



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. The Division of 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. The three (3) day payment window rule refers to the requirement that all outpatient services provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital, within the three (3) days prior to an inpatient hospital admission that are related to the reason for the inpatient hospital stay must be included in the All Patient Refined Diagnosis Related Group (APR-DRG) payment for the inpatient stay.

Source: 42 C.F.R. §§ 440.2, 440.10; Miss. Code Ann. § 43-13-121.

History: Revised eff. 03/01/2019; 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 of 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. The Division of 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) used 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.
- E. The Division of Medicaid reimburses for Graduate Medical Education (GME). Payment schedules and calculations are defined in Attachment 4.19-A of the Medicaid State Plan. The Division of Medicaid does not reimburse for indirect GME costs. To qualify for GME payments, Mississippi hospitals must meet the following criteria:
1. Be located in the state of Mississippi.
 2. Have accreditation from the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) at the beginning of the state fiscal year in order to qualify for the quarterly payments during the payment year.
 3. Have a Medicare approved teaching program for direct GME costs.
 4. Be eligible for Medicare GME reimbursement.
 5. Render services on the campus of the teaching hospital or at a participating hospital site.

- a) The participating site must be listed on the ACGME website.
 - b) If the participating site uses the teaching hospital's ACGME accreditation, there must be a current affiliation agreement in place with the teaching hospital as of July 1st of the payment year.
 - c) Only the teaching hospital or the participating hospital site is eligible for GME reimbursement.
6. Have full-time equivalents (FTEs) reported on Worksheet E-4, line 6, line 15 or line 16 columns 1 and 2 of the most recent Medicare cost report filed with DOM for the calendar year immediately prior to the beginning of the fiscal year for sponsoring/participating hospitals.
7. Any hospital which is a newly accredited sponsoring/participating hospital or is within the five (5) year resident cap building period for the newly accredited sponsoring/participating hospital must be in operation as of July 1 of the payment year and must submit:
- a) Documentation of accreditation,
 - b) Medicare's most recent interim rate letter, and
 - (1) The number of residents used to calculate medical education payments during cap building years will be the number of FTEs as reported on the Medicare interim rate letter.
 - (2) If the number of FTEs reported on the Medicare interim rate letter does not cover the entire cost reporting period, the reported FTEs will be annualized and used to calculate medical education payments,
 - c) Start date of the GME accredited sponsoring/participating hospital prior to the July 1 calculation of the payments.
8. Has GME eligibility determined each year with the submission of the following annually:
- a) Documentation of accreditation,
 - b) Medicare's most recent interim rate letter,
 - c) Number of filled resident positions,
 - d) Start date of the GME program prior to the July 1 calculation of the payments, and
 - e) Documentation that the program was in operation as of July 1 of the payment year.

F. Outpatient services provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital, within the three (3) days prior to an inpatient hospital admission that are related to the reason for the inpatient hospital stay must be included in the APR-DRG payment for the inpatient hospital stay. This is referred to as the three (3) day payment window rule.

1. The inpatient hospital claim must include the following:
 - a) Diagnostic services provided to a beneficiary within three (3) days prior to and including the date of an inpatient hospital admission, and
 - b) Therapeutic (non-diagnostic) services related to an inpatient hospital admission and provided to a beneficiary within three (3) days prior to and including the date of the inpatient admission.
2. If outpatient services are provided more than three (3) days prior to admission to a beneficiary by the admitting hospital, or an entity wholly owned or operated by the admitting hospital, and the outpatient service dates span to days outside of the three (3) day window the hospital must:
 - a) Split bill for the outpatient services provided outside of the three (3) day window on a claim separate from the inpatient claim, and
 - b) Include the outpatient services provided that are related to the reason for the inpatient hospital stay within the three (3) day window on the inpatient hospital claim.
3. Maintenance renal dialysis services are excluded from the three (3) day window payment rule.
4. Although the Division of Medicaid's policy is based on Medicare policy, the Division of Medicaid's policy applies if there is a difference.

Source: 42 U.S.C. § 1395f; 42 C.F.R. § 447.325; Miss. Code Ann. §§ 43-13-121, 43-13-117; SPA 20-0018; SPA 19-0019.

History: Revised to correspond with SPA 19-0019 (eff. 10/01/2019) and SPA 20-0018 (eff. 07/01/2020) eff. 12/01/2020; Revised eff. 03/01/2019; 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 Diagnosis Related Groups (DRG)-based payment, hospitals cannot split bill inpatient hospital Medicaid claims when a stay crosses a state fiscal year end, cost report year end, or under any other circumstance unless otherwise specified by the Division of Medicaid.

