Administrative Code

Title 23: Medicaid
Part 305
Program Integrity

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Title 23: Division of Medicaid

Part 305: Program Integrity

Part 305 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. Administrative Hearing is defined as a trial-like proceeding before the Division of Medicaid at which evidence and testimony may be offered.

C. Beneficiary error is defined as the beneficiary's incomplete, incorrect or misleading information because the beneficiary misunderstood, was unable to comprehend the relationship of the facts about the situation to eligibility requirements or there was other inadvertent failure on the beneficiary's part to supply the pertinent or complete facts affecting Medicaid or Children's Health Insurance Program (CHIP) eligibility.

D. Corrective Action Plan (CAP) is defined as a documented plan that includes a well-defined identification of the problem, a specific time frame for the remedy to be implemented, specific actions taken to remedy the defined problem, plan on how to prevent the problem from recurring and the consequences if the problem is not resolved. At a minimum, the CAP must include:

a) The specific obligations violated,

b) The specific actions taken that address correction of the behavior that led to the violation(s),

c) The duration of the CAP which must be greater than ninety (90) calendar days, and

d) The means by which compliance with the CAP will be monitored and assessed.

E. 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.

F. Demand Letter is defined as a notification that a provider is required to refund improper payments.

G. 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.

H. 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.

I. Overpayment is defined as an incorrect payment that results in the provider receiving a higher reimbursement than is appropriate for the service provided.

J. Peer Review (PR) is defined as a retrospective review of medical records by the Division of Medicaid's Utilization Review/Quality Improvement Organization (UM/QIO) to assess if:

a) Services and items were reasonable and medically necessary;

b) The quality of services met professionally recognized standards of health care;

c) The beneficiary received the appropriate health care in a safe, appropriate and cost-effective setting based on the beneficiary's diagnosis and severity of the symptoms;

d) Services were provided economically and only when and to the extent they were medically necessary; and

e) The utilization billing and coding practices and/or overall utilization patterns of a provider for beneficiaries being reviewed are appropriate.

K. Peer Review Consultant (PRC) is defined as the medical reviewer in a comparable specialty as the provider or a certified professional coder (CPC) when appropriate.

L. Peer Review Panel (PRP) is defined as at least three (3) providers, at least one (1) of whom practices in the same class group as the subject provider; Selection of the PRP members shall ensure that their objectivity and judgment will not be affected by personal bias for or against the subject provider or by direct economic competition or cooperation with the subject provider.

M. Reconsideration Review is defined as an impartial review of the case by a Peer Review Consultant not involved in the initial Peer Consultant Review determination, at the request of the Division of Medicaid, a provider, or as part of a UM/QIO follow-up.

N. 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 eff. 03/01/2023; 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: Provider Peer Review Protocol

A. Mississippi Medicaid providers must ensure that the services or items provided to beneficiaries are:

1. Provided economically, to the extent medically necessary,

2. Of a quality that meets professionally recognized standards of health care,

3. Supported by the appropriate documentation of medical necessity and quality,

4. Provided when no other effective and more conservative or substantially less costly treatment, service and/or setting are available,

5. Not solely for the convenience of the beneficiary, the beneficiary's family, or the provider, and/or

6. Not primarily custodial care, unless custodial care is a covered service.

B. Providers with a possible violation of one (1) or more of the obligations listed in Rule 1.4.A. are generally referred to the fee-for-service (FFS) Utilization Management/Quality Improvement Organization (UM/QIO) to perform a Peer Review (PR).

1. A Peer Review Consultant (PRC) is selected by the Medical Director of the UM/QIO, or designee, when a referral is received from the Division of Medicaid, which has already made an initial audit/investigation.

a) The selection process of the PRC ensures that they practice in a comparable specialty as the provider being reviewed and that the PRC's objectivity and judgment will not be affected by personal bias for or against the subject provider, or by direct economic competition or cooperation with the provider.

b) The Division of Medicaid will provide records relevant to the possible violation to the PRC.

c) If the PRC determines that there is no further action needed, then the case is closed. If the PRC identifies violations or confirms violations, then the PRC refers the case for a Peer Review Panel (PRP).

