 1396d; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.3: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Provider Participation Requirements

A. Enrolled Mississippi Medicaid providers who have signed an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) specific provider agreement must conduct periodic screenings and medically necessary interperiodic visits for all EPSDT-eligible beneficiaries in accordance with the EPSDT Periodicity Schedule as recommended by the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and must provide or refer EPSDT-eligible beneficiaries with an identified need for additional assessment, diagnosis, and/or treatment services to an appropriate provider.

B. Dental providers must provide services to all EPSDT-eligible beneficiaries in accordance with the dental schedule of the American Academy of Pediatric Dentistry (AAPD) and in accordance with AAP guidelines. Dental providers must provide or refer EPSDT-eligible

beneficiaries with an identified need for additional assessment, diagnosis, and/or treatment services to an appropriate provider.

C. EPSDT screening providers must refer EPSDT-eligible beneficiaries to other enrolled Mississippi Medicaid licensed practitioners of the beneficiary's choice for assessment, diagnosis and/or treatment services necessary to correct or ameliorate any physical, mental, psychosocial and/or behavioral health conditions discovered by the screenings, whether or not such services are covered under the State Plan.

Source: 42 U.S.C § 1396d; Miss. Code Ann. § 43-13-117.

History: Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.4: Periodicity Schedule

A. EPSDT providers must adhere to the current American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule.

B. EPSDT providers must schedule all health assessment screening appointments for the EPSDT-eligible beneficiary according to the AAP Bright Futures Periodicity Schedule.

C. EPSDT providers must maintain a screening periodicity tracking system for EPSDT-eligible beneficiaries seen for initial screening to ensure that subsequent screenings are performed timely and in accordance to the AAP Bright Futures Periodicity Schedule. EPSDT-eligible beneficiaries, guardians and/or legal representatives must be informed of the AAP Bright Futures Periodicity Schedule.

    1. EPSDT providers must follow up on missed appointments. If the beneficiary fails to keep the scheduled appointment, or the beneficiary, guardian and/or legal representative fails to contact the provider to reschedule, an appointment letter or telephone contact must be made providing the beneficiary another opportunity to be screened within thirty (30) days of the initial appointment.

    2. Two (2) good faith efforts, defined as an attempt to contact the beneficiary, guardian and/or legal representative, are required to reschedule a screening appointment. EPSDT providers must document in the medical record any missed appointments and two (2) good faith efforts to reschedule the appointment.

    3. Failure of a beneficiary, guardian and/or legal representative to keep the second appointment and respond to the provider's attempted contact is considered a declination of that screening only. The provider must continue to maintain periodicity and schedule the beneficiary for the next screening due following the same process.

Source: 42 C.F.R § 441.58; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.5: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screenings

A. An initial or established age appropriate medical screening which must include at a minimum:

   1. A comprehensive health and developmental history including assessment of both physical and mental health development and family history,

   2. A comprehensive unclothed physical examination,

   3. Appropriate immunizations according to the Advisory Committee on Immunization Practices (ACIP), and specific to age and health history,

   4. Laboratory tests adhering to the AAP Bright Futures Periodicity Schedule,

   5. Sexual development and sexuality screening adhering to the AAP Bright Futures Periodicity Schedule, and

   6. Health education, including anticipatory guidance.

B. Adolescent counseling and risk factor reduction intervention to include diagnosis with referral to an enrolled Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

C. Developmental screening or surveillance to include diagnosis with referral to an enrolled Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

D. Psychosocial/behavioral assessment to include diagnosis with referral to an enrolled Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

E. Vision screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid optometry or ophthalmology provider for diagnosis and treatment for defects discovered.

F. Hearing screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid audiologist, otologist, otolaryngologist or other physician hearing specialists for diagnosis and treatment for defects discovered.

G. Dental screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid dental provider for beneficiaries at eruption of the first tooth or twelve (12) months of age for diagnosis and referral to a dentist for treatment and relief of pain and infections, restoration of teeth and maintenance of dental health.

Source: 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.6: Documentation Requirements for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screenings

A. The medical record must include, at a minimum, documentation of the specific age appropriate screening requirements according to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule including the date the test or procedure was performed, the specific tests or procedures performed, the results of the tests or procedures or an explanation of the clinical decision to not perform a test or procedure in accordance with the AAP Bright Futures Periodicity Schedule, and the following:

1. Consent for screening with the beneficiary's and/or legal guardian/representative's signature,

2. Beneficiary and family history with appropriate updates at each screening visit, including, but not limited to, the following:

   a) Psychosocial/behavioral history,

   b) Developmental history,

   c) Adolescent counseling and risk factor history, and

   d) Immunization history,

3. Measurements, including, but not limited to:

   a) Length/height and weight,

   b) Head circumference,

   c) Weight for length percentiles,

   d) Body mass index (BMI), and

   e) Blood pressure,

4. Sensory screenings, subjective and/or objective:

   a) Vision, and

   b) Hearing,

5. Developmental/behavioral assessment, as appropriate, including:

a) Developmental screening to include, but not limited to:

1) A note indicating the date the test was performed,

2) The standardized tool used which must have:

(a) Motor, language, cognitive, and social-emotional developmental domains,

(b) Established reliability scores of approximately 0.70 or above,

(c) Established validity scores of approximately 0.70 or above for the tool conducted on a significant amount of children and using an appropriate standardized developmental or social-emotional assessment instrument, and

(d) Established sensitivity/specificity scores of approximately 0.70 or above, and

3) Evidence of a screening result or screening score,

b) Autism screening,

c) Developmental surveillance,

d) Psychosocial/behavioral assessment,

e) Alcohol and drug use assessment, and

f) Depression screening,

6. Unclothed physical examination,

7. Procedures, as appropriate, including, but not limited to:

a) Newborn blood screening,

b) Vaccine administration, if indicated,

c) Hematocrit and/or hemoglobin,

d) Lead screening and testing,

e) Tuberculin test, if indicated,

f) Dyslipidemia screening,

g) Sexually transmitted infection/disease screening,

h) Cervical dysplasia screening, and

i) Other pertinent lab and/or medical tests, as indicated,

8. Oral health, including:

a) Dental assessment,

b) Dental counseling, and

c) Referral to a dental home at the eruption of the first tooth or twelve (12) months of age,

9. Anticipatory guidance, including, but not limited to:

a) Safety,

b) Risk reduction,

c) Nutritional assessment,

d) Supplemental Nutrition Assistant Program (SNAP) and Women, Infants and Children (WIC) status, and

e) Adolescent counseling, including but not limited to:

1) Reproductive health,

2) Substance abuse,

3) Relationships,

4) Coping skills, and

5) Wellness,

10. Appropriate referral(s) to other enrolled Mississippi Medicaid providers for diagnosis and treatment,

11. Follow-up on referral(s) made to other enrolled Mississippi Medicaid providers for diagnosis and treatment,

12. Next scheduled EPSDT screening appointments, and

13. Missed appointments and any contacts or attempted contacts for rescheduling of EPSDT

screening appointments.

B. Medical records must be available to the Division of Medicaid and/or designated entity upon request. [Refer to Maintenance of Records Part 200, Rule 1.3]

Source: Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129.

History: Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.7: Diagnostic and Treatment Program Services

The Division of Medicaid covers any medically necessary Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) diagnostic and treatment services required to correct or ameliorate physical, mental, psychosocial, and/or behavioral health conditions discovered by a screening, whether or not such services are covered under any Medicaid Administrative Rule or the State Plan for EPSDT-eligible beneficiaries and, if required, prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity. [Refer to Miss. Admin. Code Part 200, Rule 5.1].

Source: 42 U.S.C § 1396d; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.8: Reimbursement

The Division of Medicaid reimburses a separate fee in addition to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodic screenings and medically necessary interperiodic visits for each of the following when documented in accordance with Miss. Admin. Code Part 223 Rule1.6.A.

A. Developmental screenings according to American Academy of Pediatrics (AAP) guidelines,

B. Vision screenings,

C. Hearing screenings,

D. Adolescent counseling,

E. Autism screenings,

F. Depression screenings, and

G. Other medically necessary services prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity, if required:

1. Lab tests, excluding hemoglobin or hematocrit,

2. Diagnostic tests, and

3. Other procedures.

Source: Miss. Code Ann. § 43-13-121.

History: New Rule to correspond with SPA 15-017 (eff. 11/01/2016) eff. 10/01/2016.

Part 223 Chapter 2: Early Intervention / Targeted Case Management

Rule 2.1: Provider Participation

A. Providers

1. Qualified providers shall be state agencies, private and public providers and their subcontractors.

2. Providers must meet the following Medicaid criteria to ensure that case managers for the children with developmental disabilities are capable of providing needed services to the targeted group:

   a) Demonstrated successfully a minimum of three (3) years of experience in all core elements of case management including:

      1) Assessment,

      2) Care/services plan development,

      3) Linking/coordination of services, and

      4) Reassessment/follow-up.

   b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population,

   c) Demonstrated experience with the target population, and

   d) Demonstrated the ability to provide or has a financial management system that documents services delivered and costs associated.

B. Case Managers

1. Each case manager must be a Mississippi Early Intervention Program certified service provider and have both of the following:

a) A bachelor's degree in child development, early childhood education, special education, social work, or be a registered nurse, and

b) Two (2) years' experience in service coordination for children with disabilities up to age eighteen (18) or two (2) years' experience in service provision to children under six (6) years of age.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b); 34 CFR 303

Rule 2.2: TCM Activities

A. Early Intervention/Targeted Case Management (EI/TCM) is an active ongoing process that involves activities carried out by a case manager to assist and enable a child enrolled and participating in the Mississippi Early Intervention Program to gain access to needed medical, social, educational and other services. Service Coordination to assist the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs identified on the Individualized Family Services Plan (IFSP). Additionally, Service Coordination assists the child and child's family, as it relates to the child's needs, with ongoing service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized.

B. These activities include:

1. Arranging for evaluation and assessment activities to determine the identification of services as it relates to the child's medical, social, educational and other needs,

2. Arranging for and coordinating the development of the child's IFSP,

3. Arranging for the delivery of the needed services as identified in the IFSP,

4. Assisting the child and his/her family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs,

5. Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs,

6. Make a minimum of one (1) face-to-face contact quarterly and documented successful contacts monthly,

7. Obtaining, preparing and maintaining case records, reports, documenting contacts, services needed, and the child's progress,

8. Providing case consultation, with the service providers/collaterals in determining child's status and progress,

9. Coordinating crisis assistance, intervention on behalf of the child, making arrangements for emergency referrals and coordinating other needed emergency services, and

10. Coordinating the transition of an enrolled child to ongoing services prior to the child's third (3rd) birthday.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b); 34 CFR 303

Rule 2.3: Quality Assurance and Monitoring

A. The Division will establish and maintain an assurance process that ensures a quality case management program and the delivery of necessary covered services that appropriately address the individual needs. The provider agrees to share data as part of the quality assurance program timely upon request by the Division.

B. The providers will make available to the Division the documentation/records maintained for case management services with the following information:

1. The name of eligible client,

2. Dates of case management services,

3. The nature, content, and units of the case management services received and whether goals specified in the care plan have been achieved,

4. Whether the client has declined services in the care plan, the need for and occurrences of coordination with other case managers,

5. The time line for obtaining needed services,

6. The time line for reevaluation of the plan,

7. Case Management Needs Assessment to determine the services needed and requested by the individual,

8. Service Coordination and Linkage to identify, assess, and link eligible individuals with the appropriate medical, social, and educational services to ensure that appropriate services are being provided while reducing duplication of services, and

9. Individual Service Monitoring to assure that all services are being appropriately delivered according to the Individualized Family Service Plan (IFSP) and in accordance with the established time lines.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b)

Rule 2.4: Freedom of Choice

A. Enrolled and participating recipients will have free choice of the available providers of case management services; and

B. Enrolled and participating recipients will have free choice of the available providers of other medical care under the plan.

Source: Miss. Code Ann. § 43-13-121; Section 1920(a) (23) of the Social Security Act.

Rule 2.5: Reimbursement

A. The Division of Medicaid uses rate setting as a prospective method of reimbursement on both the state and federal level. This method does not allow for retrospective settlements. The rates are determined from cost reports and appropriate audits.

B. Standard rates will be re-determined annually. The Division of Medicaid uses a fee-for-service reimbursement rate for private providers. In no case may the reimbursement rate for services provided exceed an individual facility's customary charge to the public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.

C. Payments under the plan do not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

D. Case management providers are paid on a unit of service basis that does not exceed fifteen (15) minutes.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b); 34 CFR 303

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 224
Immunizations

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Title 23: Division of Medicaid

Part 224: Immunizations

Part 224 Chapter 1: General

Rule 1.1: Reserved

Rule 1.2: Refer to Part 219, Rule 1.10.

Rule 1.3: Vaccines for Children (VFC) Program

A. The Division of Medicaid defines the Vaccines for Children (VFC) Program as a federally funded program that provides vaccines at no cost to Mississippi Medicaid providers registered as VFC providers. The Mississippi State Department of Health (MSDH) is the lead agency in administering the VFC Program and distributing the vaccines to VFC registered providers allowing for eligible children aged eighteen (18) and under to receive free vaccines.

B. The Division of Medicaid covers the administration of VFC vaccines for beneficiaries eighteen (18) years of age and younger according to the indications and guidelines of the Centers for Disease Control and Prevention (CDC).

C. The Division of Medicaid reimburses VFC providers an administration fee for each single or combination VFC vaccine at a rate set by the Division of Medicaid.

    1. The Division of Medicaid reimburses for the administration of vaccines to beneficiaries eighteen (18) years of age and younger only if the vaccines are obtained from the VFC Program through the MSDH.

    2. The Division of Medicaid reimburses for the administration of a VFC vaccine in addition to an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visit or physician office visit only when a separately identifiable service is provided at the time of the vaccine administration.

    3. The administration of a VFC vaccine is included in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC) or the MSDH clinic encounter rate.

D. The Division of Medicaid reimburses for vaccines in long-term care facilities for residents whose only payment source is Medicaid:

    1. If the purchase and administration of the vaccine(s) is reported on the cost report, or

    2. If an outside VFC provider administers the vaccine(s) the Division of Medicaid reimburses the outside provider an administration fee and the long-term care facility cannot claim the cost on the Medicaid cost report.

