

Administrative Code

Title 23: Medicaid
Part 200
General Provider Information

Title 23: Division of Medicaid 1
Part 200: General Provider Information 1
Part 200 Chapter 1: General Administrative Rules for Providers 1
Rule 1.1: Disclosure of Confidential Information 1
Rule 1.2: Access to Public Information 2
Rule 1.3: Maintenance of Records 3
Rule 1.4: Fundraising 6
Rule 1.5: Limited English Proficiency Plan (LEP) 7
Rule 1.6: Timely Filing 7
Rule 1.7: Timely Processing of Claims 8
Rule 1.8: Administrative Reviews for Claims 9
Rule 1.9: Authorized Provider Representative 10
Rule 1.10: Electronic Signatures 10
Rule 1.11: Provider Claim Submission Signatures 12
Rule 1.12: National Correct Coding Initiative (NCCI) Edits 13
Rule 1.13: Rounding of Timed Codes 14
Part 200 Chapter 2: Benefits 15
Rule 2.1: Medicaid Services 15
Rule 2.2: Non-Covered Services 17
Rule 2.3: Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles 21
Part 200 Chapter 3: Beneficiary Information 22
Rule 3.1: Coverage of Eligibility Groups 22
Rule 3.2: Newborn Child Eligibility 24
Rule 3.3: Beneficiary Retroactive Eligibility 24
Rule 3.4: Eligibility for Medicare and Medicaid 25
Rule 3.5: Verification of Eligibility 26
Rule 3.6: Freedom of Choice of Providers 26

Rule 3.7: Beneficiary Cost Sharing 27
Rule 3.8: Charges Not Beneficiary's Responsibility 27
Rule 3.9: Charges Beneficiary's Responsibility 28
Part 200 Chapter 4: Provider Enrollment 29
Rule 4.1: Definitions 29
Rule 4.2: Conditions of Participation 31
Rule 4.3: Change of Ownership 35
Rule 4.4: Effective Date of Provider Agreement and Provider Agreement Termination 37
Rule 4.5: Licensure, Certification and Permits 39
Rule 4.6: Advertising by Provider 40
Rule 4.7: Change of Tax ID 40
Rule 4.8: Requirements for All Providers 41
Rule 4.9: Group Providers 43
Rule 4.10: 340B Providers 45
Part 200 Chapter 5: General 48
Rule 5.1: Medically Necessary 48
Rule 5.2: Consent for Minors 49
Rule 5.3: Wellness Program 49
Rule 5.4: Tobacco Cessation 52
Rule 5.5: Mobile Medical Units Other Than Independent Diagnostic Treatment Facilities 53
Rule 5.6: Diabetes Self-Management Training (DSMT) 54
Rule 5.7: Electronic Health Records 56
Part 200 Chapter 6: Indian Health Services 58
Rule 6.1: Provision of Indian Health Services 58
Rule 6.2: Beneficiary Enrollment 58
Rule 6.3: Provider Enrollment/Participation Requirements 58
Rule 6.4: Covered Services 59

Rule 6.5: Reimbursement..... 59
Rule 6.6: Cost-Sharing..... 59

Title 23: Division of Medicaid

Part 200: General Provider Information

Part 200 Chapter 1: General Administrative Rules for Providers

Rule 1.1: Disclosure of Confidential Information

A. Records and information acquired in the administration of any part of the Social Security Act are confidential and may be disclosed only under the conditions prescribed in rules and regulations of the Department of Health and Human Services (DHHS) or when authorized by the Secretary of Health and Human Services.

B. A provider may disclose records or information acquired under the Medicaid program only when:

1. The record or information is to be used in connection with a claim, or

2. To verify the utilization of Medicaid benefits; and

3. The disclosure is necessary for the proper performance of the duties of any employee of:

a) The Division of Medicaid,

b) Any public or private agency or organization under an agreement with Division of Medicaid in regard to meeting requirements of the Medicaid program,

c) The Attorney General Medicaid Fraud Control Unit,

d) A duly authorized legal hearing, or

e) Representative of the Secretary of Health and Human Services office.

C. If a beneficiary or beneficiary's attorney requests medical records, billing information, etc., these records should be released in accordance with the Third Party Procedures described in Part 300, Chapter 7.

D. Providers that are utilizing collection and/or billing agencies should know that the Division of Medicaid and its fiscal agent cannot release information to these companies without a signed release from the Medicaid beneficiary. Information can only be furnished to:

1. The provider that provided the service to the Medicaid beneficiary, or

2. To a provider's business agent, billing service, or accounting firm that regularly handles claims filing for the provider,

a) If, and only if the company has a written agreement with the provider, and

b) Has a confidentiality agreement with the Division of Medicaid that is on file with the fiscal agent.

E. State law requires that any medical information concerning a Medicaid beneficiary that is released by a provider must contain the following information:

1. The person is a Medicaid beneficiary,

2. His/her Medicaid identification number, and

3. The bill has been paid by Medicaid or will be submitted to Medicaid.

Source: Miss. Code Ann. § 43-13-121; Social Security Act Section 1902(a)(7); Title XIX Social Security Act

Rule 1.2: Access to Public Information

A. Public access to records maintained by the Division of Medicaid is described in Section 25-61-1 et seq. of the Mississippi Code of 1972, as amended. An exception to this public access for Medicaid purposes is beneficiary specific information which must be kept confidential in accordance with 42 CFR 431.300 through 431.307 as discussed in Chapter 200, Rule 1.1, and the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 CFR 160 and 164.

B. Provider manuals/bulletins and other Division of Medicaid information including the complete Medicaid Eligibility Manual, the Title XIX State Plan for the Mississippi Division of Medicaid and certain fee schedules are available for viewing and/or printing.

C. Records furnished to the Division of Medicaid by third parties that may contain trade secrets or confidential commercial or financial information will not be released until notice to the third party has been given. Such records will be released within a reasonable period of time, unless the third party has obtained a court order protecting the records as confidential. If the third party notifies the Division of Medicaid that it will seek a court order to protect the records as confidential, the Division of Medicaid will notify the requestor.

D. Any person seeking a public record pursuant to the Mississippi Public Records Act, Section 25-61-1, et seq., should make the request in writing. The written request should include the following information:

1. Name of requestor,

2. Address of requestor,

3. Other contact information, including telephone number and any e-mail address,

4. Identification of the public records adequate for the public records officer or designee to locate, and

5. The date and time of day of the request.

Source: Miss. Code Ann. § 43-13-121; Miss. Code Ann. § 25-61-1; 42 CFR 431.300 – 431.307; HIPAA 45 CFR 160 and 164.

Rule 1.3: Maintenance of Records

A. All professional, institutional, and contractual providers participating in the Medicaid program must:

1. Maintain all records substantiating services rendered and/or billed under the program, and

2. Upon request, make such records available to representatives of the Department of Health and Human Services (DHHS), the Centers for Medicare and Medicaid Services (CMS), the Division of Medicaid, or the Mississippi Medicaid Fraud Control Unit (MFCU) in substantiation of any and all claims.

B. The Division of Medicaid defines medical records as documentation supporting medical services which fully disclose the extent of services, care and supplies furnished to a beneficiary and support claims billed.

1. Medical records must be legible, appropriate, and correct. All entries within a medical record should be written legibly to ensure beneficiary safety and appropriate billing and/or reviewing.

2. All information contained within a medical record must be written, entered or otherwise compiled on appropriate provider documentation forms.

3. All entries within the medical record must be made without a space between entries.

4. All entries must be made in a permanent form and cannot be in pencil.

5. Corrective tape, corrective liquid, erasers or other obliteration methods cannot be used to remove or change information in the medical record.

6. A medical record is a legal document and illegal to tamper with or falsify.

7. Entry corrections in the medical record must be documented as follows.

a) Draw a single line through the error, to ensure the error entry is still legible.

b) Document the current date and time the error was lined through and initials of who

lined out the entry.

c) Document the correct information as a new entry on the next available line or in the next available space including:

1) The date and time of the new entry,

2) The date and time the correct information occurred, and

3) The details of the correct information.

d) Do not use corrective tape, corrective liquid or other obliteration methods to change or erase any part of the medical record.

8. Late entries are defined as entries that are not completed in the same business day as the date of service and must be documented as follows:

a) Identify the new entry as a "late entry" in the medical record.

b) Document the current date and time when the late entry is actually being written in the medical record and not the date and time the event/incident actually occurred.

c) Document the late entry event/incident and refer to the date and time the event/incident actually occurred within the late entry.

d) Document information as soon as possible.

e) Do not use corrective tape, corrective liquid or other obliteration methods to change or erase any part of the medical record.

C. Medicaid providers must maintain auditable records that substantiate the payment of claims submitted to the Division of Medicaid.

1. The Division of Medicaid's staff must have immediate access to the provider's physical service location, facilities, records, documents, books, prescriptions, invoices, radiographs, and any other records relating to licensure, medical care, and services rendered to beneficiaries, and billings/claims during regular business hours, defined as 8 a.m. to 5 p.m., Monday – Friday, and all other hours when employees of the provider are normally available and conducting business of the provider.

2. The Division of Medicaid's staff must have immediate access to any administrative, maintenance, and storage locations within, or separate from, the service location.

3. The Division of Medicaid does not reimburse providers for the provision of or access to records substantiating claims submitted to the Division of Medicaid.

D. If a provider's records do not substantiate services paid under the Mississippi Medicaid program the provider must refund to the Division of Medicaid any money received from the Medicaid program for such unsubstantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

E. Providers must retain medical records for a minimum of five (5) years or longer as required by federal or state law.

1. All providers required to file a cost report must keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

2. All providers not required to submit a cost report must keep and maintain books, documents, and other records as prescribed by the Division of Medicaid in substantiation of its claim for services rendered to Medicaid beneficiaries, for a period of five (5) years from the date of service or until after the date all audit findings are resolved, whichever is later.

3. Providers whose cost reports are selected for audit must keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports until such time as the audit and/or any related appeals are finalized.

4. Providers who are required to pay assessments must keep and preserve books and records as necessary to determine the amount of the assessments for which it is liable for no less than five (5) years.

5. Coordinated Care Organizations (CCOs) must keep and maintain books, documents and other records as prescribed by the Division of Medicaid for a period of no less than ten (10) years or until all issues are finally resolved whichever is later.

6. The Division of Medicaid is entitled to full recoupment of the amount paid to any provider of a medical service who has failed to keep or maintain records as required.

7. A provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil and monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.

Source: 42 C.F.R. § 422.504; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129, 43-13-145.

History: Revised eff. 08/01/2018.

Rule 1.4: Fundraising

A. Fundraising may only be used to obtain funds needed to pay for medical/treatment costs not normally covered by the Mississippi Medicaid program. Such costs include, but are not limited to the following:

   1. Transportation for family members,

   2. Food and lodging for the beneficiary and family,

   3. Child care,

   5. Non-covered medical equipment, or

   6. Non-covered medical services.

B. Fundraising Criteria:

   1. Prior to accepting donations, arrangements must be made to place donations in a trust fund/ special account.

   2. The trust fund/special account must be established/administered in compliance with all applicable federal and state rules/regulations.

   3. The trust fund/special account must be managed/administered by someone other than the beneficiary or the beneficiary's family member/legal guardian (i.e., the beneficiary or the beneficiary's family member/legal guardian may not have direct access to the fund/account).

   4. The trust fund/special account must be maintained separate from personal monies belonging to the beneficiary or the beneficiary's family member/legal guardian (i.e., mixed funds could be counted as income or an asset which could result in a loss or reduction of Medicaid benefits).

   5. Legible documentation on income and expenditures must be maintained and must be made available to the Division of Medicaid, the fiscal agent, and/or the UM/QIO upon request.

C. All sources of income must be reported to the source of eligibility. Donated funds for the purpose of payment of medical services are considered a third party source. Refer to Part 306.

D. Provider/facilities must adhere to conditions of participation as a Medicaid provider and cannot participate in fundraising for beneficiaries to raise additional funds to pay for Medicaid covered procedures and/or related services. Refer to Part 200, Chapter 4.

Source: Miss. Code Ann. § 43-13-121

Rule 1.5: Limited English Proficiency Plan (LEP)

For Division of Medicaid purposes, this plan is established to define the mandated compliance requirements pertinent to the provision of services to individuals with limited English proficiency (LEP), established procedures for requisitioning forms in Spanish and Vietnamese, and for accessing and/or hiring and utilizing qualified interpreters. This rule provides provisions to ensure awareness of the program by beneficiaries/applicants with limited English proficiency, employee training and requirements for reporting, records retention for the LEP program and monitoring oversight of the language assistance program to ensure LEP persons meaningful access to the program.