2. After reviewing the case, the PRP may close a case if they determine that there was no violation.

   a) If they determine or confirm one or more violations exist, then the PRP will notify The Division of Medicaid with additional proposed actions. Actions by the UM/QIO PRP may include:

      1) If the PRP determines that there has been no violation of obligations, it will notify the Division of Medicaid, in writing, of that finding and recommend that the case be closed with no further action taken. Along with the written notification of the PRP recommendations, the PRP will also transmit the records it relied on to make the recommendation, as well as the transcript of the minutes of the PRP meeting.

      2) The Division of Medicaid shall make a final decision, within ten (10) business 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 PRP finds a potential violation of one or more of the requirements listed in Miss. Admin. Code Title 23, Part 305, Rule 1,4 A., the UM/QIO shall notify the Division of Medicaid in writing of the preliminary recommended findings within ten (10) business days of the PRP decision. The letter must contain all related requirements in Part 305, including, but not limited to, giving notice of potential violation(s), the specifics of the potential violation(s), and the PRP's recommended date to have the provider attend a Peer Review Panel conference, which will be set no later than thirty (30) calendar days after the notice to the Division of Medicaid.

      1) The Division of Medicaid shall make a final decision, within ten (10) business 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. If the Division of Medicaid accepts the PRP

recommendation, at the same time it notifies the UM/QIO, Director of Program Integrity, or his designee, will transmit a letter by certified mail, restricted delivery, return receipt requested to the provider with all of the relevant information listed above.

2) The provider shall be instructed in the letter to provide the PRP with any additional information in support of the provider's position within a specified time. The provider also must submit a written statement to the Division of Medicaid within ten (10) business days of receipt of the findings notification indicating whether the provider agrees or disagrees with the findings. At the UM/QIO's discretion, the provider may choose alternate dates to convene the PRP conference meeting. If the provider agrees with the findings, the Division of Medicaid may send a Corrective Action Plan (CAP) letter to the provider.

c) If the PRP determines that the provider has violated one or more of the requirements listed in Miss. Admin Code Title 23 Part 305 Rule 1.4 A., it will formulate recommendations that will include a corrective action plan (CAP), provider education requirements, and/or recoupment. The UM/QIO PRP shall submit all findings and recommendations in writing to the Division of Medicaid within ten (10) business days of the PRP decision. The letter must contain all related requirements in Part 305, including, but not limited to the violation(s), the specifics of the violation(s), and the PRP's recommended actions and recommended date to have the provider attend a Peer Review Panel conference, which will be set no later than thirty (30) calendar days after the notice to the Division of Medicaid.

1) The Division of Medicaid shall make a final decision, within ten (10) business days of its receipt of the recommendations, 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, and as defined in Part 305. If the Division of Medicaid accepts the PRP recommendation, at the same time it notifies the UM/QIO, the Division of Medicaid will transmit a letter by certified mail, restricted delivery, return receipt requested to the provider with all of the relevant information listed above.

2) The provider shall be instructed in the letter to provide the PRP with any additional information in support of the provider's position within ten (10) business days prior to the conference to allow time for its proper study. At the UM/QIO's discretion, the provider may choose alternate dates to convene the conference meeting. Regardless of a provider's acceptance of findings, for any confirmed violations of Part 305, which resulted in or identified any improper payments, the Division of Medicaid will send a certified demand letter to that provider. If the provider agrees with the findings, the Division of Medicaid may send a CAP letter to the provider.

C. The Division of Medicaid will send all provider correspondence regarding findings,

decisions, or other documents from a PRC or PRP by certified mail, restricted delivery, return receipt requested.