E. Providers must bill Medicare for vaccine(s) covered by Medicare for dually-eligible beneficiaries.

F. The Division of Medicaid does not reimburse:

1. An RHC, FQHC or MSDH clinic an encounter rate solely for the administration of vaccines, or

2. For the cost of vaccines provided through the VFC program.

G. VFC providers must comply with all federal and state laws and MSDH guidelines and requirements of the VFC program including the following required documentation:

1. The date the beneficiary, or parent or legal representative if the beneficiary is a minor, received a current copy of the relevant federal Vaccine Information Statement (VIS) for each vaccine prior to the administration and confirmation the beneficiary was given an opportunity to discuss concerns,

2. The date of publication of the VIS,

3. The date the vaccination was given,

4. The vaccine manufacturer and lot number of the vaccine administered,

5. The signature and title of the individual who administered the vaccine, and

6. Any adverse events that occurred after vaccination.

Source: 42 USC §§ 1396s, 300aa-26; Miss. Code Ann. §§ 41-23-37, 43-13-121, 43-17-5.

History: Revised eff. 01/01/2016.

Rule 1.4: Vaccines for Beneficiaries Nineteen (19) Years of Age and Older

A. The Division of Medicaid covers the following vaccines according to the indications and guidelines of the Centers for Disease Control and Prevention (CDC):

1. Rabies,

2. Tetanus,

3. Influenza,

4. Pneumococcal,

5. Human Papilloma Virus (HPV),

6. Hepatitis B Virus (HBV),

7. Varicella,

8. Herpes Zoster, and

9. Measles, Mumps, and Rubella (MMR).

B. The Division of Medicaid reimburses:

1. A physician's office for:

   a) Each vaccine and its administration fee if the office visit is only for the administration of the vaccine(s), or

   b) Each vaccine, its administration fee and an Evaluation and Management (E&M) visit only when a separately identifiable service is provided at the time of the vaccine administration.

2. A Federally Qualified Health Center (FQHC), a Rural Health Clinic (RHC), and the Mississippi State Department of Health (MSDH) clinic providers an encounter rate for a core service which includes the vaccine(s) and its administration.

3. A long-term care facility for Medicaid only residents:

   a) On the cost report for the purchase and administration of the vaccine(s), or

   b) If an outside provider administers the vaccine(s) the Division of Medicaid reimburses the outside provider for each vaccine and its administration fee and the long-term care facility cannot claim the cost on the Medicaid cost report.

C. Providers must bill Medicare for vaccine(s) covered by Medicare for dually eligible beneficiaries.

D. The Division of Medicaid does not reimburse:

1. For the administration of the intra-nasal influenza vaccine, or

2. RHC, FQHC or MSDH clinics an encounter rate solely for the administration of the vaccine(s),

3. A long-term care facility for costs on the cost report:

a) Associated with the purchase or administration of vaccines if an outside provider administers the vaccine(s), or

b) For vaccines covered by Medicare.

E. Providers administering vaccines must document the following:

1. The edition date of the Vaccine Information Statement (VIS),

2. The date the VIS was provided,

3. The date the vaccination was given,

4. The vaccine manufacturer and lot number of the vaccine administered,

5. The signature and title of the individual who administered the vaccine, and

6. Any adverse events that occurred after vaccination.

Source: 42 USC § 300aa-26; Miss. Code Ann. 43-13-121.

History: Revised eff. 01/01/2016.

Rule 1.5: Refer to Part 224, Rules 1.3 and 1.4.

Rule1.6: Vaccines for Pregnant and Postpartum Beneficiaries

A. The Division of Medicaid covers the tetanus-diptheria-acellular pertussis (Tdap) vaccine for pregnant and postpartum beneficiaries that is Food and Drug Administration (FDA) approved or that follows medically accepted indications and dosing limits supported by one (1) or more of the official compendia as designated by the Centers for Medicare and Medicaid (CMS) when:

1. Administered to pregnant beneficiaries, during each pregnancy, twenty-seven (27) to thirty-six (36) weeks of the treating physician's expected date of delivery, or

2. Administered to a postpartum beneficiary immediately after delivery only if the beneficiary:

a) Did not get a dose of a Tdap vaccine during her pregnancy, and

b) Has never received a Tdap vaccine.

B. The Division of Medicaid does not reimburse a Tdap vaccine administration fee.

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

History: New Rule eff. 04/01/2015.

Rule 1.7: Vaccines Available Through the Pharmacy Venue

A. The Division of Medicaid covers the following vaccines according to the indications and guidelines of the Centers for Disease Control and Prevention (CDC) for beneficiaries nineteen (19) years of age and older through the pharmacy program:

    1. Influenza,

    2. Pneumococcal,

    3. Herpes Zoster, and

    4. Varicella.

B. Vaccines administered by a credentialed pharmacist count against the pharmacy limits and co-payments are applicable.

C. The Division of Medicaid reimburses for the vaccine's ingredient cost and a dispensing fee for vaccinations administered in the pharmacy venue.

D. The Division of Medicaid does not reimburse a fee for administration of vaccines in the pharmacy venue.

E. The pharmacy provider must document the following:

    1. A hard copy physician's order for the vaccine,

    2. The date the beneficiary received a current copy of the relevant federal Vaccine Information Statement (VIS) for each vaccine prior to the administration and confirmation the beneficiary was given an opportunity to discuss concerns,

    3. The date of publication of the VIS,

    4. The date the vaccination was given,

    5. The vaccine manufacturer and lot number of the vaccine administered,

    6. The pharmacy name, pharmacy address, and the signature and title of the individual who administered the vaccine, and

    7. Any adverse events that occurred after vaccination.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2016.

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 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 the healthcare provider at the originating site who introduces the beneficiary to the distant site provider for examination and assists the distant site provider with requested tasks and activities that are within the telepresenter's scope-of-practice and license.

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

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

Rule 1.2: General Provider Information

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. Telehealth 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, including but not limited to, authorization of prescription medications at both the originating and distant site.

C. The following enrolled Medicaid providers are eligible to provide telehealth services at the distant site as a substitution for an in-person visit or encounter for consultations, office visits, and/or outpatient visits:

1. Physicians,

2. Physician Assistants,

3. Nurse Practitioners,

4. Psychologists,

5. Licensed Clinical Social Workers (LCSWs), and

6. Licensed Professional Counselors (LPCs).

D. The Division of Medicaid allows any enrolled Medicaid provider to provide telehealth services at the originating site.

E. A telepresenter at the originating site must:

1. Be employed by an enrolled Medicaid provider,

2. Perform tasks and activities within the telepresenter's scope-of-practice and license, and

3. Be physically present during the entirety of the telehealth visit or encounter.

F. The use and delivery of telemedicine 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 Health Insurance Portability and Accountability Act (HIPAA) requirements the provider or entity would for a service provided in person.

Source: 42 CFR § 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) 0f 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 15-003.

History: 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 or encounter for consultations, office visits, and/or outpatient visits.

B. The Division of Medicaid requires that the audio and video equipment and technology be sufficient enough to provide real-time interactive communications that provide the same information as if the telehealth visit or encounter was performed in-person.

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

History: 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 telehealth services in the inpatient setting.

B. Cover a separate reimbursement for the installation or maintenance of telehealth hardware, software and/or equipment, videotapes, and transmissions.

C. 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.

D. Cover the installation or maintenance of any telecommunication devices or systems.

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

History: 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 a provider delivering the medically necessary telehealth service at the distant site the current applicable Mississippi Medicaid fee for the service provided.

   1. If a service in an in-person setting is not covered by the Division of Medicaid, it is not covered if provided through telehealth.

   2. The provider must include the appropriate modifier on the claim indicating the service was provided through telehealth.

B. The Division of Medicaid reimburses the originating site the Mississippi Medicaid telehealth originating site facility fee for telehealth services per completed transmission.

   1. The following enrolled Medicaid 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, and

      h) A school-based clinic.

   2. The telepresenter must be one (1) of the following for the originating site to receive the originating site facility fee:

      a) Physicians,

b) Physician Assistants,

c) Nurse Practitioners,

d) Psychologists,

e) Licensed Clinical Social Workers (LCSWs), and

f) Licensed Professional Counselors (LPCs).

3. The telehealth presenter must be physically present in the room at all times.

C. The originating site provider cannot bill for an encounter or Evaluation and Management (E&M) visit unless a separately identifiable service is performed.

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

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

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") 0f 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, and

   5. External mobile cardiovascular telemetry.

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 following chronic conditions:

      a) Diabetes,

      b) Congestive Heart Failure (CHF), or

      c) Chronic Obstructive Pulmonary Disease (COPD).

   2. Has had two (2) or more hospitalizations in the previous twelve (12) months for one (1) of the chronic conditions listed above,

   3. Hospitalizations for two (2) different chronic conditions cannot be combined to satisfy the two (2) or more hospitalizations requirement, and

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

Source: Miss. Code Ann. § 43-13-121.

History: 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") 0f 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") 0f 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 service when using an FDA approved minimally invasive glucose monitoring system 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 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) Has documented self-monitoring of blood glucose at least four (4) times per day.

   c) Requires insulin injections three (3) or more times per day or requires the use of an insulin pump for maintenance of blood glucose control.

2. One (1) retrospective review and interpretation of blood glucose values per month.

3. A one (1) time device hook-up which includes beneficiary education.

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: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 4.4: Non-Covered Services

The Division of Medicaid does not cover continuous glucose monitoring for:

A. Non-diagnostic or personal use at home, or

B. Beneficiaries with type II diabetes mellitus.

Source: Miss. Code Ann. § 43-13-121.

History: 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 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 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. Is compliant with the physician ordered diabetic treatment plan including, but not limited to:

   a) Regular self-monitoring of at least four (4) times a day, and

   b) Multiple alterations in insulin administration orders.

C. The monitoring equipment is Food and Drug Administration (FDA) Class II hospital-grade medical device and is capable of accurately measuring and transmitting beneficiary blood data.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 300
Appeals

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Title 23: Division of Medicaid

Part 300: Appeals

Part 300 Chapter 1: Appeals

Rule 1.1: Administrative Hearings for Providers

A. According to the provisions of Section 43-13-121 of the Mississippi Code of 1972, as amended, and the applicable federal statutes and regulations, administrative hearings shall be available to providers of services participating in the Mississippi Medicaid Program. These hearings are for providers who are dissatisfied with a decision of the Division of Medicaid relating to disallowances, withholding of funds, refusals in the renewal of a provider agreement, terminations of provider agreements, suspensions of provider participation or matters relating to payment rates or reimbursement if not previously considered by the Division of Medicaid under Public Notice or Public Hearing Procedures. Administrative hearings are also available for providers who are terminated or denied enrollment for any of the reasons set forth in 42 C.F.R. § 455.416.

B. The procedures for conducting provider administrative hearings shall be as follows:

1. Within thirty (30) calendar days after an agency decision has been made, the provider may request a formal administrative hearing. The request must be in writing and must explain the facts that support the provider's position and the reasons the provider believes he/she has complied with Medicaid regulations. Any available documentation supporting the provider's statement should be attached to the written request.

    a) If the decision of the Division of Medicaid involves the disqualification of a provider, the Executive Director of the Division of Medicaid may suspend payments to the provider beginning with the date the provider is advised in writing the reasons for the suspension.

    b) Unless the Division of Medicaid receives a timely and proper request for an administrative hearing from the provider, the agency decision shall not be subject to review. If the issue involves disqualification of the provider, the findings shall be final and binding unless the provider can submit documented good cause for not requesting an administrative hearing within the time and manner described above. The Executive Director of the Division of Medicaid or his/her designee will decide whether the provider has submitted documented good cause.

2. The Executive Director of the Division of Medicaid shall notify the provider in writing by certified, return receipt mail at least thirty (30) days in advance of the date that the matter has been set for an administrative hearing. This notice period may be shortened if both parties agree.

3. The Executive Director of the Division of Medicaid will designate a hearing officer on

behalf of the Division of Medicaid to preside over the administrative hearings conducted within the guidelines stated below:

a) The hearing officer shall have the power to issue subpoenas, to administer oaths, to compel the attendance and testimony of witnesses, to require the production of books, papers, documents, and other evidence as required to take depositions, to preserve and enforce order during the administrative hearing, and to do all things conformable to law and Medicaid regulations which may be necessary to enable him/her to effectively discharge his/her duties as hearing officer.

b) The hearing officer shall be authorized to call informal, status, or pre-hearing conferences and to invite stipulations by and between the parties. The administrative hearing shall be held at the Division of Medicaid's main office, unless otherwise designated.

4. The provider may, at his/her discretion, be assisted and represented by counsel, examine any evidence or witnesses presented at the administrative hearing, and present evidence and witnesses of his/her own. All witnesses shall be sworn in prior to testifying. Any presentations made or evidence presented at the administrative hearing pursuant to these rules and procedures are subject to the judgment of the hearing officer that said presentations or evidence are pertinent or relevant to the case and are not redundant in nature.

5. The Division of Medicaid will provide a court reporter and/or a tape recorder to make an accurate record of the administrative hearing procedures. The administrative hearing shall be conducted in an informal manner but consistent with courtroom practices and procedures.

6. After all witnesses have been heard and all evidence has been presented, the hearing officer shall, as soon as possible, but not more than sixty (60) days, review the evidence and record of the proceedings and, based on the facts as he/she determines them to be, prepare a written summary of his/her findings and make a written recommendation to the Executive Director of action to be taken by the Division of Medicaid. This could include, but is not limited to, one or more of the following:

a) Evidence presented did not, in his/her opinion, substantiate the agency decision and that no action should be taken against the provider. If the case involves issues of reimbursement, that it either be recommitted to the appropriate Medicaid staff for further consideration based on the documentation or evidence presented during the course of the administrative hearing; or recommended to the Executive Director that the matter be administratively reconsidered.

b) Evidence presented was, in his/her opinion, sufficient to substantiate the agency decision. If the matter relates to the possible suspension or probation of a provider or the refusal to renew a provider agreement, then the hearing officer may recommend appropriate action that might include, but is not limited to, one or more of the

following:

1) That the provider be required within sixty (60) days from receipt of the final administrative decision to refund the amount determined to be due the Division of Medicaid, plus any interest allowable under state law, and that if the provider refuses to make full restitution, proper civil recovery action be taken.