B. For Mississippi Medicaid, the twenty-three (23) hour observation stay is not considered a split bill.

C. Refer to Miss. Admin. Code Part 202, Rule 1.14.E. for split billing of claims for services subject to the three (3) day window rule.

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

History: Revised eff. 03/01/2019; 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: 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. The Division of Medicaid covers outpatient hospital services provided by a licensed hospital in hospital outpatient departments to a beneficiary by or under the direction of a physician or dentist which are preventive, diagnostic, therapeutic, rehabilitative or palliative and include, but are not limited to:
1. Emergency department services,
 2. Observation services,
 3. Outpatient department services including same-day surgery,

4. Laboratory tests,
5. X-ray and other radiology services,
6. Medical supplies,
7. Physician-administered drugs and implantable drug system devices, and
8. Mental health services.

B. The Division of Medicaid requires prior authorization for certain physician-administered drugs and implantable drug system devices as determined by the Division of Medicaid.

Source: 42 C.F.R. § 440.20; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 05/01/2021; Revised to correspond with SPA 20-0022 (eff. 09/01/2020) eff. 11/01/2020; Revised eff. 12/01/2019.

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 (IHS), are reimbursed using the outpatient prospective payment methodology.
- B. The date of service for evaluation and management procedure code line items for outpatient hospital emergency department claims must be the date the beneficiary enters the emergency department even if the beneficiary's encounter spans multiple dates of service.
- C. 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 Number (TAN) on the inpatient hospital claim is received from the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid, or a designated entity 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.
 - b) A TAN issued by the UM/QIO, the Division of Medicaid, or a designated entity is only required for an inpatient admission or continued stay.

Source: 42 CFR §§ 440.230, 447.204; SPA 2012-008; SPA 2012-009; Miss. Code Ann. § 43-13-121.

History: Revised eff. 09/01/2018. 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

A. 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.

C. 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.

D. 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 provided in an outpatient department of a general hospital are covered when:

1. Provided by appropriate staff operating within the scope of their practice, and
2. Appropriate for the setting according to the licensure of the hospital.

B. Partial hospitalization services are covered:

1. When prior authorized as medically necessary through the Utilization Management and Quality Improvement Organization (UM/QIO).
2. When provided in an outpatient department of a general hospital or an acute freestanding psychiatric facility.
3. And include, but are not limited to:
 - a) Group Therapy,
 - b) Individual Therapy,
 - c) Drugs and biologicals that cannot be self-administered,
 - d) Family Therapy, and
 - e) Diagnostic services, to include, psychiatric and psychological evaluations and assessments.
4. When the services are part of an individualized treatment plan provided and approved by

the appropriate practitioner.

5. When the beneficiary:

- a) Has been diagnosed with a mental disorder that severely interferes with multiple areas of daily life, including social, vocational, and/or educational functioning,
- b) Is able to cognitively and emotionally participate in the active treatment process, and be capable of tolerating the intensity of a partial hospitalization program,
- c) Requires a minimum of twenty (20) hours per week of therapeutic services, as evidenced by their plan of care, and
- d) Is being discharged from an inpatient hospitalization or is at risk of inpatient hospitalization.

C. Partial hospitalization services are reimbursed:

1. When provided for no less than four (4) hours per day at a minimum of five (5) days per week.
2. A facility fee.

D. A professional fee for the physician, nurse practitioner and/or physician assistant services are reimbursed separately from the facility fee.

E. Intensive outpatient psychiatric services are covered:

1. When prior authorized as medically necessary through the Utilization Management and Quality Improvement Organization (UM/QIO).
2. When provided in an outpatient department of a general hospital or an acute freestanding psychiatric facility.
3. And include, but are not limited to:
 - a) Group Therapy,
 - b) Individual Therapy,
 - c) Medication management when applicable,
 - d) Case Management,
 - e) Psychiatric and psychological evaluations and assessments.

4. When the services are part of an individualized treatment plan provided and approved by the appropriate practitioner.
5. When the beneficiary:
 - a) Has been diagnosed with a mental disorder that interferes with multiple areas of daily life, including social, vocational, and/or educational functioning,
 - b) Is able to cognitively and emotionally participate in the active treatment process, and
 - c) Requires a minimum of nine (9) hours per week of therapeutic services, as evidenced by their plan of care.