Source: Miss. Code Ann. § 43-13-121; Title VI Civil Rights Act 1964 USC Section 2000(d)

Rule 1.6: Timely Filing

A. The Division of Medicaid requires providers to submit claims no later than three hundred sixty-five (365) calendar days from the date of service.

B. Claims for services submitted by newly enrolled providers must be submitted within three hundred sixty-five (365) calendar days from the date of service and must be for services provided on or after the effective date of the provider's enrollment.

C. Claims originally submitted to and paid by a coordinated care organization (CCO) but which are subsequently recouped by the CCO retrospectively due to a change in the beneficiary's enrollment from the CCO to fee-for-service (FFS), must be submitted to the Division of Medicaid within:

    1. Three hundred sixty-five (365) calendar days from the date of service, or

    2. Within ninety (90) calendar days of the CCO recoupment if the CCO recoupment date is after the timely filing period of three hundred sixty-five (365) calendar days from the date of service.

D. If a claim for payment under Medicare has been filed in a timely manner, the Division of Medicaid will process a Medicaid claim relating to the same services within one hundred eighty (180) calendar days after the agency or the provider receives notice of the disposition of the Medicare claim.

E. If a provider fails to meet the timely filing requirements, the beneficiary cannot be billed for those services.

Source: 42 C.F.R. § 447.45; Miss. Code Ann. §§ 43-13-113, 43-13-117, 43-13-121.

History: Revised eff. 12/01/2020; New rule eff. 07/01/2019.

Rule 1.7: Timely Processing of Claims

A. The Division of Medicaid defines a clean claim as a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

   1. Claims with errors originating in the Division of Medicaid's claims system are considered clean claims.

   2. The following are not considered clean claims:

      a) Claims from providers under investigation for fraud or abuse, or

      b) Claims under review for medical necessity.

B. The Division of Medicaid processes claims in accordance with federal and state timely processing requirements.

C. The Division of Medicaid processes all claims within three hundred sixty-five (365) calendar days from the date of receipt except:

   1. If a claim for payment under Medicare has been filed in a timely manner, the Division of Medicaid will process a Medicaid claim relating to the same services within one hundred eighty (180) calendar days of the Medicare paid date.

   2. Retroactive adjustments paid to providers who are reimbursed under a retrospective payment system.

   3. When the claim is from a provider that is under investigation for fraud or abuse.

   4. When payments are made to carry out:

      a) A court order,

      b) Hearing decision, or

      c) Agency corrective actions taken to resolve a dispute.

   5. To extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

D. The processing period begins on the date a claim is timely received by the Division of Medicaid and ends three hundred sixty-five (365) calendar days from the date the original claim is received by the Division of Medicaid.

E. Providers may submit a corrected claim during the processing period.

F. If the Division of Medicaid adjusts claims after the processing period has ended, providers may submit a written request for an Administrative Review within ninety (90) calendar days of the date of the remittance advice (RA). Providers must submit additional documentation to support claims payment.

G. Providers may request an administrative hearing if they are dissatisfied with the disposition of their claim as described in Miss. Admin. Code, Title 23, Part 300, Rule 1.1.

Source: 42 C.F.R. § 447.45; Miss. Code Ann. §§ 43-13-113, 43-13-117, 43-13-121.

History: Added Miss. Admin. Code Rule 1.7.F. eff. 10/01/2019; New rule eff. 07/01/2019.

Rule 1.8: Administrative Reviews for Claims

A. Providers may request an Administrative Review regarding claims within ninety (90) calendar days of the denial of a claim when:

1. The provider is unable to meet the timely filing requirement due to retroactive beneficiary eligibility and has:

   a) Received prior authorization, if required, from the Utilization Management/Quality Improvement Organization (UM/QIO) within 90 days of the system add date of the eligibility determination, and

   b) Filed the claim within ninety (90) days of the system add date of the eligibility determination,

2. The Division of Medicaid adjusts claims after timely filing and timely processing deadlines have expired, or

3. A Medicare crossover claim has been filed within one hundred eighty (180) calendar days from the Medicare paid date and the provider is dissatisfied with the disposition of the Medicaid claim.

B. Requests for an Administrative Review must include:

1. Documentation of timely filing or documentation that the provider was unable to file the claim timely due to the beneficiary's retroactive eligibility,

2. Documentation that explains the facts that support the provider’s position as to how the denied claim meets one (1) or more of the requirements in Miss. Admin. Code, Title 23, Part 200, Rule 1.8.A. and the reasons the provider believes he/she complied with Medicaid regulations, and

3. Other documentation as required or requested by the Division of Medicaid.

C. Providers may appeal certain decisions made by the Division of Medicaid as described in Miss. Admin. Code, Title 23, Part 300.

Source: Miss. Code Ann. §§ 43-13-113, 43-13-117, 43-13-121.

History: Revised eff. 07/01/2021; Revised eff. 08/01/2020; New Rule eff. 07/01/2019.

Rule 1.9: Authorized Provider Representative

The Division of Medicaid defines an authorized provider representative as an employee or agent of a provider designated by the provider to act for the provider with the provider's knowledge and written consent in order to manage and submit claims to the Division of Medicaid for payment.

A. An authorized provider representative must not have been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors including, but not limited to, fraud, forgery, counterfeiting, embezzlement, identity theft, tax evasion, money laundering, or any other crime related to dishonesty or concealment. Reversal on appeal or a pardon granted for the conviction or plea of these crimes does not mitigate this requirement.

B. A provider designating an authorized provider representative or agent must use the Appointment of Authorized Provider Representative or Agent Form included in the Mississippi Medicaid Provider Billing Handbook. This form must be kept on file at the provider's main office and be available to the Division of Medicaid upon request.

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

History: New rule eff. 04/01/2020.

Rule 1.10: Electronic Signatures

A. The Division of Medicaid defines an electronic signature (e-signature) as an electronic symbol attached to or logically associated with a document or communication to be transmitted or submitted to the Division of Medicaid.

1. The Division of Medicaid recognizes an electronic signature as an electronic symbol or process attached to, or logically associated with, a document or communication with the Division of Medicaid when executed or adopted by a person with the intent to electronically sign a document or communication when the application of the electronic signature:

a) Is made by the person whose electronic signature is being applied,

b) Identifies a person as the signer,

c) Authenticates a person as the signer,

d) Includes the date and time of the application of the electronic signature, and

e) Indicates intent of approval of information contained in the electronically signed document or communication.

2. The Division of Medicaid considers electronic signatures the equivalent of full handwritten signatures or handwritten initials.

a) An electronic signature will not be denied solely on the grounds that it is in electronic form.

b) A duplicative image of the original electronic signature or a signature stamp is not a valid electronic signature.

c) A provider cannot refuse to accept a handwritten signature from a beneficiary.

B. Providers must ensure that electronic signatures applied to an electronic health record EHR and/or medical document cannot be excised, copied, or otherwise transferred to falsify an EHR or medical document.

C. Providers are permitted to use e-signatures in submissions to the Division of Medicaid including, but not limited to, Provider Enrollment Applications and claim forms.

1. Provider e-signatures must be created using e-signature software including, but not limited to, the following:

a) Right Signature™,

b) Adobe E-Sign,

c) Electronic health record (EHR) software. [Refer to Miss. Admin. Code Part 200, Rule 5.7], or

d) Any technology solution provided by the Mississippi Division of Medicaid and utilized by providers to conduct business with the Mississippi Division of Medicaid.

2. An authorized provider representative may use a provider's e-signature to make submissions for payment to the Division of Medicaid at the provider's direction. The authorized provider representative must print their name next to the provider's e-signature. [Refer to Miss. Admin. Code Part 200, Rule 1.9.]

3. Any e-signature appearing on an EHR must be made by the treating practitioner.

a) EHR e-signature-making authority may not be delegated to any other party.

b) E-signatures appearing on an EHR must comply with Division of Medicaid requirements regarding EHR. [Refer to Miss. Admin. Code Part 200, Rule 5.7.]

D. Beneficiaries are permitted to use e-signatures in submissions, including Medicaid applications, to the Division of Medicaid.

1. Beneficiaries may create e-signatures through touchscreen technology, online verification systems, and other methods regularly used for beneficiary applications and receipt of benefits in accordance with applicable state and federal laws.

2. Beneficiaries may use e-signatures in records that normally appear in an EHR including, but not limited to, consent for treatment. [Refer to Miss. Admin. Code Part 200, Rule 5.7.]

3. A beneficiary's representative may use an e-signature for purposes of both application and receipt of benefits.

a) The representative must sign both the beneficiary's name and the representative's name when using an e-signature.

b) A representative's use of an e-signature must comply with Division of Medicaid requirements regarding applicant and beneficiary representatives. [Refer to Miss. Admin. Code Part 101, Rules 3.3 and 3.4.]

Source: 12 C.F.R. § 609.910, 42 C.F.R § 435.907, Miss. Code Ann. §§ 43-13-117, 43-13-121, 75-12-3, 75-12-9.

History: Revised eff. 06/01/2022; New Rule eff. 04/01/2020.

Rule 1.11: Provider Claim Submission Signatures

A. The Division of Medicaid allows providers' signatures on claims to be applied using one (1) of four (4) different methods:

1. Electronic signature [Refer to Miss. Admin. Code Part 200, Rule 1.10],

2. Typed signature,

3. Signature stamp bearing the signature of the provider, or

4. Handwritten only by the provider. The ability to make a handwritten signature may not be delegated to another party.

B. A provider may delegate the ability to affix their electronic, typed, or stamped signature to an authorized provider representative when submitting claims on the provider's behalf. The provider must complete and keep on file the Appointment of Authorized Provider Representative or Agent Form included in the Mississippi Medicaid Provider Billing Handbook. [Refer to Miss. Admin. Code part 200, Rule 1.9.]

C. If there is no printed name accompanying an electronic, typed, or signature stamp, it is presumed that the provider affixed the signature to the claim.

Source: Miss. Code Ann. §§ 43-13-117, 43-17-121.

History: New Rule eff. 04/01/2020.

Rule 1.12: National Correct Coding Initiative (NCCI) Edits

A. The Division of Medicaid defines National Correct Coding Initiative (NCCI) edits as edits implemented in the Medicaid Management Information System (MMIS) to control improper coding leading to inappropriate payments which includes:

1. NCCI procedure to procedure (PTP) edits defined as pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that cannot be billed together, and

2. NCCI medically unlikely edits (MUEs) defined for each HCPCS/CPT code utilizing the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.

B. The Division of Medicaid requires providers to follow the Medicaid National Correct Coding Initiative (NCCI) policies and edits:

1. Medicaid NCCI and medically unlikely edit (MUE) values are reviewed with the quarterly file updates, and

2. Located at https://www.medicaid.gov/medicaid/program-integrity/national-correct-coding-initiative/medicaid-ncci-edit-files/index.html

C. Providers must append NCCI associated modifiers only when appropriate clinical circumstances are documented in accordance with the NCCI policies and the HCPCS/CPT Manual instructions/definitions for the modifier/procedure code combination. A modifier cannot be appended to a HCPCS/CPT code solely to bypass an NCCI PTP edit if the clinical circumstances do not justify its use.

D. Providers are required to bill for services according to Medicaid NCCI coding policies, the Fee Schedules on the Division of Medicaid's website and/or Administrative Code.

Source: 42 U.S.C. § 1396b; Miss. Code Ann. §§ 43-13-117, 43-17-121.

History: New Rule eff. 12/01/2020.

Rule 1.13: Rounding of Timed Codes

A. The Division of Medicaid requires providers to adhere to Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) billing and coding guidelines when reporting timed-based services.

   1. Providers are required to bill for services according to Medicaid National Correct Coding Initiative (NCCI) coding policies, the Fee Schedules on the Division of Medicaid's website and Administrative Code.

   2. Should a conflict arise between this rule and specific CPT/HCPCS coding guidelines, the CPT/HCPCS guidelines take precedence.

B. Documentation must support the level of service billed and the medical appropriateness of the service by providing a detailed description of services provided.

C. Providers may bill for CPT/HCPCS codes with 15-minute allotment as follows:

   1. Providers may bill the first initial unit if direct patient contact time is at least eight (8) minutes.

   2. Providers may bill for additional 15-minute increment units after completing the initial full fifteen (15) minutes of service, if at least eight (8) minutes of the next time block are used to perform direct patient services.