2) That the provider be suspended as a provider of Medicaid services for a specified period of time with a follow-up review to be made to determine if the suspension is to be lifted.

3) That the provider be placed on probation for a specified period of time with proper monitoring of the provider's Medicaid activities to be conducted during the period of probation to determine if the probation should be lifted or if further sanctions are warranted.

c) Evidence presented was, in his/her opinion, sufficient to substantiate the agency decision. If the matter relates to the disqualification of a provider or the refusal to renew a provider agreement, then the hearing officer may recommend that the provider be disqualified as a provider of Medicaid services.

7. The recommendations of the hearing officer shall be in writing and shall contain findings of fact and a determination of the issues presented. The recommendation of the hearing officer in this form shall be submitted to the Executive Director of the Division of Medicaid for further review and decision.

8. The Executive Director of the Division of Medicaid, upon a review of the proceedings and the recommendation of the hearing officer, shall issue a final administrative decision. The Executive Director may sustain and adopt the recommendations of the hearing officer, reject the same and have a decision prepared based on the record, or remand the matter to the hearing officer to take additional testimony and evidence. In the last instance, the hearing officer thereafter shall submit to the Executive Director of the Division of Medicaid a new recommendation.

9. If the case does not involve a reimbursement issue and the Executive Director concludes that the provider shall be disqualified or substantiates the declination of the agency to renew a provider agreement with the provider, the provider may be disqualified at the direction of the Executive Director of the Division of Medicaid. Should the Executive Director disqualify a provider, all claims held in abeyance will be handled according to the directive of the Division of Medicaid. Payment will not be allowed toward any claims submitted by said provider for services rendered on or after the date of disqualification. The Executive Director may disqualify a provider permanently or for such other period as the Executive Director may deem proper, and the decision of the Executive Director is final, subject only to judicial review by the courts. The Executive Director may assess all or any part of the costs of the administrative hearing to the provider if the provider is unsuccessful in overturning the agency decision or the final

administrative decision, if appealed to a court of proper jurisdiction.

10. Any specific matter or grievance necessitating an administrative hearing or an appeal not otherwise provided under agency rules shall be afforded under the Administrative Hearing Procedures for Providers as outlined in this section. If the specific time frames of such a unique matter relating to the requesting, granting, and concluding of the hearing is contrary to the time frames as set out in the general administrative procedures above, the specific time frames will then govern over the time frames as set out within these procedures.

11. Appeal of a final administrative decision must be filed in a court of proper jurisdiction within sixty (60) days after the date that the Division of Medicaid has notified the provider by certified mail sent to the proper address of the provider on file with the Division of Medicaid and the provider has signed for the certified mail notice, or sixty (60) days after the date of the final decision if the provider does not sign for the certified mail notice.

Source: 42 C.F.R. § 455.422; Miss. Code Ann. § 43-13-121.

History: Revised eff. 10/01/2016; Revised eff. 11/01/2013.

Rule 1.2: Administrative Hearings - Eligibility Decisions

A. The Mississippi Medicaid Law governing the administration of medical assistance makes provision under Section 43-13-116 of the Mississippi Code of 1972, as amended, for fair and impartial hearings in full implementation of the Federal statutory and regulatory requirements. Any person whose claim for assistance is denied or not acted upon promptly may request a hearing from the Division of Medicaid, if the Division of Medicaid is the determining agency.

B. The Social Security Administration is the Federal agency charged with the responsibility of determining who is eligible for Supplemental Income (SSI). In Mississippi, individuals who are eligible for SSI are automatically eligible for Medicaid. Applicants who are denied SSI are also denied Medicaid. Beneficiaries whose entitlement to SSI is terminated also lose Medicaid. These individuals denied or terminated from SSI may apply for Medical Assistance Only provided the application qualifies under one (1) of the Medicaid only coverage groups covered by the Medicaid regional offices.

C. If an SSI applicant or beneficiary disagrees with the decision to deny or terminate SSI benefits, the individual must contact the Social Security office that issued the adverse decision. A request for a hearing must be made with the Social Security Administration when the issue to be determined is SSI benefits and automatic Medicaid eligibility.

D. The Division of Medicaid is the State agency charged with the responsibility of determining Medicaid eligibility for families, children, pregnant women and aged, blind and disabled individuals who do not qualify for SSI. If an applicant's application for Medicaid as

determined by the Division of Medicaid is disapproved or a decision is made to terminate or reduce a beneficiary's benefits under any Division of Medicaid program, and he/she disagrees with the decision, the individual may request a local and/or state hearing by contacting the Regional Office that made the decision or by contacting the Division of Medicaid State Office. Hearing requests must be made in writing within thirty (30) days of the adverse action to deny, terminate or reduce Medicaid benefits. All adverse action notices issued to applicants or beneficiaries contain their appeal rights and explain how to request a hearing.

E. The Department of Human Services (DHS) is the State agency charged with the responsibility of determining Medicaid eligibility for foster children in the custody of DHS. In the event DHS denies, terminates or reduces the Medicaid benefits of a foster child, DHS is the agency responsible for handling the appeals of such adverse actions.

Source: Miss. Code Ann. § 43-13-121

Rule 1.3: Administrative Hearings for Beneficiaries

A. In accordance with Section 43-13-116 of the Mississippi Code of 1972, as amended, and 42 CFR 431.200 et. seq., the Division of Medicaid provides beneficiaries the opportunity to request a fair hearing in order to appeal decisions of denial, termination, suspension or reduction of Medicaid covered services.

B. If a decision is made to reduce, deny, suspend or terminate covered services provided to a Medicaid beneficiary, and the beneficiary disagrees with the decision, the beneficiary and/or his/her legal representative must request a hearing in writing within thirty (30) days of the notice of adverse action.

C. The Division of Medicaid is not required to grant an administrative hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all beneficiaries.

D. When an ongoing course of treatment is at issue, services will be maintained at the previous level during the appeals process.

E. The Division of Medicaid may deny or dismiss a request for a hearing if the beneficiary and/or legal representative withdraws the request in writing or fails to appear at a scheduled hearing without good cause.

F. The case shall be heard by an impartial hearing officer employed by or on contract with the Division of Medicaid. Hearing officers will be individuals with appropriate expertise and who have not been involved in any way with the action or decision on appeal in the case.

G. When feasible the case will be evaluated by an appropriate independent review professional in the same or a similar specialty as would typically manage the case being reviewed, or another healthcare professional. In no case shall the review professional have been involved

in the initial adverse determination.

H. Before the hearing, the beneficiary and/or his or her legal representative will be provided a copy of the case file that will be used at the hearing in support of the adverse decision.

I. The hearing will be held by telephone unless, at the hearing officer's discretion, it is determined that an in-person hearing is necessary.

J. The final hearing decision shall be rendered by the Executive Director of the Division of Medicaid based solely on the evidence produced at the hearing and the case record. The Division of Medicaid must take final administrative action on a hearing within ninety (90) days from the date the initial appeal request was received.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Healthcare Practitioner Peer Review Protocol

A. Health care practitioners and any other persons, including institutions, that provide health care services or items for which payment may be made, in whole or in part, by the Division of Medicaid have certain obligations as set forth in Title XI of the Social Security Act (U.S.C. Section 1320c *et seq*.) and Mississippi State Law (Miss. Code Ann. Section 43-13-121) that must be met. These obligations are to ensure that the services or items are:

   1. Provided economically and only when and to the extent they are medically necessary,

   2. Of a quality that meets professionally recognized standards of health care, and

   3. Supported by the appropriate documentation of medical necessity and quality.

B. When the Division of Medicaid has identified, by data analysis and other means, a possible violation by a health care practitioner of one (1) or more of these obligations, the matter will be referred to the Medicaid Utilization Management/ Quality Improvement Organization (UM/QIO) required by contract to carry out a proper peer investigation and review. Special accommodations will be made to consider the protocol for the various health care practitioner roles. As the case moves through Level I of the process, the UM/QIO will report its status to the Division of Medicaid at least monthly.

C. This protocol employs three levels of due process:

   1. Level I - Peer review panel considerations and actions,

   2. Level II - Division of Medicaid administrative hearing, and

   3. Level III - Division of Medicaid sanctions.

D. Progress to Level III is contingent upon recommendations adverse to the subject health care

practitioner at Levels I and II as well as the failure of the subject health care practitioner to successfully carry out a corrective action plan, if one is recommended at Level I.

E. Peer Review Panel Considerations and Actions

1. Panel Selection - When a referral is received from the Division of Medicaid, the Medical Director of the UM/QIO, or his/her designee will select a panel of at least three (3) health care practitioners, at least one (1) of whom practices in the same class group as the subject health care practitioner. Selection of the peer review panel members will be done in such a way as to ensure that their objectivity and judgment will not be affected by personal bias for or against the subject health care practitioner or by direct economic competition or cooperation with the subject health care practitioner. The Division of Medicaid will make records relevant to the possible violation available to the Peer Review Panel.

2. Peer Review and Preliminary Deliberation - Following their review of the relevant records, the Peer Review Panel will meet, either in person or by conference call, to deliberate on the matter. Minutes of the meeting will be taken and documented in the case record. The Peer Review Panel must complete this process within thirty (30) to sixty (60) calendar days of the receipt of the records by the Medical Director of the UM/QIO.

3. Peer Review Findings

   a) If the Peer Review Panel determines that there has been no violation of obligations, it will notify the Division of Medicaid UM/QIO Contract Administrator, in writing, of that finding and recommend that no action be taken. The records relied upon to make the recommendation, as well as the minutes of the Peer Review Panel meeting, will accompany the written recommendation. The Division of Medicaid will make a final decision, within not more than fourteen (14) working days of its receipt of the recommendation, and so inform the UM/QIO. The Division of Medicaid may accept the recommendation, take other action on the case, or return the case to the UM/QIO for further action, as specified by the Division of Medicaid.

   b) If the Peer Review Panel finds a potential violation of obligations, it will present that preliminary finding to the Medical Director of the UM/QIO, or his/her designee who will notify the health care practitioner by certified mail, restricted delivery, return receipt requested, of the preliminary finding of the Peer Review Panel and of the right of the health care practitioner to a conference with the Peer Review Panel to address this matter.

   c) If the Peer Review Panel finds violations that arise to the level of gross and flagrant, such that the life and welfare of the health care practitioner's patients are in jeopardy, it will immediately relay its finding to the UM/QIO Medical Director, or his/her designee who will recommend to the Executive Director of Division of Medicaid that the health care practitioner be immediately suspended from the Medicaid program.

Based upon this recommendation, the Executive Director of the Division of Medicaid may take such action as deemed appropriate and notify the health care practitioner. The procedures set forth herein in Section II will be followed.

4. Peer Review Panel Conference with the Healthcare Practitioner

   a) Notification of Conference

      1) The letter giving notice of potential violation will:

         i) Set forth the specific preliminary finding of potential violation or violations,

         ii) Instruct the health care practitioner to attend a Peer Review Panel conference, which will be set no later than thirty (30) days after the letter date, in order to present his or her position on the matters at issue,

         iii) Inform the health care practitioner that he or she may have an attorney present for advisory purposes only but that the health care practitioner will make all presentations and representations,

         iv) Instruct the health care practitioner to provide the Peer Review Panel with any information in support of the health care practitioner's position no later than ten (10) days prior to the conference in order to allow time for its proper study,

         v) Convey a copy of this protocol,

         vi) Provide notice that, at the conference, the Peer Review Panel will consider all relevant information, whether provided by the Division of Medicaid or by the health care practitioner, prior to making its final recommendation on the matter, and

         vii) Provide notice that, although the conference will be informal, it will be carried out in an orderly manner and minutes will be kept to provide a proper record.

   b) Conduct of the Conference

      1) The Peer Review Panel will either select one (1) of its members to preside at the conference or invite the Medical Director of the UM/QIO, or his/her designee to do so. If the Medical Director or his/her designee does preside, he or she will not participate in the Panel's deliberation. The potential violation or violations will be explained to the health care practitioner as well as the reasons why the Peer Review Panel has come to make its preliminary finding. The health care practitioner will then be afforded reasonable opportunity to present information in support of his or her position.

2) After all information has been presented, the health care practitioner will be excused from the Conference, and the Peer Review Panel will deliberate and render its findings and recommendation based upon a thorough review of the clinical records and of the information presented at the conference.

c) Outcome of the Conference

1) If the Peer Review Panel finds that the health care practitioner has not violated any obligations, it will report that finding and its recommendation in writing to the Medical Director of the UM/QIO, or his/her designee, who will convey that written recommendation to the Division of Medicaid UM/QIO Contract Administrator. The records relied upon to make the recommendation, as well as the minutes of the Peer Panel Conference with the health care practitioner, will accompany the written recommendation. The Division of Medicaid will make a final decision within not more than fourteen (14) working days of its receipt of the recommendation and so inform the UM/QIO. The Division of Medicaid may accept the recommendation, may take other action on the case, or return the case to the UM/QIO for further action, as specified by the Division of Medicaid. The UM/QIO will inform the health care practitioner, as directed by the Division of Medicaid, if it is determined to close the case.

2) If the Peer Review Panel determines that the health care practitioner has violated one or more Division of Medicaid obligations, it will formulate a corrective action plan (CAP) and recommend it to the Division of Medicaid's UM/QIO Contract Administrator within ten (10) days following the conference. The CAP will list the specific obligations violated; the specific elements of the CAP which will address correction of the behavior which led to the violation(s); the duration of the CAP which is a minimum of ninety (90) days; and the means by which compliance with the CAP will be monitored and assessed. Upon the Division of Medicaid's approval, within not more than fourteen (14) working days of its receipt of the CAP, the UM/QIO will notify the health care practitioner of the CAP by certified mail, restricted delivery, return receipt requested.

3) The health care practitioner will be required to sign the CAP and return it within ten (10) days to the Peer Review Panel. If the health care practitioner fails to submit the signed CAP, the Peer Review Panel will immediately recommend to the Executive Director of the Division of Medicaid that a sanction be imposed on the health care practitioner. The procedures set forth in Level II will be followed.