D. The provider must sign and return the CAP within ten (10) business days after receipt of the Demand Letter and CAP. If the provider fails to submit the signed CAP to the Division of Medicaid within (10) business days, a sanction may be imposed on the provider. The UM/QIO Medical Director, or designee, and the Peer Review Consultant will monitor the signed CAP.

E. Within thirty (30) calendar days of the receipt of a completed CAP, the PRC will determine if the provider complied with the CAP, and whether or not the CAP was effective. If the CAP was effective and the provider has met all requirements, the Division of Medicaid will notify the provider that the review is closed. If the CAP was not effective and the provider is deemed to be continuing to violate requirements, the provider will be subject to a sanction.

1. If the provider disagrees with the findings of the PRC, the provider may request a Reconsideration Review using the following steps:

    a) The provider may submit a request for a Reconsideration Review to the Division of Medicaid within ten (10) business days of receipt of the final findings notification.

    b) The Reconsideration Review request must include the reason for the request, pertinent medical documentation, or other information to justify the need for reconsideration.

    c) The UM/QIO will select a different PRC, who practices in a comparable specialty, to obtain a second opinion.

    d) The Reconsideration Review will include the findings of the initial PRC.

    e) The Division of Medicaid is notified in writing by the UM/QIO Contract Administrator of the findings, action recommended, the records relied upon to make the recommendation, and the Peer Review Consultant's notes.

    f) The Division of Medicaid will notify the provider of the results of the Reconsideration Review which will be one (1) of the following:

        1) No violation of requirements and the review is closed, or

        2) Violation of requirements affirmed and a Demand Letter and CAP are sent to the provider.

2. If the provider disagrees with the findings of the Reconsideration Review, the provider may request an Administrative Hearing. [Refer to Miss. Admin. Code Part 300]

3. If the provider does not request an Administrative Hearing, the Division of Medicaid will proceed with the appropriate administrative action outlined in the Demand Letter.

F. The process for sanctions include the following steps and information:

1. The Executive Director of the Division of Medicaid, upon review of the record, proceedings, and recommendation of the Division of Medicaid Administrative Hearing Officer and/or Peer Review Consultant, will render a final written decision whether or not to impose sanctions, which may include disqualification, suspension, or termination from the Medicaid program for a limited period or permanently.

2. A violation of requirements such that the life and welfare of the provider's beneficiaries are in jeopardy, the provider is subject to immediate suspension.

3. The Executive Director of the Division of Medicaid will notify the provider of the intent to impose a sanction by sending a notice containing the following:

a) The authority and responsibility afforded the Division of Medicaid under Miss. Code Ann. Section 43-13-121;

b) The requirement(s) violated;

c) The situation, circumstance, or activity that resulted in the violation;

d) A summary of the information used in arriving at the determination to initiate sanction; and

e) Notice that the Division of Medicaid will impose the sanction(s) within thirty (30) calendar days of the date of provider's receipt of the notice unless the provider requests an Administrative Hearing within thirty (30) calendar days of the receipt of the notice.

4. The Executive Director may assess all or any part of the cost of implementing the sanction protocol to the provider.

5. The Executive Director's decision is a final administrative decision.

Source: 42 C.F.R. Part 455; Miss. Code Ann. § 43-13-121.

History: Revised and moved from Miss. Admin. Code, Part 300, eff. 03/01/2023; 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.

Part 305 Chapter 2: Beneficiary Health Management

Rule 2.1: Authority and Purpose

A. The Division of Medicaid defines Beneficiary Health Management (BHM) as the program implemented by the Division of Medicaid to:

1. Closely monitor program usage and to identify beneficiaries who may be potentially over utilizing or misusing their Medicaid services and benefits.

2. Restrict beneficiaries whose utilization of medical and/or pharmacy services is documented at a frequency or amount that is not medically necessary.