   3. Providers may not round up to the next timed code if less than eight (8) minutes of direct patient services are performed of a 15-minute increment.

D. Providers may bill for units of service that are measured in minutes based on the following:

   1. The provider must have provided services for more than half of the time allotment in the code description for the service to bill the unit of service.

   2. Additional units may be billed in increments, provided that at least more than half of the time of each billable increment has been provided.

   3. Providers are not permitted to bill for a unit of service if half or less than half the time requirement is met.

E. For time-based, evaluation and management services, providers must document the activities related to the beneficiary visit including the total time with start and end times of all procedures or services performed for time-based codes. Total time includes all activities related to the visit performed by the physician, physician assistant or nurse practitioner on the date of the visit and may comprise activities including, but not limited to the following:

1. Preparing to see the beneficiary, including review of previous documentation and test results,

2. Obtaining and/or reviewing separately obtained history,

3. Ordering medications, tests, or procedures,

4. Documentation of clinical information in the health record or other records; and,

5. Communicating with the patient, family, or caregiver.

F. Providers may round CPT/HCPCS procedure codes with a one-hour allotment as follows:

1. Providers may bill one unit for one hour of service if at least forty-five (45) minutes but less than 60 minutes is spent with the beneficiary.

2. Providers may not round up to the next level of service if total time spent with the beneficiary is equal to or less than forty-five (45) minutes.

3. If a more appropriate time code is available according to Medicaid National Correct Coding Initiative (NCCI) coding policies, the provider must bill the available code.

G. The Division does not allow the billing of mixed remainder minutes across multiple codes.

H. The Division of Medicaid may conduct audits of provider billing to ensure compliance with rounding rules and recoup payments as necessary.

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

History: New Rule eff. 03/01/2025.

Part 200 Chapter 2: Benefits

Rule 2.1: Medicaid Services

A. Federally Mandated Services - The following services are mandated for Mississippi Medicaid:

1. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (Mississippi Cool Kids Program,

2. Expanded EPSDT,

3. Family Planning,

4. Federally Qualified Health Center (FQHC),
5. Home Health,
6. Hospital Inpatient,
7. Hospital Outpatient,
8. Laboratory,
9. Nurse Practitioner,
10. Nursing Facility,
11. Physician,
12. Radiology,
13. Rural Health Clinic, and
14. Transportation (including emergent/non-emergent ambulance, air ambulance & NET).

B. Optional services covered by State:

1. Ambulatory Surgical Center,
2. Chiropractic,
3. Community Mental Health,
4. Dental,
5. Dialysis,
6. Durable Medical Equipment,
7. Eyeglasses and Vision,
8. Freestanding Psychiatric Hospital,
9. Hearing Services and Hearing Aids,
10. Hospice,
11. Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Services,

12. Medical Supplies,

13. Occupational Therapy,

14. Physical Therapy,

15. Podiatry,

16. Prescription Drugs,

17. Psychiatric Residential Treatment Facilities,

18. Speech Therapy,

19. Hospital Swing Bed, and

20. MS State Department of Health Clinic.

C. Waivered services which are optional:

1. HCBS – Assisted Living Waiver,

2. HCBS – Elderly and Disabled Waiver,

3. HCBS – Independent Living Waiver,

4. HCBS – Intellectual Disabilities/Developmental Disabilities Waiver,

5. HCBS - Traumatic Brain Injury/Spinal Cord Injury Waiver,

6. Mississippi Youth Programs Around the Clock (MYPAC),

7. Family Planning Waiver, and

8. Healthier Mississippi 1115 Waiver.

Source: Miss. Code Ann. § 43-13-121; Social Security Act Section 1902(a); 42 CFR 440.1; 42 USC § 1396d; 440.210; 440.220

Rule 2.2: Non-Covered Services

A. The Division of Medicaid does not cover certain items and services including, but not limited to, the following:

1. Items or services which are furnished gratuitously without regard to the beneficiary's ability to pay and without expectation of payment from any source, including, but not limited to:

    a) Free diagnostic services provided by a health department, and

    b) Services provided as part of a health fair.

2. Services provided by the following except as specified by the State Plan or a 1915(c) waiver:

    a) Anyone legally responsible for a beneficiary/participant,

    b) An individual, corporation, partnership or other organization which has assumed the responsibility for the care of a beneficiary, but does not include the Division of Medicaid, a licensed hospital, or a licensed nursing home within the state,

    c) The following family members:

        1) Spouse,

        2) Parent, step-parent or foster parent,

        3) Child, step-child, grandchild or step-grandchild,

        4) Grandparent or step-grandparent,

        5) Sibling or step-sibling, or

    d) Anyone who resides in the home with the beneficiary regardless of relationship.

3. Services provided by a registered nurse (RN) or licensed practical nurse (LPN) to their family members, as defined in Miss. Admin. Code Part 200, Rule 2.2 A.2.c).

4. Services denied by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or a designated entity.

5. Services, procedures, supplies or drugs still in clinical trials deemed as investigational or experimental in nature.

6. Procedures, products and services for conditions and indications not approved by the Federal Drug Administration (FDA) and/or that do not follow medically accepted indications and dosing limits supported by one (1) or more of the official compendia as designated by the Centers for Medicare and Medicaid Services (CMS) including, but not limited to:

a) Physician administered drugs and implantable drug system devices,

b) Skin and tissue substitutes, and/or

c) Implantable medical devices.

7. Any operative procedure, or any portion of a procedure, performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

8. Reconstructive breast procedures performed to produce a symmetrical appearance.

9. Infertility studies, procedures to enhance fertility including reversal of sterilization, artificial or intrauterine insemination, or in-vitro fertilization.

10. Gastric surgery techniques or procedures for the treatment of obesity or weight control, regardless of medical necessity.

11. Routine foot care in the absence of systemic conditions.

12. Prosthetic or orthotic devices and orthopedic shoes except crossover claims allowed by Medicare.

13. Services provided to Specified Low Income Medicare Beneficiaries (SLMB), Qualified Medicare Beneficiaries (QMB), and Qualifying Individuals (QI) except as described in Miss. Admin. Code Part 200, Rule 3.4.

B. The Division of Medicaid does not cover items or services not directly related to the treatment of an illness or injury, including, but not limited to:

1. Television except as described in Miss. Admin. Code Part 207,

2. Massage,

3. Haircuts except as described in Miss. Admin. Code Part 207,

4. Interest on late pay claims,

5. Telephone contacts/consultations,

6. Missed or cancelled appointments, or

7. Wigs.

C. The Division of Medicaid does not reimburse for items and services ordered, prescribed, administered, supplied or provided by providers, entities, or financial institutions who:

1. Have been excluded by the Department of Health and Human Services (DHHS),

2. Have been excluded by Medicare,

3. Are no longer licensed by their governing board(s),

4. Are respiratory therapists requesting direct payment for services,

5. Are freestanding substance abuse rehabilitation centers,

6. Are free-standing psychiatric facilities,

7. Are located outside of the United States,

8. Are not currently enrolled as a Mississippi Medicaid provider, or

9. Have not conducted criminal history records checks on each employee of the entity hired since 1989 who provides, and/or would provide direct patient care or services to adults or vulnerable persons in accordance with the Mississippi Vulnerable Persons Act.

D. The Division of Medicaid does not cover the following three (3) Never Events in the inpatient hospital, outpatient hospital and other types of healthcare settings:

1. Wrong surgery or other invasive procedure performed on a beneficiary,

2. Surgical or other invasive procedure performed on the wrong body part, or

3. Surgical or other invasive procedure performed on the wrong beneficiary.

E. The Division of Medicaid does not cover inpatient hospital Health Care-Acquired Conditions (HCACs) as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric beneficiaries.

F. The Division of Medicaid does not cover nursing facility services or duplicative hospice services for persons enrolled in a Home and Community-Based Services (HCBS) waiver program or enrollment in more than one (1) HCBS waiver program including, but not limited to:

1. Elderly and Disabled (E&D) Waiver,

2. Independent Living (IL) Waiver,

3. Assisted Living (AL) Waiver,

4. Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver, or

5. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver.

G. Services not specifically listed or defined by the Division of Medicaid are not covered, unless part of the expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.

H. The Division of Medicaid does not reimburse for any exclusion listed elsewhere in the Miss. Admin. Code Title 23, Mississippi Medicaid Bulletins, or other Mississippi Medicaid publications.

Source: 29 USC § 1185b; 42 USC § 1396n; Miss. Code Ann. §§ 43-13-121, 43-47-7; SPA 2011-006, 2012-001; 30 Miss. Admin. Code Part 2820, Rule 1.2 S.2).

History: Revised Miss. Admin. Code Part 200, Rule 2.2.F. eff. 06/01/2016; Added a New Miss. Admin. Code Part 200, Rule 2.2 A.2.a)-d) and C.9., reformatted and revised Miss. Admin. Code Part 200, Rule 2.2 including removing duplicative language, effective 12/01/2015; Added Miss. Admin. Code Part 200, Rule 2.2 A. 36. and Rule 2.2 D. eff. 10/01/2014; Rule 2.2 B. and 2.2 C. added to correspond with approved SPA 2011-004 and 2011-006 effective 10/01/11 and SPA 2012-001 effective 06/01/2012.

Rule 2.3: Medicaid Cost Sharing for Medicare/Medicaid Dually Eligibles

A. A state is not required to cover any Medicare cost sharing expenses related to payment for deductibles, coinsurance, or co-payments for dual eligibles which exceed what the state's Medicaid program would have paid for such service for a beneficiary who is not a dual eligible. When a state's payment for Medicare cost-sharing for a dual eligible is reduced or eliminated the Medicare payment plus the state's Medicaid payment is considered payment in full. The dually eligible beneficiary cannot be billed the difference between the provider's charge and the Medicare and Medicaid payment.

B. Medicare Part A crossover nursing facility, hospice and home health agency claims for dually eligible beneficiaries are reimbursed as listed below:

1. The Medicaid reimbursement combined with the Medicare reimbursement will not exceed what the Mississippi Medicaid program would have paid for such service for a beneficiary who is not dually eligible.

2. All service limits will be applied to beneficiaries who are dually eligible when reimbursement is made toward covered services with service limits. Once the service limits are reached each state fiscal year, no additional payments will be made for these services.

3. All providers must accept the Medicare and Medicaid payment as payment in full. The provider is prohibited from billing the beneficiary the balance between the provider's charge and Medicare and Medicaid payments.

C. For Medicare Part A crossover claims from hospitals (inpatient) and all Part B crossover claims, Medicaid reimburses the full deductible and coinsurance amount for dual eligibles.

Source: Miss. Code Ann. § 43-13-121; Balanced Budget Act of 1997

Part 200 Chapter 3: Beneficiary Information

Rule 3.1: Coverage of Eligibility Groups

A. The Division of Medicaid covers full Medicaid benefits for the following eligibility groups:

1. Individuals receiving Supplemental Security Income (SSI),
2. Certain former SSI recipients specified in federal and/or state law,
3. Parents and caretaker relatives of minor children living at home whose income is at or below the applicable limit,
4. Pregnant beneficiaries,
5. Infants born to Medicaid eligible mothers,
6. Children up to age nineteen (19) whose household income is at or below the applicable limit,
7. Children receiving adoption assistance or foster care maintenance payments,
8. Former foster care children under twenty-six (26) years old who received Medicaid at age eighteen (18) prior to being released from foster care by the Department of Human Services (DHS),
9. Institutionalized beneficiaries,
10. Disabled children living at home,
11. Working disabled, and
12. Certain women with breast and/or cervical cancer screened by the Mississippi State Department of Health (MSDH).

B. The Division of Medicaid covers:

1. Medicare Part A premiums for certain qualified working disabled persons,
2. Medicare Part B premiums for Specified Low Income Beneficiaries (SLMB) and Qualified Individuals (QI),

3. Medicare Part A and B cost sharing, including premiums, deductibles, coinsurance and any copays, for Qualified Medicare Beneficiaries (QMB) regardless of whether or not the service provided is covered by the Division of Medicaid, and

4. Medicare Part C coinsurance and deductible for beneficiaries in applicable Categories of Eligibility (COE).

C. The Division of Medicaid covers full Medicaid benefits for beneficiaries receiving Home and Community-Based Services (HCBS) and additional services as specified in Miss. Admin. Code Part 208 through the following 1915(c) waivers:

1. Assisted Living (AL) Waiver,

2. Elderly and Disabled (E&D) Waiver,

3. Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver,

4. Traumatic Bain/Spinal Cord Injury (TBI/SCI) Waiver, and

5. Independent Living (IL) Waiver.

D. The Division of Medicaid covers those services specified in Miss. Admin. Code Part 221 for beneficiaries enrolled in the 1115(a) Family Planning Waiver (FPW).