4) The UM/QIO Medical Director, or his/her designee and the Peer Review Panel will monitor the signed CAP. After the CAP has been completed, all information subject to being monitored, including, but not limited to medical service claims history, copies of patient records, files, and charts will be obtained by the Division of Medicaid Bureau of Program Integrity and submitted to the Peer Review Panel for review. Within thirty (30) days of the receipt of such information from the Division of Medicaid, the Peer Review Panel will meet to determine whether or

not the health care practitioner complied with the CAP and whether the CAP was effective. Minutes will be kept of the meeting.

5) If the CAP was effective and the health care practitioner is now meeting all obligations, the Peer Review Panel will provide a written recommendation to the Division of Medicaid's UM/QIO Contract Administrator that the peer review process has been completed and the identified violation(s) corrected and resolved. The records relied upon to make the recommendation, as well as the minutes of the Peer Panel meeting, will accompany the written recommendation. The Division of Medicaid will make a final decision within not more than fourteen (14) working days of its receipt of the recommendation and so inform the UM/QIO. The Division of Medicaid may accept the recommendation, take other action on the case, or return the case to the UM/QIO for further action, as specified by the Division of Medicaid. The UM/QIO will inform the health care practitioner, as directed by the Division of Medicaid, if it is determined to close the case, by certified mail, restricted delivery, return receipt requested.

6) If the CAP was not effective and the health care practitioner, as noted in the minutes of the meeting, is still deemed to be violating obligations, the Peer Review Panel will, by a motion approved by a majority of its members, recommend to the Executive Director of the Division of Medicaid that a sanction be imposed. The full and complete record relied upon to make the recommendation and the minutes of the Peer Panel will be submitted to the Executive Director of the Division of Medicaid within fifteen (15) days of the Peer Review Panel's recommendation for sanction.

F. Level II Division of Medicaid Administrative Hearing

1. Notice of Sanction

a) Upon receipt of the Peer Review Panel's recommendation to sanction, the Executive Director of the Division of Medicaid may send notice to the health care practitioner, by certified mail, restricted delivery, return receipt requested of the Executive Director's intent to impose a sanction for violation of obligations. The Notice will contain the following:

1) The obligation(s) violated,

2) The situation, circumstance, or activity that resulted in the violation,

3) The authority and responsibility afforded the Division of Medicaid under Miss. Code Ann. Section 43-13-121,

4) A summary of the information used in arriving at the determination to initiate sanction, and

5) Notice that the Division of Medicaid will impose the recommended sanction within thirty (30) days of the date of health care practitioner's receipt of the notice letter unless the health care practitioner requests an administrative hearing within these thirty (30) days.

2. Administrative Hearing Panel - If the health care practitioner requests an administrative hearing, the hearing will be administered in accordance with the procedures outlined in Part 300, Chapter 1, Rule 1.1.

G. Level III Division of Medicaid Sanction - The Executive Director of the Division of Medicaid, upon review of the record, proceedings, and recommendation of the Division of Medicaid Administrative Hearing Officer, will render a final written decision whether or not to impose sanctions, which may include disqualification from participation in the Medicaid program. The Executive Director may disqualify the health care practitioner for a limited period or permanently. The Executive Director's decision is a final administrative decision. The Executive Director may assess all or any part of the cost of implementing this sanction protocol to the health care practitioner.

Source: Miss. Code Ann. § 43-13-121

Rule 1.5: Review for Medical Necessity and/or Independent Verification and Validation (IV&V)

A. Inpatient hospital providers may request an Administrative Appeal when the provider is dissatisfied with final administrative decisions of the Division of Medicaid relating to disallowances as a result of a review for medical necessity or Independent Verification and Validation (IV&V) decision described in Miss. Admin. Code Part 202, Rule 1.18.A.

B. Inpatient hospital providers must comply with the appeal provisions in Miss. Admin. Code Part 300, Rule 1.1.

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

History: New eff. 09/01/2014.

Administrative Code

Title 23: Medicaid
Part 301
School Based
Administrative Claiming

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Title 23: Division of Medicaid

Part 301: School Based Administrative Claiming

Part 301 Chapter 1: School Based Administrative Claiming

Rule 1.1: Purpose

A. The Division of Medicaid, the Mississippi Department of Education (MDE) and individual schools share in the responsibility for promoting access to healthcare for students in the public school system, preventing costly or long term healthcare problems for at-risk students, and coordinating student's healthcare needs with other providers.

B. The Medicaid School-Based Administrative Claiming program (SBAC) allows school districts to be reimbursed for some of their costs associated with school-based health and outreach activities which are not claimable under the Medicaid School Health-Related Services "fee for service" program or under other Medicaid "fee for service" programs. In general, the types of school-based health and outreach activities funded under SBAC are the referral of students/families for Medicaid eligibility determinations, the provision of health care information and referral, coordination and monitoring of health services and interagency coordination. These activities include:

1. Medicaid Outreach,

2. Facilitating application for Medicaid and eligibility determination,

3. Transportation-related activities in support of Medicaid covered services,

4. Medicaid related Translation services,

5. Program planning, policy development and interagency coordination related to medical services,

6. Medicaid specific training, and

7. Referral, coordination and monitoring of Medicaid services.

Source: Miss. Code Ann. § 43-13-121; Section 1903 (a)(7) of the Act; 42 CFR 430.1 and 42 CFR 431.15; OMB Circular A-87

Rule 1.2: Provider Qualifications

State school districts that participate in the School Based Administrative Claiming (SBAC) program must meet the following requirements:

A. Have a signed agreement with the Mississippi Department of Education (MDE),

B. Attend staff training conducted by MDE,

C. Keep time studies of work activities via computer generated electronic documentation,

D. Determine statistically valid time sample results,

E. Prepare cost determinations and allocations,

F. Prepare and submit to MDE a quarterly invoice, and

G. Follow the yearly calendar published by MDE.

Source: Miss. Code Ann. § 43-13-121; Section 1903 (a)(7) of the Act; 42 CFR 430.1 and 42 CFR 431.15; OMB Circular A-87

Rule 1.3: Quality Assurance & Monitoring Plan

A. The Division of Medicaid will establish and maintain a quality assurance process which ensures the quality management of the program. It is necessary to monitor the SBAC program in order to assure that Medicaid dollars are utilized to make Administrative Claiming available to eligible Mississippi Public School Districts enrolled in the SBAC program.

B. Mississippi Department of Education (MDE) Oversight and Monitoring

1. MDE will implement and provide oversight and monitoring actions to ensure that school districts are in compliance with SBAC requirements. At a minimum, these actions are to ensure that:

   a) The time study is performed correctly,

   b) The time study results are valid,

   c) The financial data submitted is true and correct,

   d) Training requirements are met, and

   e) Appropriate documentation is maintained to support the time study and invoices.

C. Division of Medicaid Oversight and Monitoring

1. Validation of the program will include the Division of Medicaid performing the following actions quarterly:

   a) Randomly select ten (10) percent of the sampled responses,

b) Review the sampled responses and independently code the activities of the ten (10) percent selected, and

c) Validate the accuracy of the original coder.

2. Documentation must be readily accessible and available to the Division of Medicaid or CMS. The MDE agrees to share data as a apart of the quality assurance program timely upon request by the Division of Medicaid. The MDE will make available to the Division of Medicaid the documentation/records/reports maintained for the SBAC program.

3. The Division of Medicaid areas of review include:

   a) The time study – sampling methodology, the sample, and time study results,

   b) Compliance with training requirements,

   c) Financial reviews, and

   d) Documentation compliance.

4. The school districts will make available to the Division of Medicaid the documentation/records/reports maintained from the SBAC program.

5. These documentation/records/reports include, but are not limited to:

   a) Random Moment Sampling (RMS) documents,

   b) Methodology that supports the construction of the Administrative Claiming billing process,

   c) Revenue projection reports, and

   d) School district quarterly reports.

6. The school districts must submit copies of the time logs for each participating school in the area to MDE.

7. The Division of Medicaid will verify a small percentage of time logs quarterly to ensure accuracy. Verification will be through direct face-to-face contact with the sampled participants.

8. Each quarter the Division of Medicaid will audit the following:

   a) A percentage of the time logs of the sampled school staff to ascertain if the sampled participants understood the instructions on sampling time forms, and

b) Verify that the time study form turned in was completed by the individual who signed the form and that he/she accurately reported his/her activity at the time he/she was sampled, to the best of his/her knowledge.

D. Monitoring Objectives: Monitors from various organizations review the Administrative Claiming program documents and provide performance standards to validate whether or not the providers and/or Administrative Claiming program have:

1. Complied with federal and state laws, regulations and policies,

2. Complied with the terms of the Administrative Claiming Guide agreement,

3. Billed the Division of Medicaid for those services that were authorized and actually delivered in compliance with the Administrative Claiming Guide, and

4. Provided a service which produced an effective and cost effective outcome for beneficiaries and the Medicaid program.

E. Desk Reviews: Periodically the Division of Medicaid staff may conduct desk reviews of Administrative Claiming services. These desk reviews include, but are not limited to, the analysis of required documentation and various reports.

F. On-Site Visits: The on-site visits will be scheduled periodically to be conducted by Medicaid Administrative Claiming staff. During on-site visits, required records and documents will be reviewed for consistency with claims submitted and with applicable program requirements.

G. Cooperation Required of the Provider During Monitoring Activities

1. The school districts must cooperate fully with monitoring activities, evaluations or other reporting requirements authorized by the Division of Medicaid. Records and supporting information must be made available as required for any authorized monitoring activities.

2. The school districts' Administrative Claiming Coordinator or authorized representatives must cooperate fully with monitoring activities, evaluations or other reporting requirements authorized by the Division of Medicaid. Records and supporting information must be made available as required for any authorized monitoring activities. He/she must also be available to answer questions during the monitoring review and to receive the results of the review.

H. Findings from Monitoring Reviews

1. The Division of Medicaid staff that conducts the monitoring review will prepare a report of monitoring activity. A copy of the report will be forwarded to the school district with a request, when appropriate, for a response to be submitted to the Division of Medicaid within thirty (30) days after the receipt of the report. The response should include a plan

of correction, as necessary, which addresses any deficiencies noted in the monitoring report.

2. The staff of the Division of Medicaid will review the response and contact the reviewer within thirty (30) days of the receipt of the response regarding the acceptance of the response and approval of the plan of correction.

3. The school district will be notified in writing by the Division of Medicaid of any administrative noncompliance with provider agreement terms or applicable regulations.

4. If items of noncompliance are not corrected, the Division of Medicaid may take appropriate actions to ensure correction by the school district of noted problem(s), or the Division of Medicaid may terminate the provider's participation in the Medicaid Administrative Claiming program.

5. Erroneous overpayments to providers are subject to restitution. The provider is entitled to notification by the Division of Medicaid of the erroneous payment(s). If the provider has been overpaid, he/she will be contacted regarding the repayment schedule.

I. Technical Assistance Provided by Medicaid

1. Medicaid staff is available to provide technical assistance to the Administrative Claiming provider and SBAC districts in resolving any contractual or performance problems. However, technical assistance visits by the Division of Medicaid staff are not comprehensive reviews of the services under the terms of contracts or provider agreements for services. If deficiencies are not identified during the provision of technical assistance, the provider is still responsible for audit exceptions and correcting any other contractual or performance problems noted during monitoring activities.

2. The Division of Medicaid is not liable for acts or omissions of the Administrative Claiming provider, contracted providers, school districts or their employees. The provider should seek their own legal counsel regarding questions of liability.

J. All records pertaining to the Administrative Claiming program must be maintained for a period of five (5) years after each quarterly claim is filed with the Division of Medicaid, unless an ongoing audit or resolution of an audit exception is in process which requires that the records be maintained until the audit is resolved.

Source: Miss. Code Ann. § 43-13-121; Section 1903 (a)(7) of the Act; 42 CFR 430.1 and 42 CFR 431.15; OMB Circular A-87

Rule 1.4: Reimbursement

Reimbursement under the SBAC program is paid from those invoices filed during the quarter directly following the quarter of billing, for reported allowable reimbursable activities, in accordance with the Mississippi School Based Administrative Claiming Guide (as approved by

CMS), following applicable federal and state rules and regulations. However, it is imperative that claims for all allowable reimbursable activities be documented. The school district will be responsible for any refund due to an audit exception or denial considered appropriate by CMS or the Division of Medicaid. In the event of determination by federal authorities of non-compliance with federal regulations and standards, the school district will be liable to the Division of Medicaid in full for all penalties, sanctions and disallowances assessed against the Division of Medicaid.

Source: Miss. Code Ann. § 43-13-121; Section 1903 (a)(7) of the Act; 42 CFR 430.1 and 42 CFR 431.15; OMB Circular A-87

Administrative Code

Title 23: Medicaid
Part 302
Beneficiary Health Management

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Title 23: Division of Medicaid

Part 302: Beneficiary Health Management

Part 302 Chapter 1: Beneficiary Health Management

Rule 1.1: Authority and Purpose

A. In accordance with 42 CFR 431.54 (3)(e), a state has the authority to lock-in beneficiaries who over utilize Medicaid services. If a Medicaid agency finds that a beneficiary has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that beneficiary for a reasonable period of time to obtain Medicaid services from designated providers only.

B. Beneficiary Health Management is the program implemented by the Division of Medicaid to closely monitor program usage and to identify beneficiaries who may be potentially over utilizing or misusing their Medicaid services and benefits. The purpose of Beneficiary Health Management (BHM) is to:

1. Promote quality health care,

2. Prevent harmful practices such as duplication of medical services, drug interaction, and possible drug abuse,

3. Identify beneficiaries for review who may misuse or over utilize their Medicaid benefits,

4. Analyze beneficiary pattern of utilization of health services,

5. Modify the beneficiary's improper utilization of Medicaid services through educational contacts and monitoring,

6. Prevent fragmentation of services and improve the continuity of care and coordination of services, and

7. Assure beneficiaries are receiving only health care services which are medically necessary and justified, thereby curtailing unnecessary costs to the program. "Medical Necessity" is defined as the determination by the Medical Assistance Program that a service is reasonably necessary to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap or cause physical deformity or malfunction. There must also be no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service.

Source: Miss. Code Ann. § 43-13-121

Rule 1.2: Program Oversight

The Division of Medicaid's Bureau of Program Integrity has the responsibility of initiating and coordinating BHM.