F. Intensive outpatient psychiatric services are reimbursed:

1. When provided for no less than three (3) hours per day at a minimum of three (3) days per week.
2. A facility fee.

G. A professional fee for the physician, nurse practitioner and/or physician assistant services is reimbursed separately from the facility fee.

H. Outpatient hospital mental health services are reimbursed using the same methodology as other outpatient hospital services.

Source: 42 CFR § 410.155; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 05/01/2021; Revised to correspond with SPA 20-0022 (eff. 09/01/2020) eff. 11/01/2020.

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 Hospital Rates

The Division of Medicaid reimburses all outpatient hospital services except for Indian Health Service Facilities, using the outpatient prospective payment system (OPPS) methodology.

Source: 42 C.F.R. § 447.321; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/01/2019; 09/01/2012.

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

Rule 2.12: Hospital-Based Physician Clinics

- A. The Division of Medicaid defines a provider-based entity as a hospital-based physician clinic that meets the Centers for Medicare and Medicaid Services (CMS) requirements to be considered provider-based.
- B. A hospital cannot bill a hospital clinic evaluation and management code for hospital-based physician clinic services unless the hospital meets all of the following:
 1. Is a teaching hospital within the state of Mississippi,
 2. Has a medical resident-to-bed ratio of 0.25 or greater as derived from a calculation from the hospital provider's cost report, Worksheet E, Part A, Line 19,
 3. Is located:
 - a) On the campus of the main provider's hospital facility, or
 - b) Within thirty-five (35) miles of the physician clinic if the physician clinic is located

off campus.’

4. Meets the hospital-based determination as outlined in 42 C.F.R. § 413.65 (b), and
5. Meets and follows all Division of Medicaid rules and State and Federal regulations.

Source: 42 C.F.R. § 413.65; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 01/01/2019.

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. The Division of Medicaid defines Hyperbaric Oxygen Therapy (HBOT) as a modality in which the beneficiary's entire body is placed into the hyperbaric chamber and exposed to oxygen under increased atmospheric pressure.

1. The beneficiary is entirely enclosed in a pressure chamber breathing 100% oxygen (O₂) at greater than one atmosphere pressure.
2. Either a mono-place chamber pressurized with pure O₂ or a larger multi-place chamber pressurized with compressed air where the beneficiary receives pure O₂ by mask, head tent, or endotracheal tube may be used.

- B. The Division of Medicaid covers systemic HBOT in an inpatient or outpatient hospital setting in accordance with current standards of the Undersea and Hyperbaric Medical Society (UHMS) and when administered in a Food and Drug Administration (FDA) approved chamber.
- C. The Division of Medicaid covers HBOT for medical conditions that are FDA approved or that follow medically accepted indications supported by one (1) or more of the official compendia as designated by the Centers for Medicare and Medicaid (CMS) or the UHMS when the following criteria are met:
 - 1. A physician or non-physician practitioner (NPP), practicing within their scope of practice, must:
 - a) Order HBOT treatments which must include the estimated number of treatments and duration,
 - b) Document medical necessity,
 - c) Establish the plan of care which must:
 - 1) Specify the goals for HBOT and
 - 2) Include revisions as appropriate with justification for extending treatments.
 - 2. A cardiopulmonary resuscitation (CPR) team and a fully equipped emergency cart must be immediately available where the hyperbaric chamber is located when a beneficiary is receiving HBOT in the event of a complication.
 - 3. Emergency response procedures are in place that ensures timely beneficiary access to a hospital or acute care facility capable of providing emergent clinical support and treatment of any complications arising from hyperbaric therapy or, when indicated, the beneficiary's underlying disease processes for outpatient hospital HBOT facilities located on or off the hospital's campus.
- D. The Division of Medicaid requires HBOT treatment facilities to meet the UHMS standards for the number of trained and credentialed hyperbaric medicine physicians and non-physician providers on staff for appropriate treatment and medical care required by a beneficiary.
 - 1. The Division of Medicaid defines:
 - a) Direct supervision as supervision by a physician or non-physician provider (NPP) providing services within their scope of practice and hospital-granted privileges, the knowledge, skills, and ability in accordance with UHMS standards during a performed procedure in which the physician or NPP must be immediately available to furnish assistance and direction

throughout the performance of the procedure.