E. The Division of Medicaid covers full Medicaid benefits for beneficiaries enrolled in the 1115(a) Healthier Mississippi Waiver (HMW) excluding the following:

1. Long-term care services, including, but not limited to:

a) Nursing facility,

b) Swing bed,

c) Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or

d) Services provided by an HCBS waiver.

2. Maternity and newborn care services.

F. The Division of Medicaid covers emergency services, excluding transplant services, for aliens who meet the requirements of Miss. Admin. Code Part 100, Rule 8.10.

Source: 42 USC § 1396a(a)(10)(E)(i); 42 USC § 1396a(a)(17); 42 USC § 1396d(p)(3); 42 CFR § 435.116; Miss. Code Ann. §§ 43-13-115, 43-13-121; SPA 13-0019.

History: Revised to correspond with SPA 13-0019 (eff. 01/01/14) and Healthier Mississippi Waiver (eff. 01/01/2015) and eff. 04/01/2016; Removed 3.c.2.d.v) to reflect CMS waiver (eff. 04/01/2004) eff. 12/01/2013.

Rule 3.2: Newborn Child Eligibility

A. The Division of Medicaid covers an infant:

1. Whose mother was eligible for Medicaid in the child's birth month for the first year of life.

    a) Deemed newborn Medicaid eligibility begins with the birth month and continues through the month of the child's first (1st) birthday unless one (1) of the termination reasons in Miss Admin Code Part 101, Rule 11.2 is applicable.

    b) There is no requirement that the newborn live with the biological mother in order for the continuous eligibility to apply for the infant.

2. Born to immigrant mothers who qualify for Medicaid on the basis of emergency medical services for the first (1st) year of the infant's life.

3. If the mother is not eligible for Medicaid at the time her child is born, she may apply for Medicaid for herself and her newborn. An application must be filed by the end of the third (3rd) month following the birth to be considered for coverage and in order for the infant to be eligible for the first (1st) year of life.

Source: 42 U.S.C. 1396a; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2018.

Rule 3.3: Beneficiary Retroactive Eligibility

A. Retroactive eligibility is available to individuals during all or part of a three (3) month period before application for Medicaid. Applicants must meet financial and need requirements.

B. Medicaid covered services paid for by a beneficiary during the three (3) month period may be refunded at the option of the provider of services and billed to Medicaid when eligibility is validated in accordance with timely filing requirements.

C. Medically necessary services rendered which require authorization during the period of retroactive eligibility cannot be denied due to failure to secure prior authorization. In accordance with timely filing requirements, authorization must be obtained and the claim must be filed within ninety (90) days of the system add date of eligibility determination.

Source: Miss. Code Ann. § 43-13-117.

History: Revised eff. 08/01/2020.

Rule 3.4: Eligibility for Medicare and Medicaid

Medicare is the primary payor for a beneficiary who is both Medicare and Medicaid eligible and has four (4) parts:

A. Medicare Part A

1. The Division of Medicaid pays for the Medicare Part A premium through a "buy-in" process for individuals who have income that does not exceed 100% of the poverty level and are classified as Qualified Medicare Beneficiaries (QMB) and QMB-dual recipients, meaning the recipient is dually eligible as both a QMB and has full Medicaid through other coverage.

2. The Centers for Medicare and Medicaid Services (CMS) and the Division of Medicaid work jointly to ensure that all eligible individuals are included in the "buy-in" process for Medicare coverage. Persons who may be Medicaid-eligible should apply at the appropriate certifying agency.

B. Medicare Part B

1. The Division of Medicaid pays the Medicare Part B premium through a "buy-in" agreement with the Social Security Administration (SSA) for all Medicaid eligible individuals who also qualify for Medicare Part B. CMS and the Division of Medicaid work jointly to ensure that all eligible individuals are included in the "buy-in" process.

2. The Division of Medicaid also pays Part B premiums for specified low-income Medicare beneficiaries (SLMBs) and certain qualifying individuals (QIs). SLMBs and QIs do not receive a Medicaid ID card or any other benefits.

C. Medicare Part C (Medicare Advantage Plans)

1. The Division of Medicaid pays for the Medicare Part C coinsurance and deductible for beneficiaries in applicable Categories of Eligibility (COE).

2. For purposes of reimbursement, co-payments charged by a Medicare Part C plan are considered to be coinsurance.

D. Medicare Part D (Medicare Prescription Drug Plan)

1. When Medicaid beneficiaries have both Medicare and Medicaid coverage, pharmacy providers are required to bill Medicare for drugs covered by that program.

2. The Division of Medicaid considers the Medicare payment as payment in full for Medicare Part D pharmacy claims.

Source: 42 U.S.C. § 1396a; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/2015.

Rule 3.5: Verification of Eligibility

A. It is the responsibility of the Medicaid provider to verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service. Evidence of eligibility is demonstrated by the Medicaid identification card issued to each Medicaid eligible member in a family. A beneficiary is expected to present his/her Medicaid identification card when services are rendered.

B. A picture ID such as a driver's license or school ID card is required to confirm the identity of the person presenting for service. If no picture ID is available, verification must be made by verifying the social security number and/or date of birth.

C. If it is found that the person presenting for services was not the Medicaid beneficiary to whom the card was issued, the provider is responsible for refunding any monies paid by Medicaid to the provider for those services provided.

D. A plastic identification card is not a guarantee of Medicaid eligibility.

E. Medicaid providers may verify beneficiary eligibility status by one (1) of the following methods:

    1. Calling the Automated Voice Response System (AVRS),

    2. Using the point of service eligibility verification system, or

    3. Calling the fiscal agent.

Source: Miss. Code Ann. § 43-13-121

Rule 3.6: Freedom of Choice of Providers

A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Any individual eligible for medical assistance, including drugs, may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required.

B. Providers of Medicaid services agree to comply with this section of the Act in the Provider Agreement. This means that providers may not take any action to deny freedom of choice to individuals eligible for Medicaid by using systems, methods, or devices which would require persons eligible for Medicaid to obtain a service from a particular provider.

C. This also means that providers may not require any individuals eligible for Medicaid to sign a statement of waiver, if such statement would, in any manner, deny or restrict that individual's free choice of a provider of any services for which the individual may be eligible. Providers cannot use any method of inducement, including free transportation, refreshments, cash or gifts, to influence a beneficiary to select a certain provider.

D. Exception: Under a federal waiver or approved State Plan amendment, freedom of choice may be restricted for individuals enrolled in a managed care program. These individuals are required to receive primary care from a primary care provider (PCP) and have specialty care prior authorized by the PCP.

Source: Miss. Code Ann. § 43-13-121; Social Security 1902(a)(23)

Rule 3.7: Beneficiary Cost Sharing

A. The Division of Medicaid does not impose premiums on beneficiaries.

B. The Division of Medicaid does not impose cost sharing on beneficiaries.

Source: U.S.C § 1396a; 42 C.F.R. § 447.50 *et seq.*; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 23-0011 (eff. 5/01/2023) eff. 09/01/2023. Revised eff. 07/01/2021; Revised Miss. Admin. Code Part 200, Rule 3.7.B.h) to correspond with SPA 2012-008 (eff. 10/01/2012) eff. 05/01/2014.

Rule 3.8: Charges Not Beneficiary's Responsibility

A. Providers who have agreed to be Medicaid providers are expected to bill Medicaid for Medicaid covered services and accept Medicaid payment as payment in full.

B. Some charges are not the beneficiary's responsibility and must not be billed to the beneficiary. Those included, but not limited to:

1. The beneficiary may not be billed for Medicaid covered services except in the following situations:

   a) If the person is ineligible; or

   b) If person has chosen to receive and agreed to pay for care not covered by the Medicaid program.

2. The beneficiary may not be held liable for a claim or portion of a claim when a determination that the services were not medically necessary is made based on the professional opinion of appropriate and qualified persons performing peer review of Medicaid cases.

3. The beneficiary may not be held liable for billed charges above the Medicaid maximum allowable.

4. The beneficiary may not be billed for claims denied because of provider errors. It is the responsibility of the provider to file claims in a timely manner, to correct errors, and to provide essential information necessary to process the Medicaid claim.

5. The beneficiary may not be billed for claims denied because of errors made by DOM, the fiscal agent, or due to changes in federal or state mandates.

6. The beneficiary may not be billed for services denied because a provider failed to request required authorization for a service or failed to meet procedural requirements.

7. For dual eligibles, the beneficiary may not be billed for the portion of a claim remaining after Medicare and Medicaid have paid.

8. The beneficiary may not be billed for the completion and submission of a Medicaid claim form. If the provider agrees to accept the patient as a Medicaid beneficiary and agrees to bill Medicaid for the services rendered, the beneficiary may not be charged for this billing procedure.

9. The beneficiary may not be billed for telephone calls or missed/cancelled appointments.

10. The beneficiary may not be charged for the cost of copying medical records.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 447.15

Rule 3.9: Charges Beneficiary's Responsibility

A. Medicaid beneficiaries may be charged for the following:

1. The beneficiary is responsible for all expenses for non-covered services, such as services that are not covered under the scope of the Medicaid program, or services received in excess of program benefit limitations. The beneficiary is responsible for services received during a period of ineligibility.

2. Any applicable cost-sharing amount applied by the Medicaid program is the responsibility of the beneficiary.

3. Beneficiaries enrolled in managed care programs that insist upon receiving services that are not authorized by the primary care provider (PCP) may be required to pay for such services. For example, if the beneficiary seeks care in a hospital emergency room (ER) for services that can be provided in the PCP's office and are not authorized by the PCP for treatment in the ER; the beneficiary may be responsible for payment of the ER services beyond the medical assessment. The beneficiary sees a specialist for services that are not excluded from managed care and are not considered emergent/urgent, and the

PCP has not made the referral or denies authorization; the beneficiary may be responsible for payment of such services.

4. The beneficiary, or responsible adult, is held accountable and responsible for knowingly allowing or continuing to allow an unauthorized person to use a Medicaid card or beneficiary's identity to obtain benefits otherwise not allowed. Any charges to or payments by the Division of Medicaid for services requested and/or received in an attempt to defraud the provider of services and/or Medicaid are billable to the cardholder or his/her responsible party, or the imposter.

B. This list is not all-inclusive.

Source: Miss. Code Ann. § 43-13-121

Part 200 Chapter 4: Provider Enrollment

Rule 4.1: Definitions

A. Providers: All health care entities including individual practitioners, institutional providers, and providers of medical equipment or goods related to care that are currently enrolled in the Medicaid program.

B. National Provider Identifier (NPI): A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers as noted in 45 C.F.R. § 162. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA.

C. Sole Proprietor: A Sole Proprietor is a form of business in which one (1) person owns all of the assets of the business and is solely liable for all debts on an individual basis. As a result of the National Provider Identifier (NPI) requirements, a Sole Proprietor must apply for their NPI as individuals. Medicaid will no longer issue a group number to an individual effective with the adoption of this rule revision. The subpart concept does not apply to a sole proprietorship, even one (1) with multiple locations, because the sole proprietorship is not an organization as defined in the final NPI Rule. An individual Medicaid provider number and the appropriate NPI issued by the Centers for Medicare & Medicaid Services (CMS) are entered into the Medicaid system with the individual's social security number (SSN); and if applicable, the Federal Employer Identification Number (FEIN) assigned to it. If this number is used as a Medicaid provider billing number, income or earnings information are reported to the IRS for this SSN or FEIN, as applicable. Deferred compensation is only available via a sole proprietor's SSN.

D. Group/Organization: A Group/Organization provider is not an individual/sole proprietor. This may include hospitals, long-term care facilities, laboratories, home health agencies, ambulance companies, and group practices; suppliers of durable medical equipment or pharmacies. Any subpart of the group/organization must apply for a different Medicaid

provider number as determined by the provider type per Medicaid rule. A group provider requesting individual providers/servicing providers to be affiliated to their billing provider number must be approved Medicaid providers. For monies to be reported to the IRS on its Tax Identification, the group provider should be the biller, unless otherwise restricted by the Division of Medicaid. Group providers that have various servicing locations should apply to Medicaid to become a provider according to their enumeration application with CMS. The provider should also apply to Medicaid to become a provider according to the conduct of their own standard transactions and as required by the Division of Medicaid‘s program rules.