3. Prevent beneficiaries from obtaining non-medically necessary quantities of prescribed drugs through multiple visits to physicians and pharmacies.

B. The Division of Medicaid will lock-in beneficiaries for twelve (12) consecutive months whose utilization of medical and/or pharmacy services is documented as being excessive, as determined in accordance with utilization guidelines established by the Division of Medicaid, to specific providers in order to monitor services received and reduce unnecessary or inappropriate utilization.

C. The Division of Medicaid requires a beneficiary to designate a physician and/or a pharmacy of choice when the beneficiary's medical record indicates utilization is excessive or inappropriate with reference to medical need, and in accordance with the BHM program, to:

1. Promote quality health care,

2. Promote coordination of care and ensure appropriate access for beneficiaries at high risk of overdose,

3. Provide continuity of medical care,

4. Prevent harmful practices such as duplication of medical services, drug interaction, and possible drug abuse,

5. Prevent misuse or excessive utilization of beneficiary's Medicaid benefits,

6. Provide education and monitoring to deter misuse and/or excess utilization, and

7. Assure beneficiaries are receiving only health care services which are medically necessary as defined in Miss. Admin. Code Part 200, Rule 5.1.

Source: 42 C.F.R. § 431.54; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.

Rule 2.2: Program Oversight

A. The Division of Medicaid's Office of Program Integrity:

1. Manages the Beneficiary Health Management (BHM) program,

2. Screens beneficiaries against criteria designed to identify drug seeking behavior and inappropriate use of prescription drugs, and

3. Reviews claims and pharmacy point-of-sale data to identify patterns of inappropriate, excessive or duplicative use of pharmacy services.

B. The Division of Medicaid may request the Mississippi Coordinated Access Network (MSCAN) contractor to lock-in beneficiaries who have had prior lock-ins with the Medicaid fee-for-service program or other Medicaid-participating Coordinated Care Organizations (CCOs).

Source: 42 C.F.R. § 431.54; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 05/01/2025. Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.

Rule 2.3: Provider Participation

The Beneficiary Health Management (BHM) program may include physician only, pharmacy only, or physician and pharmacy providers.

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

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.

Rule 2.4: Beneficiary Notification

A. The Division of Medicaid will notify the beneficiary in writing prior to the imposing of the restrictions of:

1. Its intent to enroll them in the Beneficiary Health Management (BHM) program, and

2. Their opportunity for a hearing as outlined in Miss. Admin. Code Part 300.

B. The Division of Medicaid will ensure that the beneficiary has reasonable access to Medicaid services of adequate quality taking into account geographic location and reasonable travel time.

C. The BHM program restrictions do not apply to emergency services provided to the beneficiary.

Source: 42 C.F.R. § 431.54; Miss. Code Ann §§ 43-13-117, 43-13-121.

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.

Rule 2.5: Provider Selection

A. The beneficiary has ten (10) days to choose his/her Beneficiary Health Management (BHM)

designated physician and/or pharmacy provider(s) from the date of receipt of the notification letter.

B. The Division of Medicaid will designate a BHM physician and/or pharmacy provider for the beneficiary if the beneficiary does not specify a provider within the ten (10) day time-frame.

C. Beneficiaries are required to specify one (1) physician and/or one (1) pharmacy and up to three (3) physician specialists, if requested, for his/her medical and/or pharmacy services while in the Beneficiary Health Management (BHM) program.

D. The beneficiary may request a change in his/her BHM physician and/or pharmacy provider if any of the following occur:

1. Change in physical address of the beneficiary or a provider,

2. Death, retirement, or closing of the specified physician, pharmacy and/or specialist,

3. Change in primary diagnosis which requires a different specialist, or

4. The BHM physician and/or pharmacy provider disenrolls or loses eligibility to participate in the Mississippi Medicaid Program.

E. The BHM physician or specialist may refer the beneficiary to another provider for consultation by submitting the BHM Referral Form to the Division of Medicaid, Office of Program Integrity, or designee.