Source: Miss. Code Ann. § 43-13-121

Rule 1.3: Provider Participation

This program may include physician only, pharmacy only or physician and pharmacy type beneficiary health management.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Covered Services

A. Beneficiaries will be placed in the Beneficiary Health Management program for a period of eighteen (18) months with ongoing reviews to monitor pattern of care.

B. Beneficiaries in the BHM program are allowed two (2) counseling sessions per month per lock-in provider - physician and/or pharmacy during the eighteen (18) month lock-in.

C. Beneficiaries in BHM will continue to have access to emergency room, inpatient and outpatient hospitalizations, dental, optical, psychiatric, home health, hospice, Medicaid Waiver and DME services. All service limits are applicable.

D. The Division of Medicaid will reimburse for inpatient hospitalization for treatment of alcohol and/or drug abuse when the primary diagnosis is a mental health diagnosis (DSM diagnosis) and the inpatient hospital stay is approved by the Division of Medicaid Utilization Management and Quality Improvement Organization (UM/QIO). In addition, the Division will pay for mental health services up to twelve (12) visits per fiscal year, where counseling can be received for addiction problems.

Source: Miss. Code Ann. § 43-13-121

Rule 1.5: Exclusions

A. Beneficiaries who have received a utilization review completed within the past year are not eligible for re-review of benefits in BHM until after twelve (12) months.

B. Beneficiaries no longer eligible for Medicaid benefits.

Source: Miss. Code Ann. § 43-13-121

Rule 1.6: Provider Selection

A. Beneficiaries are required to specify one (1) physician and/or one (1) pharmacy and up to five (5) physician specialists, if requested, for his/her medical/pharmaceutical services while in the BHM program.

B. The beneficiary has thirty (30) days to choose his/her provider(s). When the beneficiary does not specify within the thirty (30) day time frame, the Division of Medicaid may designate a provider or providers for him/her.

C. Change of Provider: The beneficiary may request a change in his/her specified physician and/or pharmacy if any of the following occurs:

1. Change in geographical location of the beneficiary or the provider(s),

2. Death, retirement, or closing of the specified physician, pharmacy or specialist,

3. Irreconcilable differences between the beneficiary and the provider(s) that may affect the quality of medical care the beneficiary receives,

4. Primary diagnosis changes and therefore requires different specialist,

5. Specified provider(s) stop(s) participating in the Mississippi Medicaid Program, or

6. Specified provider(s) lose(s) eligibility to participate in the Mississippi Medicaid Program.

D. Referrals

1. Beneficiaries in BMH may be referred to another provider for consultation by the specified physician or specialists by using the BHM Referral Form. Prior approval is required before the beneficiary can be seen by the referral physician. Emergency situations are excluded from this requirement.

2. The referral may cover one (1) visit or may cover multiple visits as long as those visits are a part of the referral physician's plan of care and are medically necessary. No referral can last for more than one (1) year.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Reimbursement

A. Reimbursement shall be made for office visits only. Prescriptions will be reimbursed only if written by the specified physician or by the consultant physician, except on an emergency basis.

B. Payment will be made to provider(s) other than the specified provider(s) in the following instances:

   1. Emergency care is required and the specified provider is not available, or

   2. The specified provider requires consultation with another provider.

C. Billing Guidelines - Providers of BHM services are required to bill specified procedure codes for the two (2) required counseling sessions per month. These codes can be billed in conjunction with any other service the physician provides to the beneficiary. Documentation must support billing of the specified procedure codes by the physician and/or pharmacy. The specified codes must be billed two (2) times per month for each provider.

Source: Miss. Code Ann. § 43-13-12

Administrative Code

Title 23: Medicaid
Part 303
Pre-Admission Screening and Resident Review (PASRR)

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Title 23: Division of Medicaid

Part 303 Pre-Admission Screening and Resident Review (PASRR)

Part 303 Chapter 1: Pre-Admission Screening and Resident Review (PASRR)

Rule 1:1: Purpose

A. The purpose of the Pre-Admission Screening and Resident Review (PASRR) is to fulfill the necessary duties required by Medicaid in conducting pre-admission screening and resident review of individuals with mental illness and/or mental retardation seeking admission to a Medicaid-certified nursing facility (NF).

B. The goal of PASRR is to insure the provision of appropriate and needed services to individuals who have been diagnosed with mental illness and/or mental retardation.

C. The Appropriateness Review Committee (ARC), administered by the Department of Mental Health (DMH), is responsible for determining the appropriateness of nursing facility placement for individuals with mental illness and/or mental retardation and for determining the need for specialized or rehabilitative services.

D. Legal Authority is as stated in the Code of Federal Regulation (CFR) 42CFR483, States must operate a PASRR program. No Federal payment may be made for nursing facility (NF) services provided to individuals with mental illness (MI) and mental retardation (MR) not screened by a state PASRR program.

Source: Miss. Code Ann. § 43-13-121, 42CFR483, Code of Federal Regulations

Rule 1.2: Level I Pre-Admission (PAS) Screening

A. Any person who applies for admission to a Medicaid-certified nursing facility is required to participate in a Level I Screening, referred to as the Pre-Admission Screening (PAS).

B. The PAS must be submitted by either the nursing facility to which the individual is being considered for admission or the hospital from which the individual is being discharged. A nurse practitioner/physician must certify on the PAS the need for NF level of care and Mental Illness/Mental Retardation (MI/MR) Evaluation. The PAS must include a medical history and physical examination (H&P) completed by a nurse practitioner/physician within six (6) months of the PAS date.

C. If an indication of MI/MR is found, the PAS must certify the need for a Level II evaluation.

D. Protected health information regarding the patient must be kept confidential, and cannot be released without written consent or written authorization, as appropriate, from the individual, or to provide treatment, payment or healthcare operations.

Source: Miss. Code Ann. § 43-13-121; Health Insurance Portability and Accountability Act of 1996 (HIPAA) 45 CFR Parts 160 & 164.

Rule 1.3: Advanced Group Categorical Determinations

A. Sometimes a PAS may identify an individual who has indications of MI and/or MR and who needs NF placement but who, for specific reasons, is unlikely to need or benefit from specialized services. These individuals may be recommended for nursing facility admission without being referred for a Level II Evaluation, provided that they are not dangerous to themselves or others, if their exempting conditions are documented, and the ARC, after reviewing this documentation, determines that a Level II Evaluation is not required.

B. If the screening physician believes that the applicant would benefit from specialized services despite the presence of conditions considered to be in the advanced category, he/she must refer the applicant for a Level II Evaluation.

C. Findings for Advanced Group Categorical Determinations must be documented in a brief written evaluative report by the screening physician, or nurse practitioner, and must, at a minimum:

    1. Identify the name and professional title of the person recommending the determination and the date of the recommendation,

    2. Identify the specific condition(s) which qualifies the individual for exemption from the Level II Evaluation,

    3. If applicable, describe the nature of any further assessment(s) which may be needed to determine the most appropriate setting and/or services for the individual,

    4. Identify, to the extent possible based on the available information, NF services that may be needed, including any mental health or specialized rehabilitative services, and

    5. Include evidence to support the evaluator's conclusions.

Source: Miss. Code Ann. § 43-13-121, 42CFR483.130 Code of Federal Regulations

Rule 1.4: Level II Evaluations

A. A Level II Evaluation is the assessment of an individual who has an indication of MI/MR to determine the appropriateness for NF services and the need for specialized services.

B. There are two (2) types of Level II Evaluations.

    1. The first Level II Evaluation of an individual is termed "Initial" and any other Level II Evaluation an individual receives is termed "Subsequent."

a) An Initial Level II Evaluation may be recommended and is conducted prior to a NF admission, except for extremely rare situations.

1) If, at the time of the PAS prior to NF admission, a LTC applicant is identified as meeting the requirements for LTC services and having an indication of MI and/or MR, then he/she must be certified by the physician for referral to an Initial Level II Evaluation so that appropriateness of NF services and any needs for special services can be identified, and the appropriate services be recommended.

2) The physician certifying the PAS recommends the Level II Evaluation based on questions contained in the PAS. The State PASRR Coordinator will then contact the appropriate CMHC/RC responsible for conducting the Level II Evaluation for those individuals determined to require a Level II Evaluation. Both the PAS and an initial Level II Evaluation must be completed prior to admission.

b) A Subsequent Level II Evaluation must be considered anytime there is a significant change in the physical/mental/emotional condition of a NF resident with previously identified MI/MR needs. The purpose of the subsequent evaluation is to assess whether or not the resident is still appropriate for the NF level of care, and if there have been any changes in his/her need for specialized services.

C. The Level II Evaluation process:

1. All Pre-Admission Screenings must be submitted to LTC within twenty-four (24) hours of completion of the screening. Medicaid will refer all applicants for whom a Level II Evaluation was recommended to the State PASRR Coordinator. The State PASRR Coordinator will refer the individual to the appropriate CMHC/RC.

a) When a significant change in the resident's physical/mental/emotional condition becomes apparent, the NF must notify the State PASRR Coordinator of the significant change by submission of the Significant Change Report. The State PASRR Coordinator, with assistance from the ARC, will determine if a Level II Evaluation is required and contact the appropriate CMHC/RC, if necessary.

b) For those individuals determined by the ARC to require both a Level II Evaluation for MI and a Level II Evaluation for MR, the RC will have responsibility for compiling all information, completing the PASRR packet and submitting it to the State PASRR Coordinator.

2. PASRR Level II Evaluations must be conducted by the CMHC/RC within five (5) business days of receiving the referral from the PASRR Coordinator.

3. The completed Level II PASRR Packet must be submitted, to the State PASR Coordinator as soon as possible but no later than two (2) business days after the evaluation is conducted.

4. When the completed PASRR packet has been received by the PASRR Coordinator, it is forwarded to the ARC for determination review.

   a) The ARC will render a determination within two (2) business days of receipt of the PASRR Packet or Subsequent Level II Evaluation.

   b) If the individual is determined to be appropriate for nursing facility services, the ARC will determine whether additional specialized and/or rehabilitative services are indicated for the individual.

5. The PASRR process must be completed within seven (7) to nine (9) business days.

Source: Miss. Code Ann. § 43-13-121, 42CFR 483.122(b) Code of Federal Regulations

Rule 1.5: Credential Requirements for Level II Evaluators

A. The Level II Evaluation for MI must be completed by individuals who possess the following credentials, at a minimum:

   1. A qualified mental health professional, as designated by the State,

   2. The psychosocial assessment portion of the Level II must be conducted by an individual who is duly licensed/certified as a CMHT, LCMHT, LCSW, LMFT, LMSW, LPC, LSW, psychologist, or RN, and

   3. The psychiatric history and evaluation must be completed by a psychiatrist, psychologist or PMHNP.

B. The Level II Evaluation for MR must be completed by an interdisciplinary team of diagnostic and evaluation professionals who possess the following credentials, at a minimum:

   1. The social history and adaptive behavior assessment must be completed by a CMRT, LCMRT, LSW, psychologist, RN or other DMH approved personnel,

   2. The psychological assessment must be completed by DMH approved personnel and signed by a psychologist, and

   3. The medical summary must be completed by a physician, nurse practitioner, or an RN.

Source: Miss. Code Ann. § 43-13-121

Rule 1.6: Credentials for the ARC

A. Level II Evaluations for MI must be reviewed by the ARC, consisting of an RN and a psychiatrist, serving as the designated State Mental Health Authority Representative.

B. Level II Evaluations for MR must be reviewed by the ARC, consisting of an RN and a psychologist, LCMRT, or CMRT, serving as the designated State Mental Retardation Authority Representative.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Specialized Services

A. The CMHC/RC is required to assess each applicant's need for mental health rehabilitative services and/or specialized services for MI/MR in the Level II Evaluation. If the need for specialized services exists, the CMHC/RC will recommend the specific services needed in the PASRR Level II Screening Summary. The ARC will determine:

   1. Whether or not an applicant needs NF services, and

   2. Which, if any, specialized services are required.

B. If the ARC determines mental health rehabilitative services are required, the NF is responsible for providing them.

C. If the ARC determines that specialized services for MI and/or MR (services requiring a higher level of MI/MR expertise) are needed, the CMHC (for MI) or RC (for MR) is responsible for providing them.

D. Specialized rehabilitative services are rehabilitative services which the NF is required to provide to meet the daily physical, social, functional or mental health needs of its residents. Examples of specialized rehabilitative services include, but are not limited to:

   1. Physical therapy,

   2. Speech/language therapy,

   3. Occupational therapy, and

   4. Mental Health Rehabilitative Services for MI and/or MR. Refer to Part 303, Chapter 1 Rule 1.7 G.

E. The NF must provide the services necessary for the well-being of its residents, even when the services are not specifically mentioned in the Medicaid State Plan. The Medicaid beneficiary cannot be charged a fee for specialized rehabilitative services because they are covered facility services.

F. A facility is not obligated to provide specialized rehabilitative services when there is no current resident who requires the services. If a resident develops the need for a service after admission, the facility must either provide the service or obtain the service from an outside

resource.

G. Mental Health Rehabilitative Services for MI and MR are rehabilitative services which the NF is required to provide to meet the daily mental health needs of its residents. These services may include, but are not limited to:

1. Consistent implementation, during the resident's daily routine and across settings, of systematic plans which are designed to change inappropriate behaviors,

2. Administering and monitoring the effectiveness and side effects of medications which have been prescribed to change inappropriate behavior or to alter manifestations of psychiatric illness,

3. Provision of a structured environment for those individuals who are determined to need such structure such as structured socialization activities to diminish tendencies toward isolation and withdrawal,

4. Development, maintenance, and consistent implementation across settings of those programs designed to teach individuals the daily living skills they need to be more independent and self-determining. Program focus may include but not be limited to grooming, personal hygiene, mobility, nutrition, health, medication management, mental health education, money management, and maintenance of the living environment,

5. Development of appropriate personal support networks, or

6. Formal behavior modification programs.

H. If Mental Health Rehabilitative Services for MI and MR services are needed by a resident, they must be provided by the NF, regardless of whether the need was identified through the PASRR process, and regardless of whether the resident requires other specialized services through the CMHC/RC.