E. Effective Date: The earliest date a provider may begin billing for services.

F. Officer: Any person whose position is listed as being that of an officer in the provider's "articles of incorporation" or "corporate bylaws" or anyone who is appointed by the board of directors as an officer in accordance with the provider's corporate bylaws.

G. Director: A member of the provider's "board of directors." It does not necessarily include a person who may have the word "director" in his/her job title. Moreover, where a provider has a governing body that does not use the term "board of directors," the members of that governing body will still be considered "director". Thus, if the provider has a governing body titled "board of trustees," as opposed to "board of directors," the individual trustees are considered "directors" for Medicaid enrollment purposes.

H. Managing/Directing Employee: A managing/directing employee may be a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the entity, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the entity.

I. Authorized Official: An appointed official to whom the organization has granted the legal authority to enroll it in the Medicaid program, to make changes or updates to the organization's status in the Medicaid program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicaid program. Examples include: chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner.

J. Delegated Official: An individual who is delegated by an authorized official with the authority to report changes and updates to the entity's enrollment record. A delegated official must be an individual with an "ownership or control interest," or be a W-2 managing employee of the entity. Documentation in the application or as an attachment must be included with the application. A change of a delegated official will only be made to the file with the appropriate documentation signed by a documented authorized official.

K. Majority Interest: Ownership interest greater than fifty percent (50%) of the voting interest in a business enterprise.

Source: 42 C.F.R. Part 455, Subpart E; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2019.

Rule 4.2: Conditions of Participation

A. Providers must comply with the following conditions to participate in the Mississippi Medicaid program:

1. All providers must complete provider agreements and/or provider enrollment application packages per the requirements of the Division of Medicaid.

2. The provider must be licensed and/or certified by the appropriate federal and/or state authority, as applicable.

3. Agree to furnish required documentation of the provider's business transactions per 42 C.F.R. § 455.105(b) to the Division of Medicaid or to the Department of Health & Human Services (HHS) within thirty-five (35) days of the date on the request.

4. Agree to abide by the requirements of the Affordable Care Act (ACA) concerning the following:

    a) Provider Screening Procedures (42 C.F.R. §§ 455.400-470), based on the category of the provider type, which includes license verifications, database checks of eligible professionals, owners, managing employees, etc., fingerprinting and criminal background checks, and/or unscheduled or unannounced site visits based on required screening rules.

        1) Providers with an expired license will be denied enrollment.

        2) Providers with any current disciplinary limitations on their license may be denied enrollment.

        3) Providers that meet any of the exclusion requirements according to state and/or federal law will be denied enrollment.

    b) Provider Application Fees (42 C.F.R. § 455.460).

    c) Temporary Moratorium (42 C.F.R. § 455.470).

    d) Provider Termination (42 C.F.R. § 455.416).

    e) Payment Suspensions (42 C.F.R. § 455.23).

5. The provider agrees to review, complete and submit a completed re-validation document as required by the policies of Division of Medicaid. All providers must undergo a revalidation screening process at least once every five years in accordance with 42 C.F.R.

§ 455.414.

6. All professional and institutional providers participating in the Medicaid program are required to keep records that fully disclose the extent of services rendered and billed under the program. These records must be retained for a minimum of five (5) years in order to comply with all federal and state regulations and laws. When there is a change of ownership or retirement, a provider must continue to maintain all Medicaid beneficiary records, unless an alternative method for maintaining the records has been established and approved by the Division of Medicaid. Upon request, providers are required to make such records available to representatives of the Division of Medicaid and others as provided by law in validation of any claims. The Division of Medicaid staff shall have immediate access to the provider's physical location, facilities, records, documents, and any other records relating to medical care and services rendered to beneficiaries during regular business hours. Providers must maintain records as indicated in Part 200 Chapter 1, Rule 1.3: Maintenance of Records.

7. The provider must comply with the requirements of the Social Security Act and federal regulations concerning: (a) disclosure by providers of ownership and control information; (b) disclosure of information by a provider's owners of any persons with convictions of criminal offenses against Medicare, Medicaid, or the Title XXI services program; and (c) disclosure affiliations as described in Miss. Admin. Code Title 23, Part 200, Rule 4.8.A.9. If the Division of Medicaid ascertains that a provider has been convicted of a felony under federal or state law for an offense that the Division of Medicaid determines is detrimental to the best interests of the program or of Medicaid beneficiaries, the Division of Medicaid may refuse to enter into an agreement with such provider or may terminate or refuse to renew an existing agreement.

8. The provider must agree to accept payment for Medicaid covered services in accordance with the rules and regulations for reimbursement, as declared by the Secretary of Health and Human Services and by the state of Mississippi and established under the Mississippi Medicaid program.

9. The provider must agree to accept, as payment in full, the amount paid by the Medicaid program for all services covered under the Medicaid program within the beneficiary's service limits with the exception of authorized deductibles, co-insurance, and co-payments. All services covered under the Medicaid program will be made available to the beneficiary. Beneficiaries will not be required to make deposits or payments on charges for services covered by Medicaid. A provider cannot pick and choose procedures for which the provider will accept Medicaid. At no time shall the provider be authorized to split services and require the beneficiary to pay for one type of service and Medicaid to pay for another. All services provided to Medicaid beneficiaries will be billed to Medicaid where Medicaid covers said services, unless some other resources, other than the beneficiary or the beneficiary's family, will pay for the service.

10. For most medical services rendered, the provider must agree to take all reasonable measures to determine the legal liabilities of third parties including Medicare and private

health insurance to pay for Medicaid covered services, and if third party liability is established, to bill the third party before filing a Medicaid claim. Exceptions to this rule are outlined in Part 306 Third Party Recovery. For the purpose of this provision, the term "third party" includes an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the medical costs of injury, disease or disability of a Medicaid beneficiary and to report any such payments as third parties on claims filed for Medicaid payment.

11. Participating providers of services under the Medicaid program, i.e., physicians, dentists, hospitals, nursing facilities, pharmacies, etc., must comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age of Discrimination Act of 1975. Under the terms of these Acts, a participating provider or vendor of services under any program using federal funds is prohibited from making a distinction in the provision of services to beneficiaries on the grounds of race, color, national origin or handicap. This includes, but is not limited to, distinctions made on the basis of race, color, national origin, age or handicap with respect to: (a) waiting rooms, (b) hours of appointment, (c) order of seeing patients, or (d) assignment of patients to beds, rooms or sections of a facility. The Division of Medicaid is responsible for routine and complaint investigations dealing with these three (3) Acts.

12. Participating providers are prohibited from making a distinction in the provision of services to Medicaid beneficiaries on the grounds of being Medicaid beneficiaries. This includes, but is not limited to, making distinctions with regard to waiting rooms, hours of appointment, or order of seeing patients, third party sources (pursuant to federal regulations), and quality of services provided, including those provided in a facility.

13. The provider must agree that claims submitted will accurately reflect both the nature of the service and who performed the service.

14. The provider must maintain a copy of the Administrative Code for Mississippi Medicaid and all revisions.

15. Participating providers must be eligible to participate in the Medicaid program as determined by DHHS-Office of Inspector General (DHHS-OIG). Certain individuals and entities are ineligible to participate in the Medicaid program on the basis of their exclusion as sanctioned by DHHS-OIG by authority contained in Sections 1128 and 1156 of the Social Security Act. The effect of exclusion is that no program payment will be made for any items or services, including administrative and management services, furnished, ordered or prescribed by an excluded individual or entity under the Medicare, Medicaid, and State Children's Health Insurance Programs during the period of the exclusion. Program payments will not be made to an entity in which an excluded person is serving as an employee, administrator, operator, or in any other capacity, for any services including administrative and management services furnished, ordered, or prescribed on or after the effective date of the exclusion. In addition, no payment may be made to any business or facility that submits bills for payment of items or services provided by an excluded party. The exclusion remains in effect until the subject is

reinstated by action of the DHHS-OIG. It is the responsibility of each Medicaid provider to assure that no excluded person or entity is employed in a capacity which would allow the excluded party to order, provide, prescribe, or supply services or medical care for beneficiaries, or allow the excluded party to hold an administrative, billing, or management position involving services or billing for beneficiaries.

16. The provider must verify with the NET Broker that all non-emergency transportation (NET) services are for a Medicaid covered service only. The provider is only required to verify the date, time, beneficiary's Medicaid number, and provide confirmation that a Medicaid covered service will be provided at the appointment.

17. A provider that has not rendered services as evidenced on claims to the Division of Medicaid or coordinated care organization (CCO) for a one (1) year period will be disenrolled except for certain providers that are necessary to maintain access to covered services, as determined by the Division of Medicaid. Once disenrolled, the provider may reapply in accordance with the current enrollment policy.

B. Out-of-State Providers –

1. The Division of Medicaid may enroll an out-of-state provider to cover medical services if one (1) of the following conditions is met:

   a) That are needed because of an emergency medical condition as defined in Miss. Admin. Code Title 23, Part 201, Rule 1.2.G.

   b) That are needed because the beneficiary's health would be endangered if they were required to travel to their state of residence.

   c) That the Division of Medicaid has determined, on the basis of medical advice, are needed and more readily available in the other state.

      1) The provider must submit documentation supporting the need for out of state services, including, but not limited to:
         (a) A description of how the provider's enrollment will meet the needs of Mississippi Medicaid members and documentation of an insufficient existing provider base for the specified services in Mississippi.

         (b) A description of how the provider's enrollment will provide a unique service that is currently unavailable in Mississippi.

      2) Requests to cover specific procedure codes should not be submitted through provider enrollment and will not be reviewed.

   d) The location of services provided is within:

      1) Thirty (30) miles of the Mississippi state border for a pharmacy, or

2) Sixty (60) miles from the Mississippi state border for certain other provider types.

e) Or as determined by the Division of Medicaid.

2. The Division of Medicaid may use the results of the provider screenings performed by another state's Medicaid or Children's Health Insurance Program (CHIP) agency in the state in which the out-of-state provider is located or by a Medicare Contractor.

3. Out-of-state providers must adhere to the Division of Medicaid's policies and procedures.

C. Providers that are closing, discontinuing a service, or otherwise stopping services for reasons unrelated to the beneficiary's condition or medical necessity of the services must provide a thirty (30) day written notice to beneficiaries and the Division of Medicaid prior to ending the services:

1. Providers must assist with the transition of the beneficiary to another service provider.

2. Providers who fail to provide proper notice will not be reimbursed for services provided during the thirty (30) day period the beneficiary should have been notified unless the provider was prevented from making the notification due to causes beyond the reasonable control of the Provider, including but not limited to fire, floods, embargoes, war, acts of war, insurrections, riots, strikes, lockouts or other labor disturbances, or acts of God; provided, however, that a Provider so affected shall use reasonable commercial efforts to avoid or remove such causes of nonperformance, and shall provide proper notice hereunder immediately whenever such causes are removed. Changes to the scope of available services or reimbursement methodology for the provision of certain services through legislative or regulatory action shall not constitute an unforeseeable circumstance within the meaning of this section.

3. Facilities and/or entities that employ multiple enrolled providers are not required to provide the thirty (30) day notice when an enrolled provider that is employed leaves the facility and/or entity as long as the beneficiary has been transitioned to another provider within the same facility/entity and there is no interruption in services.

Source: 42 C.F.R. §§ 431.52, 431.107, 447.15, 455.101, 455.104-455.107, 455.412, 455.416, 455.460, 455.470; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121.

History: Revised to correspond with MS SPA 24-0011 (eff. 10/01/24) eff. 06/01/2025; Revised eff. 01/01/2025; Revised eff. 11/01/2021; Revised eff. 04/01/2021; Revised eff. 10/01/2020; Revised eff. 04/01/2020; Revised Miss. Admin. Code Part 200, Rule 4.2.B. eff. 01/01/2020; Revised eff. 12/01/2019.

Rule 4.3: Change of Ownership

A. A change of ownership of a provider/facility as defined by the Division of Medicaid includes, but is not limited to: inter vivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions or other comparable arrangements whenever the person or entity

acquires or controls a majority interest of the facility or service. The new owner, upon consummation of the transaction effecting the change of ownership, shall, as a condition of participation, assume liability, jointly and severally, with the prior owner for any and all amounts that may be due to the Medicaid program.

B. The new ownership agreement shall be subject to any restrictions, conditions, penalties, sanctions or other remedial actions taken by the Division of Medicaid, the state agency or the federal agency against the prior owner of the facility.