1. Prior approval from the Division of Medicaid or designee is required before the beneficiary can be seen by the referring physician.

2. Emergency situations are excluded from this requirement.

3. The referral may cover one (1) or multiple visits as long as those visits are part of the consulting physician's plan of care and are medically necessary.

4. A referral is limited to one (1) year from the date of approval.

F. The Division of Medicaid will lock-in beneficiaries to only one (1) pharmacy when one (1) of the following criteria is met:

1. The beneficiary has one (1) or more of the following:

a) Received services from four (4) or more prescribers and/or four (4) or more pharmacies relative to controlled substances in the past six (6) months, including emergency department visits,

b) A history of substance use disorder within the past twelve (12) months,

c) A diagnosis of drug abuse or narcotic poisoning within the past twelve (12) months, or

d) Utilizes cash payments to purchase controlled substances.

2. When any written prescription is stolen, forged or altered,

3. When the Division of Medicaid has received a proven report of fraud, waste and/or abuse from one (1) or more of the following:

a) Prescriber,

b) Pharmacy,

c) Any medical provider, and/or

d) Law enforcement entity.

Source: 42 C.F.R. § 431.54; Miss. Code Ann §§ 43-13-117, 43-13-121.

History: New Rule eff. 02/01/2019.

Rule 2.6: Beneficiary Health Management (BHM) Services

The Division of Medicaid locks-in a beneficiary in the Beneficiary Health Management (BHM) program for a period of twelve (12) months with ongoing reviews to monitor patterns of care.

A. Beneficiaries in the BHM program are allowed two (2) counseling sessions in addition to State Plan service limits per month during the twelve (12) month lock-in.

B. Beneficiaries locked-in the BHM program will continue to have access to the following services with applicable State Plan service limits:

1. Emergency department,

2. Inpatient hospital,

3. Outpatient hospital,

4. Dental,

5. Vision,

6. Mental Health,

7. Home Health and Durable Medical Equipment (DME), medical appliances and medical supplies,

8. Hospice, and

9. Medicaid Waivers.

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

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.

Rule 2.7: Exclusions

The Division of Medicaid may exclude a beneficiary from the Beneficiary Health Management (BHM) program if the beneficiary:

A. Has one (1) of the following diagnoses including, but not limited to:

1. Cancer,

2. Sickle cell anemia, or

3. Burns.

B. Is enrolled in hospice care.

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

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.

Rule 2.8: Reimbursement

A. The Division of Medicaid reimburses for:

1. Office visits only with the Beneficiary Health Management (BHM) designated physician,

2. Drugs prescribed only by the BHM designated physician, by the consultant physician, or by an emergency department physician, and

3. Drugs dispensed only by the BHM designated pharmacy provider.

B. The Division of Medicaid requires post utilization review by the Division of Medicaid or designee for reimbursement to physician and/or pharmacy provider(s) other than the BHM designated physician and/or pharmacy provider(s) when :

1. Emergency care is required and the BHM designated physician and/or pharmacy provider

is not available, or

2. The BHM designated physician and/or pharmacy provider requires consultation with another physician and/or pharmacy provider.

C. BHM designated physician and/or pharmacy providers are required to bill the specified procedure codes if counseling sessions are provided.

1. The counseling procedure codes can be billed in conjunction with any other service the BHM designated physician provides to the beneficiary.

2. Documentation must support billing of the specified procedure codes by the BHM designated physician and/or pharmacy.

D. The Division of Medicaid reimburses for inpatient hospitalization for treatment of alcohol and/or drug abuse when the diagnosis is a substance use disorder diagnosis in accordance with the most current Diagnostic and Statistical Manual (DSM) of Mental Disorders and the inpatient hospital stay is prior authorized by the Division of Medicaid or designee.

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

History: Revised and moved from Miss. Admin. Code Part 302 eff. 02/01/2019.