I. Specialized Services for MI are the services specified by the CMHC which, when combined with services provided by the NF, result in the continuous and aggressive implementation of an individualized plan of care that:

1. Is developed and supervised by an interdisciplinary team, which includes a physician and any other professional appropriate to the individual's situation,

2. Prescribes specific therapies and activities for the treatment of the individual, and

3. Is directed toward diagnosis and reduction of the resident's mental/emotional disturbance, improvement of his/her level of independent functioning, and achievement of a functional level that permits reduction on the intensity of mental health services to below the level of specialized services at the earliest possible time.

J. Specialized services provided by CMHCs include:

1. Medication Evaluation and Monitoring defined by Medicaid as an intentional face-to-face interaction between a physician or a nurse practitioner and a resident for the purpose of assessing the need for psychotropic medication, prescribing medications and regular periodic monitoring of the medications prescribed for therapeutic effect and medical safety,

2. Individual Therapy defined as Medicaid as one-on-one psychotherapy that takes place between a mental health therapist and a resident,

3. Family Therapy defined by Medicaid as psychotherapy that takes place between a mental health therapist and an individual's family members, with or without the presence of the individual. Family therapy may also include others with whom the resident has a family-like relationship. Meetings with NF staff that do not include the resident may not be considered family therapy,

4. Group Therapy defined by Medicaid as psychotherapy that take place between a mental health therapist and at least two (2), but no more that twelve (12) residents at the same time. Possibilities include, but are not limited to, groups that focus on coping with or overcoming depression, adaptation to changing life circumstances and self-esteem enhancement, and

5. Psychosocial Rehabilitation for the Elderly defined by Medicaid as a program of structured activities designed to support and enhances the ability of NF residents to function at the highest possible level of independence. The activities target the specific needs and concerns of the elderly while aiming to improve individuals' reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, task completion and other areas of competence that promote independence in daily life. Activities are designed to alleviate such psychiatric symptoms as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

K. Specialized services for MR is defined by Medicaid as the services specified by the RC which, combined with services provided by the NF or other service providers, result in treatment which meets the requirements for Condition of Participation of Active Treatment Services for the ICF/MR.

L. Specialized services provided by RCs include, but are not limited to:

1. Training targeted toward amelioration of identified basic skill deficits and/or maladaptive behavior,

2. Priority training needed to achieve greater levels of independence and self-determination, and

3. Aggressive implementation of a systematic program of formal and informal techniques and competent interactions continuously targeted toward achieving a measurable level of skill competency specified in written objective, based on a comprehensive interdisciplinary evaluation, and conducted in all client settings and by all personnel involved with the individual.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 483.45, 42 CFR 483.440,

Rule 1.8: Confidentiality Safeguards

A. As part of the PAS process, the individual and legal and/or designated representative must be notified in writing that the individual is suspected of having MI and/or MR and is being referred for a Level II Evaluation.

   1. This is accomplished by including the individual's signature on the Level I Evaluation and providing a copy of the PAS to the individual, and his or her legal and/or designated representative.

   2. The PAS and Level II Evaluation must involve the individual being evaluated, the individual/legal and/or designated representative, and the individual's family, if they are available. The individual/legal and/or designated representative must agrees to family participation.

B. The PAS, the Level II Evaluations, and all notices must be adapted to the cultural background, language, ethnic origin and means of communication used by the individual being evaluated. PAS and Level II Evaluation findings must be interpreted and explained to the individual and legal and/or designated representative.

C. Interdisciplinary coordination must occur and be documented when more than one evaluator performs any portion of the Level II Evaluation.

D. The gathering of information necessary for determining whether it is appropriate for the individual with MI and/or MR to be placed in an NF or in another appropriate setting must occur throughout all applicable portions of the PASRR evaluation. All information must be considered and recommendations must be based upon a comprehensive analysis of all data concerning the individual. If there is available data that is considered valid and accurate and reflects the current functional status of the individual, evaluators may use data obtained prior to initiation of the PASRR process. In order to supplement and verify the existing data is current and accurate, it may be necessary for the CMHC/RC to gather additional information to assess proper placement and treatment. Information may be obtained/released only with properly executed consents.

E. All ARC Determinations for PASRR made by the ARC must be maintained by the PASRR Office in accordance with State Law. All PASRR Determinations must be recorded in the resident's record at the NF to which they are admitted and maintained in accordance with

State Law.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: Appeal Process

A. If an individual or his/her legal or designated representative does not agree with the ARC Determination made by the DMH, he/she has a right to appeal the decision.

1. The individual/legal or designated representative must request an appeal in writing directed to the State PASRR Coordinator within thirty (30) days of receipt of the written notification of the ARC Determination. Documentation submitted must indicate the reason for the request for re-determination.

2. The Bureau Director of the Department of Mental Health/Mental Retardation shall review the ARC Determination and any supplemental information submitted and notify the individual/legal or designated representative of the results of the re-determination within thirty (30) days of receipt of the request for an appeal.

3. If the individual/legal or designated representative does not agree with the Bureau Director's decision, they have the right of appeal to the Executive Director of the Department of Mental Health. The individual/legal or designated representative must notify the State PASRR Coordinator in writing within thirty (30) days of receipt of written notification of the Bureau Director's decision.

4. The Executive Director of the Department of Mental Health shall review the ARC Determination and any supplemental information submitted and notify the individual/legal or designated representative of the results of the re-determination within thirty (30) days of receipt of the request for an appeal.

5. If the individual/legal or designated representative does not agree with the Executive Director's decision, they have the right of appeal to the State Board of Mental Health. The individual/legal or designated representative must notify the State PASRR Coordinator in writing within thirty (30) days of receipt of written notification of the Executive Director's decision.

6. The State Board of Mental Health shall review the individual's complete PASRR record and notify the individual/legal or designated representative of the results of this review within forty-five (45) days of receipt of the request.

7. PASRR determinations made by the Department of Mental Health cannot be countermanded by Medicaid, either in the claims process or through other utilization control/review processes or by the State Department of Health through the survey and certification process.

8. PASRR determinations made by the ARC as the State Mental Health Authority and

Mental Retardation Authority can only be overturned if the appeal process is followed as specified in this section.

B. In making the determination, the Department of Mental Health's PASRR process must not use criteria relating to the need for nursing facility care or specialized services that are inconsistent with this regulation and any supplementary criteria adopted by the Division of Medicaid under its approved State Plan.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 483.108 (a), (b).

Rule 1.10: Reimbursement for PASRR Evaluations

A. In order for the provider to be eligible for reimbursement for conducting Level II Evaluations, a completed Pre-Admission Screening/Resident Review Summary must be submitted to the PASRR Office for ARC determination. When the ARC has made a determination, Medicaid will be notified and the billing will be processed.

B. Reimbursements will be processed according to a report generated at the end of each month for all the Level II Evaluations completed within that month.

C. Requirements for reimbursement are:

1. The Level II Evaluation must be completed and submitted to the State PASRR Coordinator within two (2) business days of completing the evaluation,

2. Only completed Level II Evaluations are eligible for reimbursement, and

3. All assessments which are part of the Level II Evaluation must be signed by the person who completed that assessment.

D. Medicaid does not reimburse for:

1. Incomplete Level II Evaluations. The provider who conducts the Level II is responsible for obtaining and submitting all required components to the PASRR Office in order for any portion to be eligible for reimbursement,

2. Therapeutic services provided by CMHCs in a NF to individuals who do not have an ARC determination recommending the service,

3. Level II Evaluations for individuals who have a primary diagnosis of Alzheimer's disease or other dementia, or

4. Beneficiary time that is provided for various services cannot be conducted and/or billed by two different evaluators simultaneously.

Source: Miss. Code Ann. § 43-13-121

Administrative Code

Title 23: Medicaid
Part 304
Audit

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Title 23: Division of Medicaid

Part 304: Audit

Part 304 Chapter 1: Audit

Rule 1.1: Audit Rule

A. General: It is the mission of the Division of Medicaid to ensure compliance, efficiency, and accountability within the Mississippi Medicaid program by detecting and preventing fraud, waste, program abuse, and by ensuring that Medicaid dollars are paid appropriately by implementing tort recoveries, pursuing recoupment, and identifying avenues for cost avoidance. The Division of Medicaid shall conduct auditing and monitoring reviews of Medicaid providers accordingly.

B. Audit and Monitoring Reviews

1. The Division of Medicaid utilized bureau staff, contracted audit entities or combination of both, selects Medicaid providers for review.

2. An audit or monitoring review has the following objectives:

   a) To determine if services billed and paid under the State's Medicaid program were:

      1) Provided to an eligible beneficiary,

      2) Medically necessary,

      3) Provided at the appropriate level of care,

      4) Appropriately documented, specifically including the assignment of diagnosis and procedure codes submitted by providers and that may be used by the Division of Medicaid to calculate payment.

      5) In accordance with the Mississippi Medicaid Provider Manual, Mississippi State Plan, and official notices through other means such as, but not limited to, the Mississippi Medicaid Provider Bulletin, Remittance Advice header messages, and official communications from the Agency, and

      6) For service for which the reimbursement rate is based on a cost report, that the cost report contains only allowable costs and were completed in accordance with the Mississippi Medicaid Provider Manual, the Cost Report Instructions as posted on the Mississippi Medicaid website and Mississippi State Plan.

   b) To provide a systematic and uniform method of determining compliance with state and federal program rules and regulations,

c) To provide a mechanism for data gathering this can be used to modify the State's Medicaid program and State Medicaid Rules and procedures,

d) To determine if the services provided meet the community standard of care, and

e) To determine if the provider is maintaining clinical and fiscal records which substantiate claims submitted for payment during the review period.

C. Audit Methods and Locations: The Division of Medicaid selects the appropriate method of conducting the review including, but not limited to, the following:

1. On-site reviews, conducted on the provider's premises,

2. Desk audits, conducted at the Division of Medicaid's or contracted auditor's offices, or

3. A combination of an on-site and a desk audit.

D. Audit/Monitoring Review Overview

1. Audits/Monitoring reviews will involve the examination of the provider's medical and/or financial records. Providers must maintain appropriate documentation in the client's medical or health care service records to verify the level, type, and extent of services provided. Providers must:

   a) Keep legible, accurate, and complete charts and records to justify the services provided to each client,

   b) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains, and

   c) Make charts and records available to Medicaid staff, other State and Federal agencies, and its contractors thereof, upon request. Records shall be maintained in accordance with Part 200, Chapter 1, Rule 1.3.

2. A provider's bill for services, appointment books, accounting records, or other similar documents alone do not qualify as appropriate documentation for services rendered.

3. If a provider fails to participate or comply with the Division of Medicaid's audit process or unduly delays the audit process, the Division of Medicaid considers the provider's actions or lack thereof, as abandonment of the audit.

4. If the Division of Medicaid suspects a provider of fraud, abusive practice, audit abandonment, or present a risk of imminent danger to clients, the Division of Medicaid shall take one or more of the actions listed below.

a) Immediately issue a final report,

b) Terminate the provider's agreement with Medicaid,

c) Issue a subpoena for the provider's records, or

d) Refer the provider to the appropriate prosecuting authority.

E. Audit/Monitoring Review Process: In general, the audit/monitoring review process will consist of the following:

1. Provider Notification,

2. Field Entrance Conference,

3. Procedures for Submitting Documentation Electronically,

4. Examination of Documentation,

5. Field Exit Conference,

6. Draft Report,

7. Exit Conference,

8. Final Report, and

9. Administrative Hearings as required.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117 (A)(1)(d)

History: Revised - 10/01/2012

Rule 1.2: False Claims Act

A. General

1. Section 6032 of the federal Deficit Reduction Act (DRA) of 2005 (Public Law 109-171) set forth administrative requirements which impacts entities receiving annual Medicaid payments of at least $5,000,000. The DRA requires certain governmental, for-profit and non-profit providers and other entities that receive Medicaid funding to provide employee education regarding the False Claims Act and take actions that will address fraud, waste and abuse in health care programs that receive federal funds. Any entity that receives $5,000,000 or more annually must establish the following policies as a condition of participation in the Medicaid program:

a) The entity must establish written policies for all employees of the entity including management and of any contractor or agency of the entity that provides detailed information about the False Claims Act established under Sections 3729 through 3733 of Title 31, United States Code.

b) The entity must include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

c) The entity must include in any employee handbook for the entity, a specific discussion of the laws described above, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

2. Annually, the Division of Medicaid will identify and mail notices to providers and contractors that provide Medicaid health care items or services that were paid $5,000,000 or more during the prior federal fiscal year. The $5,000,000 threshold will be measured based upon the aggregate payments received by an entity during the federal fiscal year October 1 through September 30, even if that entity has multiple provider and/or tax id numbers. For example, a health system that includes a hospital, skilled nursing facility and home health program and collectively receives more than $5,000,000 in aggregate reimbursement annually will be subject to this requirement. Once notified, the entity will have thirty (30) calendar days to submit the documentation requested in the letter to confirm compliance.

3. It is the responsibility of each entity meeting the annual threshold to establish and disseminate written policies. In addition, the entity must provide those policies to the Division of Medicaid including any revisions. The Division of Medicaid will perform annual monitoring activities to ensure that entities are in compliance with this section. Providers will be selected on a random basis or as needed.

4. If an employee or contractor or agent of an entity reports suspected fraud, waste, or abuse in the Medicaid program, the entity must report that information to the Bureau of Program Integrity at the Division of Medicaid by the next business day. Entities must investigate all allegations within a reasonable time period and report the results of the investigation to the Division.

B. Reporting Requirements - False Claims information must be reported to the appropriate federal and/or state entity including Medicaid and the Federal Office of Inspector General in the U.S. Department of Health and Human Services.

C. Sanctions - If an entity is found not to be in compliance with any part of the requirements noted above, the provider will be given a thirty (30) day notice by the Division of Medicaid that suspension of the entity's provider number(s) and payment may be held at the sole discretion of the Division of Medicaid. The entity must submit appropriate documentation to

the satisfaction of the Division of Medicaid in order for the non-compliance status to be lifted. The Division of Medicaid will work in conjunction with the Attorney General's office and the Office of the Inspector General (OIG) on cases of non-compliance.