C. The agreement will also remain subject to all applicable statutes and regulations, including, but not limited to:

1. Any statement of deficiencies cited by the State Agency that are not in substantial compliance, including any existing plan of correction,

2. Any expiration date,

3. Compliance with applicable health and safety standards,

4. Compliance with ownership and financial disclosure requirements, and

5. Compliance with civil rights and the rights of individuals with developmental disability requirements.

D. A provider/facility that undergoes a change of ownership must:

1. Notify the Division of Medicaid within thirty-five (35) days after any change in ownership through the submission of:

a) A complete Mississippi Medicaid Provider Application Packet, and

b) Proof of change of ownership such as a bill-of-sale or Medicare Tie-In Notice.

2. Receive a new taxpayer identification segment for the new owner with the provider number remaining unchanged.

3. Comply with all applicable Mississippi Department of Health requirements for changes of ownership [Refer to 15 Miss. Admin. Code. Pt 16, Subpart 1, Rule 49.2.6 and 15 Miss. Admin. Code Pt. 9, Subpart 91, Appendices.]

E. When there is a change of ownership or retirement/closure, a provider must continue to maintain all Medicaid beneficiary records for at least six (6) years, unless an alternative method for maintaining the records has been established in writing, and approved by the Division of Medicaid as required by Health Insurance Portability and Accountability Act of 1996 (HIPAA). [Refer to Part 200, Chapter 1, Rule 1.3, Maintenance of Records.]

F. The following are examples of changes of ownership. This list is not exhaustive. Providers who are unsure of whether a transaction constitutes a change of ownership should contact the Division of Medicaid's Office of Provider Enrollment. Examples include:

1. Changes in type of organization (ex. Partnership to limited liability company, or single proprietorship to organization),

2. Mergers, when a new organization is formed and the merging companies are non-surviving,

3. Consolidation of two or more corporations resulting in a new corporate entity,

4. Changes in partnership, including the removal, addition, or substitution of one or more individuals as partners (under Mississippi law, these actions result in dissolution of an older partnership and creation of a new one),

5. Transfers between different levels of government, such as city to county, state to county, etc., and

6. Transfer (sale, gift, exchange of stock) that results in a fifty (50) percent or more change.

Source: 42 C.F.R. §§ 455.104, 489.18; Miss. Code Ann. §§ 41-7-173, 43-13-121.

History: Revised eff. 09/01/2020.

Rule 4.4: Effective Date of Provider Agreement and Provider Agreement Termination

A. Each provider or organization furnishing services under the Mississippi Medicaid State Plan must enter into a provider agreement with the Mississippi Division of Medicaid.

B. The effective date of the provider agreement is the earliest day of the following options:

1. The date all required screening has been completed by the Division of Medicaid if the Division of Medicaid cannot verify all required screenings have been completed by a:

   a) Medicare contractor, or

   b) Medicaid agency or Children's Health Insurance Program (CHIP) of another state,

2. Up to one hundred twenty (120) days prior to the date of the submission of a Mississippi Medicaid Enrollment application if the Division of Medicaid can verify that the provider had all required screenings completed by a:

   a) Medicare contractor, or

   b) Medicaid agency or Children's Health Insurance Program (CHIP) of another state,

3. The date of Medicare certification, not to exceed three hundred and sixty-five (365) days from the date of application, if the provider requests enrollment in the Medicaid program within one hundred twenty (120) days from the date the Medicare Tie-in Notice was issued to the provider, or

4. The first day of the month in which the Division of Medicaid receives the provider's enrollment application if the provider requests enrollment after one hundred twenty (120) days of the issuance of the Medicare Tie-in Notice.

C. For out-of-state providers, applications and claims must be submitted within one hundred twenty (120) days of the date of service. The effective date of the provider agreement will be:

1. The date of the service if the service was an emergency or if the beneficiary's health would be endangered if they were required to travel to their state of residence, or

2. The date determined in Miss. Admin. Code Part 200, Rule 4.4.B.

D. The Division of Medicaid does not make payments to any provider or organization prior to the date of a valid Medicaid provider agreement. This rule applies for any services rendered regardless of any time period provided for under any timely filing provision.

E. Timely filing requirements apply to all claims submitted by all providers. [Refer to Miss. Admin. Code Part 200, Rule 1.6]

F. Providers of the following state plan services will continue to receive payment for up to thirty (30) days after the effective date of termination of a provider agreement for services furnished to a beneficiary who was admitted before the effective date of the termination to permit time for an orderly transfer of Medicaid beneficiaries:

1. Inpatient hospital services,

2. Nursing facility (NF) services,

3. Psychiatric residential treatment facility services (PRTF),

4. Intermediate care facilities for the intellectually and/or developmentally disabled (ICF/ IDD) facility services, and

5. Home health services and hospice services furnished under a plan established before the effective date of termination.

G. The facilities listed in Miss. Admin. Code Part 200, Rule 4.1.D. must:

1. Notify all Medicaid beneficiaries, families, and/or sponsors in writing within forty-eight (48) hours of notice of termination of Medicaid participation,

2. Submit to the Division of Medicaid a current list of Medicaid beneficiaries who are receiving Medicaid services along with the name, address and telephone number of the family and/or the sponsor, when available, and the beneficiary's attending physician.

3. Assist the beneficiaries, families and the facility in making other facility arrangements for the beneficiaries.

H. Reinstatement may be granted after a provider has been terminated by the licensing or certification board, Office of Inspector General, the Centers for Medicare and Medicaid services (CMS), or the Division of Medicaid when conditions of reinstatement have been satisfied by the sanctioning entity. Notification of re-instatement from the appropriate entity must be provided with an application for re-instatement to participate in the Medicaid program.

Source: 42 C.F.R. §§ 431.108, 489.55, 489.57; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Added Miss. Admin. Code Part 200, Rule 4.4.C. eff. 01/01/2020; Revised eff. 12/01/2019.

Rule 4.5: Licensure, Certification and Permits

A. Medicaid providers must maintain current information as required by the Division of Medicaid such as licensure, permits, and/or certification from their governing entity on file with the Division of Medicaid at all times while enrolled as a Medicaid provider.

1. The provider is ineligible to provide services to Medicaid beneficiaries if the license, permit, or certification of the provider is suspended, revoked, surrendered, or expired, effective on the date of the suspension, revocation, surrender or expiration.

2. The provider is ineligible to provide services to Medicaid beneficiaries if the license, permit, or certification of an employee of the provider upon which provider eligibility results from, is suspended, revoked, surrendered, or expired, or the person ceases to be an agent/employee of the provider effective on the date of the suspension, revocation, surrender, expiration, or change in employment.

3. The provider is ineligible to provide services to Medicaid beneficiaries when their license, permit, or certification has been limited due to disciplinary action by the board or entity that issues the license, permit, or certification effective on the date of the limitation.

B. The Division of Medicaid will re-open the provider number of a provider whose number was closed due to license expiration back to the effective date of the license renewal if:

1. The provider's Medicaid provider number has been closed for less than one (1) year, and

2. The provider submits a copy of their current license and updates any other information that has changed or is incorrect.

C. The provider must re-enroll as a Medicaid provider when the provider's Medicaid number has been closed due to license expiration for more than one (1) year.

Source: 42 CFR §§ 455.412, 455.416, 455.450; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2021.

Rule 4.6: Advertising by Provider

A. No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet, or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems, the word "Medicaid" or "Division of Medicaid", or "Medicaid program", or "Mississippi Medicaid", or "Mississippi Division of Medicaid" in a manner which such person knows or should know would convey, or in a manner which reasonably could be interpreted or construed as conveying, the false impression that such item is approved, endorsed, or authorized by the Mississippi Division of Medicaid.

B. Providers may list Medicaid as a pay source they will accept, e.g., most third-party insurance, Medicare, and Medicaid accepted.

Source: Miss. Code Ann. § 43-13-121

Rule 4.7: Change of Tax ID

A. Providers who change tax identification numbers under circumstances other than those described in Rule 4.3, Change of Ownership and Rule 4.8, Requirements for All Providers must:

1. Request the change and the effective date of change in writing,

2. Submit a signed original W-9 form,

3. Submit verification of the tax identification number on a preprinted document from the Internal Revenue Service (IRS), and

4. Submit verification of the National Provider Identifier (NPPES confirmation).

B. The provider does not need to submit a Provider Enrollment Change of Ownership application. The provider number is not changed; however, a new taxpayer identification segment will be established.

Source: Miss. Code Ann. § 43-13-121

Rule 4.8: Requirements for All Providers

A. All providers are required to submit the following documentation:

1. Mississippi Medicaid Provider Enrollment Application

    a) Individuals and Sole Proprietor applications must be signed by the individual provider.

    b) Business/Entity applications must be signed by the Authorized Official.

2. Medical Assistance Participation Agreement (Provider Agreement)

3. Direct Deposit Authorization/Agreement Form

    a) Include a copy of a voided check, deposit slip, or letter from the bank noting the account number and transit routing number.

    b) Starter checks and counter deposit slips are not acceptable.

4. W-9

    a) Name on the W-9 should match the written confirmation from the IRS confirming your Tax Identification Number with the legal business name/legal name as noted in Section 1 of the Mississippi Medicaid Provider Enrollment Application. Note: This information is needed if enrolling as a professional corporation or limited liability company, or enrolling as a sole proprietor using the Employer Identification Number.

    b) Name on the W-9 should match the documentation to confirm the social security number verification for any provider enrolling as an individual sole proprietor.

5. EDI Provider Agreement and Enrollment Form is required if the intent is to submit electronically.

6. Civil Rights Compliance Information Request Packet including the following:

    a) A copy of the provider's Nondiscrimination Policy.

    b) A copy of the provider's Limited English Proficiency Policy.

    c) A copy of the provider's Sensory and Speech Impairment Policy.

    d) A copy of the provider's Notice of Program Accessibility Policy.

    e) Statement of compliance, signature required. A copy of the DHHS Office of Civil

Rights letter of compliance may be submitted in lieu of completing the Division of Medicaid's compliance packet.

f) A copy of the provider's published newspaper article stating the provider's non-discrimination policy, required only for healthcare facilities.

7. Providers who have changes of information which are not considered a CHOW must submit the following forms, if applicable:

   a) W9 form for a provider name change,

   b) Change of Address form for provider mailing and/or business addresses, e-mail contact information or telephone number changes,

   c) Electronic Funds Transfer (EFT) form for provider banking information changes, and/or

   d) Provider Disclosure Form for any other applicable changes.

8. Certain disclosures are required for participation as a provider in the Mississippi Division of Medicaid.

   a) The Division of Medicaid requires use of the Mississippi Medicaid Provider Disclosure Form in the following instances:

      1) Upon the provider's submission of the provider enrollment application,

      2) Upon request of the Division of Medicaid during the re-validation of enrollment process, and

      3) Within thirty-five (35) days after any change in ownership of the provider.

   b) Required disclosures include:

      1) The name and address of any individual or corporation with an ownership or control interest in the provider. The address for corporate entities must include an applicable primary business address, every business location, every P. O. Box address, and/or other mailing address.

      2) Date of birth and Social Security Number (in the case of an individual).

      3) Other tax identification number (in the case of an organization) with an ownership or control interest in the provider or in any subcontractor in which the disclosing entity has a five percent (5%) or more interest.

4) Whether the person (individual or corporation) with an ownership or control interest in the provider is related to another person with ownership or control interest in the provider as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more ownership interest is related to another person with ownership or control interest in the provider as a spouse, parent, or sibling.

5) The name of any other provider in which the ownership of the provider has an ownership or control interest.

6) The name address, date of birth, and Social Security Number of any managing employee, authorized official, and delegated official of the provider.

7) Any additional disclosures as required and enumerated by state and/or federal law.

9. Certain disclosures are required upon request by the Division of Medicaid during initial enrollment and/or during the re-validation of enrollment process as follows:

a) Any and all affiliations that the provider or any of its owning or managing employees or organizations, consistent with the terms "person with an ownership or control interest" and "managing employee" as defined in § 455.101, has with a currently or formerly enrolled Medicare, Medicaid, or CHIP provider or supplier that has a disclosable event, as defined in § 455.101.

b) Any and all affiliations that the provider or any of its owning or managing employees or organizations, consistent with the terms "person with an ownership or control interest" and "managing employee" as defined in § 455.101, had within the previous five (5) years with a currently or formerly enrolled Medicare, Medicaid, or CHIP provider or supplier that has a disclosable event, as defined in § 455.101.

B. Failure to comply with the terms of this rule may result in rejection of the Provider Enrollment Application, revocation of provider enrollment, or a suspension in the payment of claims.