- b) Immediately available as being in close physical proximity within the same building or connected building or structure, to where HBO2 treatments are provided and able to personally and physically attend to the chamber-side as soon as requested.
2. The Division of Medicaid requires a physician or NPP to provide direct supervision and be immediately available to the hyperbaric oxygen chamber(s) location while the beneficiary is receiving HBOT
 3. NPPs may supervise HBOT services, if such service including definitive evaluation of the beneficiary is included within their scope of practice, or if their required supervision or collaborative agreement is with a physician qualified to provide HBOT services who remains immediately available and if the NPP meets required educational requirements.
- E. The Division of Medicaid does not cover topical application of oxygen with portable HBOT chambers.
- F. The Division of Medicaid reimburses the:
1. Hospital per beneficiary regardless if the HBOT is received in a mono or multi-place chamber per thirty (30) minute interval.
 2. Physician or NPP per beneficiary session for attendance or supervision of HBOT.
- G. The Division of Medicaid requires the following documentation of medical necessity:
1. Must be maintained in the beneficiary's record and available for review upon request.
 2. Must be legible and include appropriate beneficiary identification information and signature of the physician or non-physician practitioner responsible for and providing care to the patient.
 3. Must support the use of the selected ICD-10-CM code(s) and CPT/HCPCS code must describe the service performed.
 4. Documentation that a trained emergency response team is available and that the hospital setting provides the required availability of intensive care unit (ICU) services that could be needed to ensure the beneficiary's safety if a complication occurred.
 5. Documentation present in the clinical record must provide an accurate description and diagnosis of the medical condition supporting that the use of HBOT is reasonable and medically necessary. The medical documentation must include but is not limited to the

following:

- a) An initial assessment, which includes a history and physical that clearly substantiates the condition for which HBOT is recommended. This should also include any prior medical, surgical or HBOT treatments.
- b) Documentation of the procedure including ascent time, descent time and pressurization level. There should be a treatment plan identifying timeline and treatment goals.
- c) Physicians' progress notes that describe the physical findings, type(s) of treatment(s) provided, number of treatments provided, the effect of treatment(s) received and the assessment of the level of progress made toward achieving the completion of established therapy goals.
- d) Physician-to-physician communications or records of consultations, additional assessments, recommendations or procedural reports.
- e) Laboratory reports (cultures or Gram stains) that confirm the diagnosis of necrotizing fasciitis are required and must be present as support for payment of HBOT.
- f) X-ray findings and bone cultures confirming the diagnosis of osteomyelitis are required and must be present as support for payment of HBOT.
- g) Documentation to support the presence of gas gangrene as proven with laboratory reports (Gram stain or cultures) and X-ray.
- h) Documentation of date and anatomical site of prior radiation treatments.
- i) Documentation supporting date of skin graft and compromised state of graft site.
- j) For diabetic wounds of the lower extremity, the Wagner classification of the wound and the failure of an adequate course (at least 30 days) of standard wound therapy must be documented at the initiation of therapy.
- k) Specific written record of the physician's or NPP's direct supervision of the hyperbaric chamber while the beneficiary is undergoing HBOT; and
- l) Specific written record of the availability of a trained CPR team and a fully equipped emergency cart where the hyperbaric chamber is located while the beneficiary is undergoing HBOT.

Source: 42 U.S.C. § 1395y; 42 C.F.R. §§ 410.26, 410.27, 410.32; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 09/01/2019; 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. Triageed, 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-threatening 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.

Rule 5.7: Dental Services Provided in a Hospital Setting

- A. The Division of Medicaid covers medically necessary dental treatment in the outpatient hospital setting when all the following are met:
1. Quality, safe, and effective treatment cannot be provided in an office setting,
 2. Inpatient hospitalization is not medically necessary [Refer to Miss. Admin. Code Part 204, Rule 1.11.B.], and

3. Certain dental procedures have been prior authorized by the Division of Medicaid or designee.
- 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/or the extent of treatment necessitate hospitalization, and
 2. Prior authorized by the Division of Medicaid or designee.
- C. Hospital providers must bill the procedure code that accurately reflects the services rendered as follows:
1. Dental procedures performed by a Mississippi licensed dentist must be billed with a Code on Dental Procedures and Nomenclature (CDT).
 2. Dental procedures performed by a Mississippi licensed dentist who is also a Mississippi licensed physician can bill either a CDT code or a Current Procedural Terminology (CPT) code.

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

History: New Rule eff. 10/01/2019.