D. Definitions- For purposes of this rule Medicaid defines the terms used as follows:

1. Entity - An "entity" includes a governmental agency, organization, unit, corporation, partnership, or other business arrangement including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists, whether for-profit or not-for-profit, which receives or makes payment, under a State Plan approved under title XIX or under any waiver of such plan. In addition, persons are considered entities. A "person" includes any natural person, corporation, firm, association, organization, partnership, limited liability company, business or trust. If an entity furnishes items or services at more than a single location or under more than once contractual or other payment arrangement, the provisions of this section will apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

2. Employee - An "employee" includes any officer or employee of the entity.

3. Contractor or Agent - A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

4. Knowingly - "Knowing" and "Knowingly" is defined to mean that a person:

   a) Has actual knowledge of falsity of information in the claim,

   b) Acts in deliberate ignorance of the truth or falsity of the information in a claim, or

   c) Acts in reckless disregard of the truth or falsity of the information in the claim. The federal False Claims Act does not require proof of a specific intent to defraud the United States government. Instead, entities can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to Medicaid. Examples include knowingly making false statements, falsifying records, double-billing for items or services, or submitting bills for services or items never furnished.

5. Whistleblower - An individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing an action under Sections 31 USC 3729 through 3733 which is based on the information.

6. Claim - A "claim" includes any request or demand for money that is submitted to the Division or its fiscal agent.

E. Appeals - Refer to Part 300, Chapter 1, Rule 1.1 for the rule regarding Administrative Hearings for Providers.

Source: Miss. Code Ann. § 43-13-121

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 305
Program Integrity

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Title 23: Division of Medicaid

Part 305: Program Integrity

Chapter 1: Program Integrity

Rule 1.1: Definitions

A. Abuse is defined as beneficiary practices that result in unnecessary cost to the Medicaid program and/or provider practices that are inconsistent with sound fiscal, business, or medical practices that result in:

   1. An unnecessary cost to the Mississippi Medicaid Program,

   2. Reimbursement for services that are not medically necessary, or

   3. Reimbursement for services that fail to meet professionally recognized standards for health care.

B. Credible allegation of fraud is defined as an allegation from any source that has indicia of reliability in which the Division of Medicaid has verified through facts and evidence including, but not limited to, alleged fraud from:

   1. Fraud hotline complaints,

   2. Claims data mining, and/or

   3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

C. Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, or an act that constitutes fraud as defined by federal or state law.

D. Incorrect payment is defined as an error in reimbursement which results in an overpayment or underpayment which may be due to a billing error, systems error and/or human error.

E. Overpayment is defined as an incorrect payment that results in the provider receiving a higher reimbursement than is appropriate for the service provided.

F. Beneficiary error is defined as the client’s incomplete, incorrect or misleading information because the client misunderstood, was unable to comprehend the relationship of the facts about the situation to eligibility requirements or there was other inadvertent failure on the client’s part to supply the pertinent or complete facts affecting Medicaid or Children's Health Insurance Program (CHIP) eligibility.

G. Waste is defined as the overutilization, underutilization, or misuse of resources.

Source: 42 C.F.R. Part 455; Miss. Code Ann. § 43-13-121.

History: Revised and moved language to Rules 1.2-1.4, and 1.6 eff. 11/01/2016; Revised Miss. Admin. Code Part 305, Rule 1.1.D. eff. 10/01/2014; Miss. Admin. Code Part 305, Rule 1.1.B.3. and D.1. revised effective 08/15/2013 to comply with the Medical Assistance Participation Agreement Section C.

Rule 1.2: Fraud, Waste, and Abuse

A. The Division of Medicaid investigates suspected cases of fraud, waste, and abuse using methods that:

   1. Do not infringe on the legal rights of persons involved, and

   2. Afford due process of law to individuals under investigations.

B. The Division of Medicaid must make a formal, written fraud referral to the Medicaid Fraud Control Unit (MFCU) for each credible allegation of fraud or an allegation that leads to the initiation of a payment suspension, in whole or in part. If the Division of Medicaid determines that good cause exists to remove a payment suspension, in whole or in part, or to discontinue a payment suspension previously imposed, the Division of Medicaid is not relieved of its obligation to make a referral to MFCU.

C. The Division of Medicaid must suspend all payments to a provider when the Division of Medicaid determines there is a credible allegation of fraud for which an investigation is pending unless the Division of Medicaid determines that good cause exists not to suspend or partially suspend such payments or not to continue a payment suspension previously imposed including, but not limited to:

   1. Law enforcement:

      a) Specifically requesting payments not be suspended, or

      b) Declining to cooperate in certifying that a matter continues to be under investigation.

   2. The Division of Medicaid determining:

      a) Other available remedies exist that could be implemented by the Division of Medicaid to more effectively or quickly protect Medicaid funds,

      b) A payment suspension is not in the best interest of the Medicaid program, or

      c) A payment suspension would have an adverse effect on beneficiary access to necessary items or services because either of the following is true:

1) An individual or entity is the sole community physician or the sole source of essential specialized services in a community, or

2) The individual or entity serves a large number of beneficiaries within a Health Resources and Services Administration (HRSA) designated medically underserved area.

d) A payment suspension should be removed based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension.

D. The Division of Medicaid will notify providers of suspension of payments within five (5) days of the suspension unless requested in writing by a law enforcement agency to temporarily withhold such notice.

E. The Division of Medicaid may grant an administrative hearing, if requested by the provider, as described in Miss. Admin. Code Part 300, to determine whether or not good cause exists to remove a payment suspension or suspend payment only in part.

F. Suspension of payments will continue until:

1. The Division of Medicaid or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider, or

2. Legal proceedings related to the provider's alleged fraud are completed.

G. The Division of Medicaid will:

1. Make a referral to the appropriate law enforcement agency if there is reason to believe that a beneficiary has defrauded the Medicaid program.

2. Conduct a full investigation if there is reason to believe that a beneficiary has abused the Medicaid program or if an applicant made a false statement or failed to disclose a material fact in his/her Medicaid application.

Source: 42 C.F.R. Part 455; Miss. Code Ann. §§ 43-13-121, 43-13-129.

History: New rule, language moved from Miss. Admin. Code Part 305 Rule 1.1 eff. 11/01/2016.

Rule 1.3: Overpayments

A. Providers must notify the Division of Medicaid's Office of Program Integrity in writing within thirty (30) calendar days of the discovery of any overpayments.

1. Any self-disclosure of overpayments submitted to the Division of Medicaid must include the following information:

a) Name and address of the affected provider,

b) A provider which is entity owned, controlled, or otherwise part of a system or network must include:

   1) A description or diagram of any pertinent business/legal relationships,

   2) The names and addresses of any related and/or affected entities, corporate divisions, departments, or branches, and

   3) The name and address of the disclosing entity's designated representative,

c) Medicaid provider number(s) associated with claims,

d) Tax identification number(s),

e) Payee identification number(s),

f) Affected claims submitted in Excel or Access which must include the following information:

   1) Beneficiary name,

   2) Claim transmittal control number (TCN),

   3) Procedure code,

   4) Dates of service,

   5) Billed amount,

   6) Paid amount,

   7) Paid date, and

   8) Refund amount,

g) A report that includes a full description of the information being disclosed, the person who identified the overpayment and the manner in which the individual discovered it,

h) A detailed account of the provider's investigation of the overpayment,

i) A statement disclosing whether the provider is under investigation by any government agency or contractor,

j) A statement detailing the provider's explanation of the cause of the overpayment,

k) A certification that the information submitted to the Division of Medicaid is based upon a good faith effort to disclose a billing inaccuracy and is true and correct, and

l) The methodology used in determining the amount of the overpayment.

2. The provider must submit additional information to the Office of Program Integrity as requested in order to verify the information submitted including the financial impact.

3. Any issues discovered during the verification process which are outside the scope of the self-disclosure may be treated as new matters subject to further investigation.

4. Refunds to the Division of Medicaid for overpayments must be conducted through the claims payment adjustment process or in the form of a refund check within thirty (30) calendar days of the overpayment discovery.

5. Self-disclosure does not release the provider from any other cause of action, civil or criminal, by another state agency or department of the United States under applicable law and regulations regarding these payments.

B. The Division of Medicaid, or designee, will send a demand letter via certified mail return receipt requesting the refund of overpayments discovered through audit or investigation:

1. On or before thirty (30) calendar days of the receipt of the demand letter, sent via certified mail, or thirty (30) calendar days from the date of the letter if the provider does not sign the certified mail notice, the provider must:

a) Request an administrative hearing [Refer to Miss. Admin. Code Part 300], or

b) Refund the overpayment by:

1) A lump sum payment,

2) Offsetting against current payments through the claims payment adjustment process until overpayment is recovered,

3) A repayment agreement executed between the provider and the Division of Medicaid, or

4) Any other method of recovery available to and deemed appropriate by the Division of Medicaid.

2. Providers that fail to refund overpayments as described in Miss. Admin. Code Part 305, Rule 1.3.B.1.b) within the thirty (30) calendar day timeframe, may:

a) Be placed under investigation for waste and/or abuse of the Medicaid program, and

b) Be subject to charges for any allowable interest under state law which will begin accruing thirty-one (31) calendar days after receipt of the demand letter sent via certified mail, or thirty (30) calendar days from the date of the letter if the provider does not sign the certified mail notice.

C. The Division of Medicaid will accept reimbursement for overpayments without penalty in the event that:

1. Overpayments are disclosed voluntarily and in good faith, and

2. The acts that led to the overpayments were not the result of fraudulent or abusive conduct.

D. The Division of Medicaid will refund any payment recovered in error.

Source: 42 C.F.R. Part 455; Miss. Code Ann. § 43-13-121.

History: New rule, language moved from Miss. Admin. Code Part 305 Rule 1.1 eff. 11/01/2016.

Rule 1.4: Corrective Action Plan (CAP)

A. The Division of Medicaid may require a provider to submit a Corrective Action Plan (CAP) to correct deficiencies found during an investigation.

1. A CAP must be specific and must, at a minimum, include:

a) Provisions aimed toward correction of the deficiencies,

b) Reasonable completion dates,

c) A full description of the methods used to permanently correct the deficiencies that necessitated the CAP, and

d) A description of methods used for ensuring full compliance with the CAP.

2. The CAP will be subject to approval by the Division of Medicaid to ensure compliance.

B. The determination of a violation of the CAP, including failure to implement as directed, will subject the provider to further adverse actions.

Source: 42 C.F.R. Part 455; Miss. Code Ann. § 43-13-121.

History: New rule, language moved from Miss. Admin. Code Part 305 Rule 1.1 eff. 11/01/2016.

Rule 1.5: Improper Payments Due to Inaccurate Eligibility Information

A. The Division of Medicaid will identify the cause of any improper payments due to an error in the beneficiary's eligibility information including, but not limited to, incorrect income or deductions, and take corrective action.

B. All underpayments are corrected upon discovery:

   1. Underpayments resulting from agency error may be corrected retroactively.

   2. Underpayments resulting from beneficiary errors are corrected, but they are not corrected retroactively.

C. The Division of Medicaid will attempt to recover the amount of any overpayment from the beneficiary directly or from the beneficiary's state tax refund when the beneficiary provides incorrect eligibility data resulting in an overpayment.

Source: Miss. Code Ann. § 43-13-121.

History: New Rule, language moved from Miss. Admin. Code Part 100, Chapter 6 eff. 11/01/2016.

Rule 1.6: Medicaid Eligibility Quality Control

A. A beneficiary must cooperate with Medicaid Eligibility Quality Control (MEQC) reviews.

B. If a beneficiary fails to cooperate with MEQC reviews and an investigator is unable to obtain information needed to complete a review, the case will be referred back to the regional office for a redetermination.

   1. As part of the redetermination process, the information needed by the MEQC will be requested.

   2. If the information is not provided to the regional office, coverage will be terminated because the Division of Medicaid will be unable to determine eligibility.

Source: 42 C.F.R. § 431.810, *et seq*.

History: New Rule, language moved from Miss. Admin. Code Part 100, Chapter 7 eff. 11/01/2016.

MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 306
Third Party Recovery

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Title 23: Division of Medicaid

Part 306: Third Party Recovery

Part 306 Chapter 1: Third Party Recovery

Rule 1.1: General

A. Federal and state laws, rules, and regulations require that the Medicaid program liability be secondary to any third party benefits to which a beneficiary is entitled. "Third party" means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under the State Plan.

B. As a condition of eligibility for Medicaid, the beneficiary is required by law to assign his/her rights to any third party benefits to the Division of Medicaid. By law, the Division of Medicaid legally stands in place of the beneficiary to pursue recovery of Medicaid's payment from any liable third party.

C. State law requires the provider to identify to the Division of Medicaid any third party source and to cooperate with the Division of Medicaid in the recovery of Medicaid's payment from the third party.

D. Federal law requires that a provider may not refuse to furnish covered Medicaid services to a beneficiary because of a third party's potential liability for the services.

E. Federal law also protects the Medicaid beneficiary when a third party source is involved. The provider must accept either Medicaid's established reimbursement or the third party payment as payment in full. The beneficiary is legally responsible for the lesser of the applicable co-payment as formulated by the Division of Medicaid, or the difference in the third party payment and Medicaid's established reimbursement.

F. When a third party payment is involved, the following restrictions to beneficiary liability apply:

    1. If the third party payment is equal to or greater than Medicaid’s established fee schedule, no collection from the beneficiary or a financially responsible person can be attempted.

    2. If the third party payment is less than the established Medicaid fee schedule, the provider may collect from the beneficiary the lesser of:

        a) The co-payment amount established by Medicaid, or

        b) The difference in Medicaid’s fee schedule and the third party payment.

G. The beneficiary is not liable for any more than the co-payment that has been established by the Division of Medicaid.

H. When violation of the above beneficiary liability is discovered, the Division of Medicaid may reduce any payment amount otherwise due the provider up to three (3) times the amount incorrectly received from the beneficiary.

Source: 42 CFR §§ 433.136, 433.137, 433.145; Miss. Code Ann. §§ 43-13-121, 43-13-125, 43-13-305, 43-13-311, 43-13-313.

History: Revised Miss. Admin. Code Part 306, Rule 1.1.A. eff. 06/01/2015.

Rule 1.2: Medicaid Cost Avoidance

A. Federal law requires that for reimbursement of covered services, other than those outlined in Rule 1.1 in this chapter, Medicaid must use the cost avoidance claims payment method. "Cost Avoidance" means the Medicaid agency pays claims involving third party liability only to the extent Medicaid's established reimbursement exceeds the amount paid by the third party. To protect the rights of the Division of Medicaid, the provider must file with the third party source before filing with Medicaid.