Source: 42 C.F.R. §§ 455.101, 455.104-455.107, 455.414; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with MS SPA 24-0011 (eff. 10/01/24) eff. 06/01/2025; Revised eff. 09/01/2020.

Rule 4.9: Group Providers

A. Business/ Entity enrolling as a group of providers so that all monies received shall report to the tax identification number of the business. The following criteria must apply:

1. The enrolling provider has a tax identification number.

2. The enrolling provider is not a sole proprietor.

3. The enrolling provider employs and notes an active individual servicing provider within their application.

B. Providers enrolling as a group must comply with the requirements set forth in Part 200, Chapter 4, Rule 4.8 for all providers, the requirements for their individual provider type requirements outlined in the assigned chapters of this code and the requirements listed below for group providers:

1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

2. Written confirmation from the IRS confirming your tax identification number and legal business name.

3. CLIA certificate and CLIA Certification form, if applicable.

4. At least one active individual provider is linked to the enrolling group.

C. This rule is applicable to the following provider types:

1. CRNA,

2. Nurse Practitioner,

3. Dentist,

4. Physician Assistant,

5. Dietician/ Nutritionist,

6. Occupational therapist,

7. Physical therapist,

8. Speech Therapist,

9. Optometrist,

10. Audiologist,

11. Nurse Midwife,

12. Pharmacist Disease Management,

13. Physician,

14. Osteopath (DO),

15. Chiropractor,

16. Podiatrist,

17. Psychologist, and

18. Licensed Certified Social Worker.

Source: Miss. Code Ann. § 43-13-121

Rule 4.10: 340B Providers

A. The Division of Medicaid defines a 340B provider as a nonprofit healthcare organization that meets the requirements of, and is considered to be, a covered entity under Section 340B of the Public Health Service Act which has elected to enroll in the 340B program.

B. The Division of Medicaid defines 340B purchased drugs as those:

1. Produced by any manufacturer which has entered into and complies with an agreement under Section 1927 (a) of the Act which are prescribed for a medically acceptable indication,

2. Purchased and administered or dispensed by 340B covered entities under the rules of the 340B program, and

3. Dispensed and administered to a 340B eligible beneficiary as defined in Miss. Admin. Code Part 200, Rule 4.10.C.

C. The Division of Medicaid defines an individual as a 340B eligible beneficiary if:

1. The individual has established a relationship with the covered entity, such that the covered entity maintains records of the individual's healthcare,

2. The individual received healthcare services from a healthcare professional who is either employed by the covered entity or provides healthcare under contractual or other arrangements such that responsibility for the care provided remains with the covered entity, and

3. The individual receives a healthcare service or range of services from the covered entity which is consistent with the service or range of services for which grant funding or

federally qualified health center look-alike status has been provided to the entity. Disproportionate share hospitals are exempt from this requirement.

D. Covered entities:

1. Eligibility to participate in the 340B program includes, but is not limited to:

a) Health Centers including, but not limited to:

1) Federally Qualified Health Centers,

2) Federally Qualified Health Center Look-Alikes, and

3) Tribal/Urban Indian Health Centers.

b) Hospitals including, but not limited to:

1) Children's Hospitals,

2) Critical Access Hospitals,

3) Disproportionate Share Hospitals,

4) Free Standing Cancer Hospitals,

5) Rural Referral Centers, and

6) Sole Community Hospitals.

c) Specialized Clinics including, but not limited to:

1) Black Lung Clinics,

2) Comprehensive Hemophilia Diagnostic Treatment Centers,

3) Title X Family Planning Clinics,

4) Sexually Transmitted Disease Clinics, and

5) Tuberculosis Clinics.

2. Must comply with all Health Resources and Service Administration's (HRSA's) regulations and requirements.

3. Must maintain detailed and auditable records regarding the compliance with all the Division of Medicaid's 340B program requirements and policies.

E. Covered entities:

1. Must notify the Division of Medicaid of their election to participate in or to terminate from the federal 340B program.

2. Who participate in the federal 340B drug program must notify the Division of Medicaid of their election to opt-in or opt-out of billing the Division of Medicaid for 340B purchased drugs and must comply with the following.

   a) The Division of Medicaid defines opt-in as a provider electing to dispense and/or administer drugs which have been purchased under the rules of the 340B federal program, and billing the Division of Medicaid for eligible Medicaid beneficiaries enrolled in either fee-for-service (FFS) or in a coordinated care organization (CCO). These covered entities must:

      1) Register, enroll and receive an identification number from HRSA.

      2) Complete, sign and submit the Division of Medicaid's 340B Covered Entity Attestation & Provider Enrollment Form to the Division of Medicaid indicating enrollment in the 340B program.

      3) Recertify with HRSA annually and notify the Division of Medicaid in writing by submitting the 340B Covered Entity Attestation & Provider Enrollment Form of any changes in 340B election status.

      4) Dispense/administer covered 340B drugs purchased under the 340B program only to eligible beneficiaries.

      5) Bill the Division of Medicaid according to Miss. Admin. Code Part 200, Rule 4.10.F.

      6) Submit drug invoices as required by the Division of Medicaid for auditing purposes.

   b) The Division of Medicaid defines opt-out as a covered entity electing never to bill the Division of Medicaid for 340B purchased drugs. These covered entities must complete, sign and submit to the Division of Medicaid the 340B Covered Entity Attestation & Provider Enrollment Form indicating election to opt-out.

   c) Covered entities must notify the Division of Medicaid immediately of any change in election in billing the Division of Medicaid for 340B purchased drugs.

F. 340B covered entities who have elected to opt-in must bill the Division of Medicaid for dispensed/administered 340B purchased drugs as follows:

1. For point-of-sale (POS) claims, pharmacy providers must bill the ingredient cost at the actual acquisition cost (AAC) in effect as of July 1, 2021, defined as the price the pharmacy paid the wholesaler or manufacturer for the 340B purchased drug with no mark-up plus the applicable professional dispensing fee. Providers must identify 340B purchased drugs dispensed or administered with the appropriate National Council for Prescription Drug Programs' (NCPDP) field values as defined by the Division of Medicaid.

2. For medical claims, providers must bill 340B purchased Physician Administered Drugs (PAD) at the same cost in effect for State Fiscal Year (SFY) 2021, with the appropriate modifier to identify the 340B purchased drug and the corresponding Healthcare Common Procedure Coding System (HCPCS) and National Drug Code (NDC).

G. Under Miss. Admin. Code Part 200, Rule 1.3, a provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under Federal and State criminal laws.

H. A contract pharmacy, defined by the Division of Medicaid as an agent of a 340B covered entity and ineligible to be a freestanding 340B covered entity, cannot dispense and bill the Division of Medicaid for 340B outpatient drugs for Medicaid beneficiaries.

I. A covered entity found in violation of Miss. Admin. Code Part 200, Rule 4.10.D.2. and D.3. is liable to the manufacturer of the covered outpatient drug that is the subject of the violation in an amount equal to the reduction in the price of the drug provided under the agreement between the entity and the manufacturer.

Source: 42 U.S.C. § 256b; 42 C.F.R Part 10; 42 C.F.R. § 447.512; Miss. Code Ann §§ 43-13-117, 43-13-121; SPA 17-0002.

History: Revised eff. 07/01/2021; Revised eff. 04/01/2019; Eff. 11/01/2018. Removed Miss. Admin. Code Part 200, Chapter 4, Rule 4.10, B, E, F, and J to correspond with the withdrawal of SPA 14-015 eff. 11/01/2014; New Rule eff. 07/01/2014 to correspond with SPA 14-015 (eff. 07/01/2014).

Part 200 Chapter 5: General

Rule 5.1: Medically Necessary

A. The Division of Medicaid will provide coverage for services when it is determined that the medically necessary criteria and guidelines listed below are met.

B. "Medically necessary" or "medical necessity" is defined as health care services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the patient's medical condition,

2. Compatible with the standards of acceptable medical practice in the United States,

3. Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms,

4. Not provided solely for the convenience of the beneficiary or family, or the convenience of any health care provider,

5. Not primarily custodial care

6. There is no other effective and more conservative or substantially less costly treatment service and setting available, and

7. The service is not experimental, investigational or cosmetic in nature.

C. All Mississippi Medicaid program policies, exclusions, limitations, and service limits, etc., apply. The fact that a service is medically necessary does not, of itself, qualify the service for reimbursement.

Source: Miss. Code Ann. § 43-13-121

Rule 5.2: Consent for Minors

A. Whenever a health care practitioner treats a Medicaid beneficiary, it is the responsibility of the practitioner to have a clear understanding of the legal framework within which care is to be provided to minors.

B. All Mississippi Medicaid providers are responsible for following and documenting compliance with their state law, federal laws, rules, policies, and/or guidance in the delivery of healthcare services to minors.

Source: Miss. Code Ann. § 43-13-121; § 41-41-3; 41-41-7; 41-41-13, 41-41-14; 41-41-13; §7129-81(h)(Supp. 1971)

Rule 5.3: Wellness Program

A. Wellness Services for Adults

1. Annual Health Screening/Physical Examinations for Beneficiaries for Adults (Age 21 and over)

a) The Division of Medicaid covers annual physical examinations for adults.

b) The annual physical examination will not be counted toward the physician visit limit of twelve (12) per fiscal year.

c) Appropriate age-related screenings such as those listed below will be reimbursed separately when performed as part of the annual physical exam.

1) Cardiovascular Screening - The Division of Medicaid will pay for an annual screening of cholesterol, lipids, and triglyceride levels.

2) Diabetes Screening - An annual screening for diabetes is covered. The screening may include appropriate laboratory and urine studies.

3) Cervical and Vaginal Cancer Screening - A Pap test and a pelvic exam are covered yearly for women.

4) Screening Mammography - The Division of Medicaid covers annual mammography for women beginning at age forty (40).

5) Colorectal Cancer Screening - A yearly screening for occult blood is covered for individuals beginning at age fifty (50), or individuals who are <50 and identified as high risk. A flexible sigmoidoscopy or barium enema is covered every five (5) years, or a colonoscopy is covered every ten (10) years. High risk individuals have one (1) or more of the following colorectal cancer risk factors:

d) A personal history of colorectal cancer or adenomatous polyps,

e) A personal history of chronic inflammatory bowel disease, either Crohn's disease or ulcerative colitis,

f) A strong family history of colorectal cancer or polyps including cancer polyps in a 1st degree relative [parent, sibling, or child] younger than sixty (60) or in two (2) or more 1st degree relatives of any age, or

g) A known family history of hereditary colorectal cancer syndromes such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colon cancer (HNPCC).

1) Prostate Cancer Screening - A prostate-specific antigen (PSA) blood test and digital rectal examination (DRE) are covered annually for men beginning at age fifty (50). Both screenings are covered annually beginning at age forty-five (45) for men of African-American descent.

2) Bone Density Studies are allowed every twenty-four (24) months for women age sixty-five (65) and older.

3) Vision and Glaucoma Screening eye exams are covered as specified in Part 217 Vision Services.

4) Influenza and Pneumonia Vaccines are covered services for both children and adults under Mississippi Medicaid as outlined in Part 224 Immunizations.

B. Wellness Services for Children (Under Age 21)

1. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, a mandatory service under Medicaid, provides preventive and comprehensive health services for Medicaid eligible children and youths up to age twenty-one (21). Children will access the mandatory periodic screening services through EPSDT providers. EPSDT providers will follow the Division of Medicaid's rules for the EPSDT Program.

2. No co-payment is applicable for services to children under age eighteen (18). The provider must report the co-payment Exception Code "C" on claims for beneficiaries under age eighteen (18). The codes for the periodic screening examinations do not apply toward the physician visit limit per fiscal year.

C. Wellness Services for Dual Eligibles

1. Beneficiaries whose Medicare Part B coverage begins on or after January 1, 2005 will have Medicare coverage for a one time only "Welcome to Medicare" Physical Examination within the first six (6) months of the Medicare coverage.

2. If the beneficiary has both Medicare and Mississippi Medicaid, the routine annual physical examination is not covered under Medicaid if the beneficiary is eligible for or has already received the "Welcome to Medicare" physical examination. The Division of Medicaid will not duplicate benefits for routine annual physical examinations covered by Medicare and will not provide an annual physical examination until twelve (12) months has elapsed from the original effective date of the Medicare Part B coverage. For these instances, it is the sole responsibility of the provider to determine whether Medicare or Mississippi Medicaid is the appropriate billing source.

3. Dual eligibles whose Medicare Part B effective date is prior to January 1, 2005 will be eligible for the physical examination as outlined above for adults or children.

D. Diagnostic and/or Screening Procedures are radiology and laboratory procedures which are a standard part of a routine adult annual age/gender physical examination or well child periodic screening may be billed by the provider performing the procedure, and coverage will be determined based on current Mississippi Medicaid policies for the individual procedures.

E. The Division of Medicaid covers a physical exam for beneficiaries enrolled in the Family Planning Waiver. [Refer to Part 221]

F. The Division of Medicaid does not cover an annual physical examination for:

1. School entrance,

2. Sports,

3. Employment, or

4. Beneficiaries in an institutional setting including those that are in a nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

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

History: Revised to correspond with SPA 23-0011 (eff. 5/01/2023) eff. 09/01/2023. Revised eff. 04/01/2018.

Rule 5.4: Tobacco Cessation

A. The Division of Medicaid covers up to twelve (12) in-person or telehealth tobacco cessation counseling sessions per State Fiscal Year, when provided by:

1. A physician, or

2. Other licensed practitioner that has prescriptive authority, operating within their scope of practice.

B. Tobacco Cessation Medications - The following types of tobacco cessation medications are covered in the Mississippi Medicaid program:

1. Over-the-counter nicotine products,

2. Legend or prescription nicotine replacement products,

3. Bupropion Hydrochloride, and

4. Varenicline Tartrate.

B. A physician's prescription will be required for all legend and over-the-counter tobacco cessation medications. Each prescription will count toward the monthly limit.

C. The Division of Medicaid will monitor the beneficiary's utilization of tobacco cessation products for over utilization or misuse; and in instances where there are patterns suggesting over utilization or misuse, the prescribing physician(s) will be contacted for justification of medical necessity.

Source: Miss. Code Ann. § 43-13-121

History: Revised to correspond with MS SPA 23-0024 (eff. 07/01/2023) eff. 01/01/2024.

Rule 5.5: Mobile Medical Units Other Than Independent Diagnostic Treatment Facilities

A. For Division of Medicaid purposes, a mobile medical unit is defined as a self-contained facility or unit that can be moved, towed, or transported from one location to another and provides prevention, screening, diagnostic, and treatment services. This rule and definition excludes services provided in an Independent Diagnostic Treatment Facility (IDTF). See Part 219, Rule 1.3.

B. Mobile medical units must satisfy the following criteria:

1. Must be owned and operated by a current Medicaid provider that has a permanent fixed office location where healthcare services are provided during normal business hours on a daily basis and the fixed office location is available for contact twenty-four (24) hours a day, seven (7) days a week.

2. Must maintain fixed schedule for locations.

3. Must have a separate Medicaid provider number from the permanent fixed office location

4. Must have a physician, physician assistant, dentist, certified audiologist, chiropractor, pharmacist, optometrist, ophthalmologist, or nurse practitioner available to furnish direct patient care services at all times during business hours.

5. Must have a written procedure that includes emergency follow-up care for beneficiaries treated in the mobile medical unit and arrangements for treatment in a facility which is permanently established in the area.

6. Must have communication capabilities which will enable the staff to contact necessary emergency personnel in the event of an emergency.

7. Must ensure the driver of the mobile unit possesses a valid Mississippi driver's license of the appropriate class, the vehicle has a current Mississippi motor vehicle tag, and the vehicle has had a current Mississippi motor vehicle inspection.

8. Must comply with all applicable federal, state, and local laws, regulations and ordinances governing biohazard waste, waste water (black and grey), construction, safety, sanitation, insurance, and zoning.

9. Must be accessible in accordance with the Americans with Disabilities Act.

10. Must have properly functioning sterilization system for sterilizing reusable medical equipment.

11. Must have access to an adequate supply of potable (suitable for drinking) and portable water, including hot water.

12. Must have access to toilets and sanitary hand washing facilities.

C. All service limits apply, and services are subject to all rules and regulations applied by the Mississippi Division of Medicaid for each program area.

D. Documentation

1. Beneficiary records must be maintained at the permanent fixed physical office location and a copy of the beneficiary's record must be maintained in the mobile unit.

2. At a minimum, the records must contain the following on each beneficiary:

a) Date of service,

b) History taken on initial visit,

c) Chief complaint on each visit,

d) Tests, radiographs and results. Radiographs must be legible, contain the beneficiary's name and the date, and must be maintained on file with the beneficiary's records,

e) Diagnosis,

f) Treatment, including prescriptions,

g) Signature or initials of provider after each visit, and

h) Copies of hospital and/or emergency room records that are available.

3. Providers must maintain proper and complete documentation to verify the services. The provider has full responsibility for maintaining documentation to justify the services provided. Maintenance of all records should be in compliance with Part 200, Chapter 1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; Americans with Disabilities Act

Rule 5.6: Diabetes Self-Management Training (DSMT)

A. The Division of Medicaid defines Diabetes Self-Management Training (DSMT) as an interactive and collaborative process through which beneficiaries with diabetes gain the knowledge and skills needed to modify their behavior and self-manage the disease and its related conditions.

B. The Division of Medicaid does not enroll a provider for the sole purpose of performing DSMT because DSMT is not a separately recognized provider type. The provider seeking reimbursement for DSMT must meet all of the required criteria set forth in Miss. Admin. Code Part 200, Rule 4.8 in addition to being:

1. A current Mississippi Medicaid provider,

2. Located in the State of Mississippi, and

3. Accredited by the American Diabetes Association (ADA) or the American Association of Diabetes Educators (AADE).

C. The Division of Medicaid covers DSMT when medically necessary, ordered by a physician, physician assistant, or nurse practitioner who is actively managing the beneficiary's diabetes, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or a designated entity and when all the following criteria are met:

1. The beneficiary has been diagnosed with diabetes by a physician,

2. The services are provided under the direct supervision of a physician, physician assistant, nurse practitioner, pharmacist or a registered nurse certified as a diabetes educator, and

3. The program meets the current ADA training standards.

D. The DSMT Plan of Care must include, but is not limited to:

1. An assessment of the beneficiary's specific needs for training,

2. Identification of the beneficiary's specific diabetes self-management goals,

3. Behavioral interventions directed toward helping the beneficiary achieve identified self-management goals, and

4. Evaluation of the beneficiary's progress towards identified self-management goals.

E. DSMT includes:

1. One (1) initial training per lifetime which:

a) Must be provided within a continuous six (6) month period which begins with the initial individual assessment visit.

b) Cannot exceed a total of seven (7) hours, provided in increments no less than thirty (30) minutes, which:

1) May include up to one (1) hour of individual training for assessment of the beneficiary's training needs.

2) Includes up to six (6) hours of training in a group setting consisting of two (2) or more individuals except when the ordering physician determines:

(a) A beneficiary would benefit from individual sessions instead of group sessions which the physician's order must include a statement specifying DSMT training in individual sessions along with an explanation, or

(b) A medical condition prevents the beneficiary from completing the seven (7) hours of initial training within six (6) months. Prior authorization for an extension to the six (6) month time-frame must be obtained from the UM/QIO.

2. Follow-up training which:

a) Must be ordered by the physician actively managing the beneficiary's diabetes, including documentation in the medical record of the specific medical condition that the follow-up training must address,

b) Is furnished any time in a year following the year in which the beneficiary completes the initial training,

c) Includes a maximum of two (2) hours each year,

d) Is furnished in increments of no less than thirty (30) minutes, and

e) Is provided in group sessions consisting of two (2) or more individuals unless the ordering physician determines a beneficiary would benefit from individual sessions instead of group sessions. The physician's order must include a statement specifying DSMT training in individual sessions along with an explanation.

F. Beneficiaries under the age of eighteen (18) must be accompanied by a parent/guardian/legal representative.

G. The Division of Medicaid pays for all medically necessary services for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: 42 CFR § 410.141; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Moved from Miss. Admin. Code Part 202, Rule 2.11 and revised Miss. Admin. Code Part 200, Rule 5.6.C. eff. 12/01/2015; New Rule eff. 04/01/2015.

Rule 5.7: Electronic Health Records

A. The Division of Medicaid recognizes an electronic health record (EHR) as an electronic version of a beneficiary's medical history and key administrative clinical data relevant to a beneficiary under the care of a particular provider, that is maintained by a provider over time, and may include, but is not limited to:

1. Demographics,

2. Progress notes,

3. Problems,

4. Medications,

5. Vital signs,

6. Past medical history,

7. Immunizations,

8. Laboratory data, and

9. Imaging data.

B. A provider may use an electronic signature (e-signature) in an EHR. E-signatures in EHR must:

1. Meet certified electronic health record technology (CEHRT) criteria according to the National Institute of Standards and Technology (NIST) and the Office of the National Coordinator for Health Information Technology (ONC) standards,

2. Be in compliance with both Uniform Electronic Transactions Act (UETA) and Electronic Signatures in Global and National Commerce Act (ESIGN Act) standards, and

3. Maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA) in regards to the access, transfer, storage and signing of EHRs.

4. Comply with Division of Medicaid requirements regarding e-signatures. [Refer to Miss. Admin. Code Part 200, Rule 1.10.]

C. A beneficiary may use an e-signature in an EHR. The beneficiary must:

1. Consent to the use of an electronic signature when completing necessary forms, including, but not limited to, the consent for treatment.

2. Be given the option to use an electronic or handwritten signature.

3. Be furnished an electronic or printed copies of all documents electronically signed.

4. Comply with Division of Medicaid requirements regarding e-signatures. [Refer to Miss. Admin. Code Part 200, Rule 1.10.]

Source: 42 C.F.R. § 435.907; Miss. Code Ann. §§ 43-13-117, 43-13-121, 75-12-1 et. seq.

History: Revised eff.04/01/2020; New eff. 07/01/2019.

Part 200 Chapter 6: Indian Health Services

Rule 6.1: Provision of Indian Health Services

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

Source: Miss. Code Ann. § 43-13-121; Public Law 93-638; Public Law 94-437

Rule 6.2: Beneficiary Enrollment

Applicants of American Indian/Alaskan Native descent are subject to the same eligibility criteria as any other applicant. Refer to Part 200, Chapter 3, Rule 3.1.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 136.12

Rule 6.3: Provider Enrollment/Participation Requirements

A. Indian Health Service (IHS) Facilities/Tribal 638 Health Facilities - In accordance with Sec. 1911.[42 U.S.C. 1396j] (a) (b) the Division of Medicaid accepts Indian Health Service Facilities/Tribal 638 Health Facilities as Medicaid providers on the same basis as other qualified providers. IHS/Tribal 638 facilities must meet all applicable standards for state licensure but need not obtain a state license. Refer to Part 200 Chapter 4, Rule 4.2 for Conditions of Participation.

B. All Other Providers - All other providers must complete the enrollment requirements for their respective provider type. Refer to Part 200 Chapter 4, Rule 4.2.

Source: Miss. Code Ann. § 43-13-121; 42 USC 1396j(a)(b)

Rule 6.4: Covered Services

American Indians/Alaskan Natives who meet the Division of Medicaid eligibility criteria receive the same benefits as any other beneficiary in the same category of eligibility. All limitations, exclusions, and prior authorization requirements apply.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 136.11

Rule 6.5: Reimbursement

A. Indian Health Service (IHS) Facilities/Tribal 638 Health Facilities/Providers

1. In accordance with Social Security Act, the Division of Medicaid will reimburse Indian Health Service Facilities/Tribal 638 Health Facilities/Providers as follows:

    a) Inpatient Hospital - per diem rate

    b) Outpatient Hospital, includes physician and clinic services – encounter rate

    c) Dental Services – encounter rate

    d) Other approved providers will be reimbursed according to the current payment methodology, e.g., fee for service, per diem, encounter etc., for the respective provider type.

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

B. Non-Indian Health/Tribal 638 Providers who are not Indian Health Service Facilities/Tribal 638 Facilities will be reimbursed according to the current payment methodology, e.g., fee for service, per diem, encounter, etc. for the respective provider type.

Source: Miss. Code Ann. § 43-13-121; Sec. 1911. [42 U.S.C. 1396j] (a)(b)(c)(d); Section 1905(b)

Rule 6.6: Cost-Sharing

A. An American Indian/Alaska Native who is eligible to receive or has received an item or service by an Indian health care provider or through referral under contract health services is exempt from Medicaid premiums.

B. American Indians/Alaska Natives who are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services are exempt from all Medicaid cost-sharing.

Source: 42 C.F.R. § 447.56; Miss. Code. Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 10/01/2019