B. Exception to Medicaid Cost Avoidance Procedures for Practitioners

1. Federal law requires the Medicaid agency to reimburse the practitioner for certain covered services even when a third party source exists. There are specific covered services in which the Medicaid agency is required to use the pay and chase method of payment. “Pay and Chase” means the Medicaid agency will reimburse the practitioner for specific covered services and then pursue recovery of the Medicaid payment from the third party source. Services which require a mandatory use of the pay and chase method include:

   a) Pregnancy related services for women (prenatal, labor and delivery, and post-partum),

   b) Preventive pediatric services (including EPSDT services), and

   c) Covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program.

2. Claims submitted for pregnancy related services and/or preventive pediatric services must be submitted on separate claim forms.

3. Claims submitted for individuals for whom child support services are enforced by the state’s Title IV-D program will pay without any additional coding by the provider. The Title IV-D program for Mississippi is managed within the Department of Human Services (DHS).

4. Claims submitted for inpatient and outpatient hospital charges for labor and delivery and postpartum must be cost avoided. Hospital claims must be filed with the third party prior

to billing Medicaid. As indicated above, practitioner claims must be handled by the "Pay and Chase" method.

C. Exception to Medicaid Cost Avoidance for Pharmacists

1. Pharmacists must pursue any third party benefits to the extent of the paid drug claims except for covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program.

2. Neither of the these exceptions to cost avoidance relieve the provider of the responsibility of notifying Medicaid of known third party cases arising out of injuries, disease, or sickness of the beneficiary as a result of products liability, a malpractice matter, etc. Refer to Rule 1.1 and Rule 1.4 in this chapter.

Source: 42 CFR § 433.139; Miss. Code Ann. § 43-13-121.

Rule 1.3: Billing

A. Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This also includes beneficiaries who are Medicare/Medicaid eligible. The law further provides that providers will be held liable, to the extent of the Medicaid payment, for failure to cooperate with Medicaid staff when they have knowledge of third party coverage.

B. Medicaid requires that claims with third party coverage should not be submitted to the Medicaid fiscal agent until payment or denial notification is received from the third party resource.

C. Any provider failing to cooperate with the Division of Medicaid in the protection and the recoupment of its payments from a legally liable third party or parties shall be liable to the Division of Medicaid to the extent of the payments made to the provider for services rendered to the beneficiary for which the third party or parties are or may be liable. Refer to Rule 1.2 and Rule 1.4 in this chapter for exceptions to the initial filing with the third party source requirement.

D. Preferred Provider Organizations

1. When a Medicaid beneficiary is covered by a private insurance policy whose administrator has a preferred provider organization in which the Medicaid provider does not participate, the provider must choose one of the following methods of billing:

a) Submit the claim to the Division of Medicaid with a statement indicating the provider is not a member of a particular preferred provider organization, the insurance company name and address, and specific third party filing data; or

b) File the claim with the third party source and hold the patient liable for the amount the insurance company pays him/her for the service rendered.

2. When a Medicaid beneficiary is covered by a private insurance policy whose administrator of the policy has a preferred provider organization in which the Medicaid provider participates, the following applies:

   a) Pursuant to the State Medicaid Manual as written by CMS, "Medicaid is to make no payment when billed for the difference between the third party payment and the provider's charges. The provider's agreement as a member of the preferred provider organization to accept payment of less than his charges constitutes receipt of a full payment of his/her services; therefore, the Medicaid recipient who is insured has no further responsibility. Medicaid is intended to make payment only when there is a recipient legal obligation to pay."

E. Assignment of Benefits

1. The provider must obtain assignment of benefits when billing third party insurance.

2. Providers unable to obtain assignment of benefits for circumstances beyond the beneficiary's control must submit the claim to the Division of Medicaid.

3. In the event the beneficiary fails to assign benefits to the provider when it is within his/her rights to do so, the provider may choose to pursue payment from the beneficiary rather than filing with Medicaid. However, if the provider files the claim with Medicaid, he/she must not violate beneficiary liability as protected by law.

F. Beneficiary Denies Insurance Coverage - The provider must obtain a signed statement from the beneficiary which includes the name of the insurance company, the policy number, and the ending date of coverage and forward to Medicaid.

G. Billing Medicare - The provider must file and obtain Medicare payment for the service or obtain a Medicare denial before Medicaid payment can be made.

H. Billing Medicare and a Private Third Party Source - When the provider determines that a Medicaid beneficiary is eligible for Medicare in addition to being covered by private insurance, the provider must follow these guidelines

1. Medicare Part A - File a claim with Medicaid after receiving third party payments or explanation of benefits of denial from Medicare Part A and the private third party source. The Medicare Part A intermediary will only crossover claims to Medicaid.

2. Medicare Part B - File a claim with Medicaid after receiving third party payments or explanation of benefits of denial from Medicare Part B and the private third party source. The Medicare Part B intermediaries will crossover all claims to the appropriate third party source.

I. Claims Paid by Medicaid for Beneficiaries with Medicare Coverage - If a beneficiary is found to have Medicare coverage after Medicaid claims have been paid, the fiscal agent shall automatically recoup the payments from the provider and the provider must bill Medicare.

J. Billing Medicaid after Receiving a Third Party Payment or Denial - After receiving payment or denial from all third party sources, the provider is required to file a claim with the Medicaid fiscal agent. The amount of third party payment must be indicated on the claim. Medicaid shall pay the balance due on the claim (the total Medicaid payment amount less the third party payment amount) or makes no additional payment if the third party payment is equal to or greater than the total amount due from Medicaid.

K. Third Party Money Received - The provider must submit the EOB from the third party source to inform Medicaid of all third party money received.

L. Third Party Denial Received – The provider must submit a copy of the denial letter to Medicaid when the third party denies the claim the following:

1. The service is not covered by insurance,

2. Insurance benefits have been exhausted, or

3. Insurance coverage has expired.

M. No Response from Third Party Source - The provider must make every effort to acquire payment from the third party source before filing Medicaid. Failure of the provider to do so, by appropriate means (e.g. written response) will result in voiding of the provider's next payment for services.

N. Receipt of Duplicate Third Party Money and Medicaid Payment - If the provider receives third party payment(s) and Medicaid payment for the same services, the provider must accept either the third party payment(s) or the Medicaid payment as payment in full for the Medicaid covered services. The other payment(s) must be refunded to Medicaid. The provider is required to make the refund to the Medicaid fiscal agent within thirty (30) days from the receipt of the duplicate payment(s).

O. Hospital Retroactive Settlements - Hospitals having preferred provider organization (PPO) contract with an insurance company and payments are subject to retroactive adjustments, the amount to be reported as third party liability on the claim form must be as follows:

1. If the third party payor pays a final amount (i.e., per diem or per discharge amount), which is not subject to change, then the third party payment should be reported as the third party liability amount.

2. If the third party payor pays an interim payment, which may be adjusted or settled later based on contractual agreements with the provider, the maximum third party

reimbursement (i.e., contractual benefit) should be reported as the third party liability amount.

a) If future settlements with other third party payors result in the provider refunding amounts to the third party payor, the Division of Medicaid makes no additional payment because of such refunds.

b) If future settlements with third party payors result in the third party payor making an additional payment to the provider, the following should be adhered to:

1) Third party liability amounts have been reported as benefits as required in item O.2 above, therefore no amounts are due the Division of Medicaid.

2) Third party liability amounts have been reported at less than the maximum amount payable by the third party payor, the provider will be liable for the overpayment by the Division of Medicaid, plus interest and penalty.

Source: 42 CFR §§ 433.139, 433.145; Miss. Code Ann. § 43-13-121.

Rule 1.4: Casualty Cases

A. A provider, who has filed and accepted Medicaid payment and who wishes to pursue the difference, shall submit written notification containing information relating to the existence or possible existence of a liable third party to Medicaid within three hundred sixty five (365) days of the accident or incident for which the third party is or may be liable. The notice shall contain the following information: Medicaid recipient's name; Medicaid recipient's Social Security number or Medicaid identification number, or both; and date of the accident or incident.

B. A provider who has filed and accepted a Medicaid payment may accept or collect the difference from a third party. Within ten (10) working days of receipt of the difference, the provider or his agent shall notify Medicaid to determine whether it has received full reimbursement for all payments made to all providers for health care services rendered to a Medicaid recipient as a result of an accident or incident. A provider shall not disburse the difference until receipt of notification from the Medicaid Third Party Recovery Bureau that it has been made "whole." Medicaid shall be made whole. The provider shall refund Medicaid within thirty (30) days from the receipt of the duplicate payment.

C. In the event Medicaid agrees to and accepts less than full reimbursement for all payments made on behalf of a Medicaid recipient, excluding any partial payment, Medicaid shall be deemed to have been made whole. Medicaid shall have ten (10) working days from receipt of notice to notify the provider whether it has been made whole.

D. In the event a provider has knowledge that an individual is a Medicaid recipient and is receiving or has received health care services which may be covered by Medicaid as a result of the accident or incident, the provider is prohibited from:

1. Demanding any payment from the Medicaid recipient or his representative, or

2. Pursuing collection of any type against the Medicaid recipient or his representative.

E. Nothing in this policy shall prevent a provider from demanding payment from, or pursuing any type of collection efforts for the difference against any liable or potentially liable third party, directly or through the Medicaid recipient or his representative who is demanding payment from any liable or potentially liable third party.

F. If the provider elects not to bill the Medicaid agency in casualty cases, the provider may seek recovery of the full charges against the potentially liable third party. Should the provider elect to pursue the collection of the claim directly against the legally liable third party unsuccessfully and the Medicaid agency pursues the collection of all other claims against the legally liable third party, the provider is not then authorized to make claim against the Division of Medicaid or the beneficiary for the services rendered on behalf of the injured Medicaid beneficiary.

G. A provider who has filed and accepted Medicaid payment and who fails to comply with the notification requirement stated above shall be limited to the Medicaid payment received as payment in full for the health care services rendered to the Medicaid recipient.

H. A provider who has filed and accepted Medicaid payment may be referred for investigation and prosecution for any possible violation of either federal or state laws.

I. A provider may be excluded from participation in the Medicaid Program if the provider:

1. Pursues the difference prior to providing written notification to the Medicaid Third Party Recovery Bureau,

2. Accepts payment from a third party and fails to comply with the provisions of this policy, or

3. Fails to refund to Medicaid a duplicate payment within thirty (30) days of receipt of the duplicate payment.

Source: Miss. Code Ann. § 43-13-121.

Rule 1.5: Requests for Medical Information

A. State law requires that any medical information concerning a Medicaid beneficiary that is released by a provider must contain the following information:

1. The person is a Medicaid beneficiary,

2. His/her Medicaid identification number, and

3. The bill has been paid by Medicaid or will be submitted to Medicaid.

B. Pharmacy providers are prohibited from assisting a beneficiary to collect directly from a third party carrier for drugs or other items covered by Medicaid.

C. If a provider receives a request for medical bills or other medical information from a Medicaid beneficiary or someone acting on the beneficiary's behalf, such as an attorney, insurance company, etc., release of said information will be restricted as follows:

1. Requests from Beneficiary or Family Member - Copies of bills or medical records requested by a beneficiary or family member must be furnished if the provider receives a written authorization for release of the information. Any data released must reflect the required three elements listed above.

2. Requests from Insurance Companies - Information requested by an insurance carrier with whom a claim has been filed must be furnished directly to the carrier. The requested information must be clearly marked with the required three elements outlined in 1.5.A.

3. Requests from Attorneys - The provider must comply as fully and promptly as possible with the request for medical information from a Medicaid beneficiary's attorney once a signed authorization from the patient has been received.

4. Requests From Other Sources Requiring No Notification - Medical records or billing information requested by the Disability Determination Service (DDS) or a school system (for educational evaluation) must be sent directly to the requester. As required by law, the data must be marked with the information listed in 1.5.A in this chapter. Notification to the Division of Medicaid is not necessary when medical records or billing information are remitted to DDS or to a school system.

Source: Miss. Code Ann. §§ 43-13-121, 43-13-313.

Rule 1.6: Third Party Sources

Third party sources that must be used to reduce Medicaid program cost include, but are not limited to the following:

A. Medicare Parts A and B,

B. Health Insurance:

1. Includes both reimbursement policies and indemnity policies that make payment because medical care and/or services are rendered. Indemnity policies that restrict payment to periods of hospital confinement are considered a third party source.

2. Does not include policies that provide for income supplementation for lost income due to

disability (without regard to hospital confinement), or policies that make payment for disability (without regard to hospital confinement), such as weekly disability policies.

C. Major medical, dental, drug, vision care or other supplements to basic health insurance contracts,

D. CHAMPUS provides coverage for off-base medical services to dependents of uniformed services personnel, active or retired,

E. Veterans Administration (CHAMP-VA) provides coverage for medical services to dependents of living and deceased disabled veterans,

F. Railroad Retirement,

G. Automobile Medical Insurance,

H. Worker's Compensation,

I. Liability Insurance includes automobile insurance and other public liability policies, such as home accident insurance, etc.,

J. Family Health Insurance carried by an absent parent,

K. Black Lung Benefits,

L. United Mine Workers of America Health and Retirement Fund, or

M. Donated Funds.

Source: 42 CFR §§ 433.136, 433.138; Miss. Code Ann. § 43-13-121.

Rule 1.7: Coordination of Benefits

A. Coverage available through the Mississippi Medicaid program is secondary to any third party benefits to which a beneficiary may be entitled. If a beneficiary has other insurance, the primary insurance should be used before billing Medicaid. Benefits available from insurance or other third party liability are used to reduce costs to the Medicaid program. To be eligible for Medicaid reimbursement, all Division of Medicaid policies including prior authorization requirements must be followed.

B. Policies that provide wage or income supplementation for lost income due to disability are not considered third party resources. However, policies, including indemnity policies that provide for payment while the beneficiary receives medical care and services such as during a period of hospitalization covered by Medicaid, are considered third party resources. The assignment of third party medical payments is a condition of eligibility for Medicaid per federal and state laws.

Source: 42 CFR §§ 433.138, 433.145; Miss. Code Ann. § 43-13-121.