MISSISSIPPI DIVISION OF
MEDICAID

# Administrative Code

# Title 23: Medicaid
# Part 202
# Hospital Services

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**Title 23: Division of Medicaid**

**Part 202: Hospital Services**

**Part 202 Chapter 1: Inpatient Services**

*Rule 1.1: Definitions*

A. Medicaid considers a patient an inpatient if formally admitted as an inpatient with the expectation that he/she will remain at least overnight and occupy a bed even though it later develops that he/she can be discharged or is transferred to another hospital and does not actually use a hospital bed overnight.

B. Inpatient services are services that are ordinarily furnished by the hospital for the care and treatments of the beneficiary, solely during his/her stay in the hospital.

C. 3-Day Payment Window

1. The 3-day Payment Window Rule applies to inpatient stays in hospitals, or an entity wholly owned or operated by an acute facility, paid under the APR-DRG methodology and the inpatient claims must include the following:

    a) Diagnostic services provided to a beneficiary within three (3) days prior to and including the date of an inpatient admission and;

    b) Therapeutic (non-diagnostic) services related to an inpatient admission and provided to a beneficiary within three (3) days prior to and including the date of the inpatient admission:

        1) Therapeutic services clinically distinct or independent from the reason for the beneficiary's inpatient admission may be separately billed on an outpatient claims with the appropriate code.

        2) Such separately billed services are subject to review. Medical record documentation must support that the services are unrelated to the inpatient admission.

2. Maintenance renal dialysis provided on an outpatient basis within the three (3) days prior to and including the date of an inpatient admission may be separately billed and separately paid.

3. Although the Division of Medicaid's policy is based on Medicare policy, Medicaid's policy applies if there is a difference.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 440.2; 440.10

History: Revised - 10/01/2012

*Rule 1.2: Provider Enrollment*

Hospital providers, including psychiatric hospitals and swing bed providers applying for enrollment into the Medicaid program must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

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

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

C. CLIA certificate and completed certification form.

D. Licensed freestanding psychiatric hospitals must submit Joint Commission on Accreditation of Health Care Organization (JCAHO).

E. Copy of current Medicare certification or Tie-In Notice. EOMB is not acceptable.

F. Out of state facility: Copy of outstanding claims, if applicable.

G. Copy of hospital license

1. Out-of-state facility: Copy of license/certification in effect during the claims period for which they are billing.

2. In-state facility: A copy of letter from the Mississippi State Department of Health is acceptable.

3. Hospital undergoing a Change of Ownership (CHOW): License in effect for the new owner.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 482.11

*Rule 1.3: Prior Authorization of Inpatient Hospital Services*

A. Requirement

1. Prior authorization is required from the appropriate Utilization Management/Quality Improvement Organization (UM/QIO) for all inpatient hospital admissions except for obstetrical deliveries and well newborns with a length of stay under six (6) days.

   a) Emergent admissions and urgent admissions must be authorized on the next working day after admission.

b) Failure to obtain the prior authorization will result in denial of payment to all providers billing for services including, but not limited to, the hospital and the attending physician.

2. Prior authorization must be obtained from the appropriate UM/QIO when a Medicaid beneficiary:

   a) Has third party insurance, and/or

   b) Is also covered by Medicare Part A only or Medicare Part B only.

3. Prior authorizations are not required for Medicaid beneficiaries who are also covered by both Medicare Part A and Part B unless inpatient Medicare benefits are exhausted.

4. Inpatient hospital stays that exceed the Diagnostic Related Group (DRG) Long Stay Threshold require a Treatment Authorization Number (TAN) for inpatient days that exceed the threshold.

B. Non-Approved Services

1. Medicaid beneficiaries in hospitals shall be billed for inpatient care occurring after they have received written notification of Medicaid non-approval of hospital services. Notification prior to the beneficiary's admission shall be cause to bill the beneficiary for full payment if he/she enters the hospital. Notification at or after admission shall be cause to bill the beneficiary for all services provided after receipt of the notice.

2. The hospital cannot bill the Medicaid beneficiary for an inpatient stay when it is determined upon retrospective review by the appropriate UM/QIO that the admission did not meet inpatient care criteria.

C. Maternity-Related Services

1. Hospitals must report all admissions for deliveries to the Division of Medicaid and the appropriate UM/QIO. The hospitals must report the admissions in accordance with the requirements provided by the Division of Medicaid and the appropriate UM/QIO. A TAN is issued to cover up to nineteen (19) days, the DRG Long Stay Threshold, for a delivery.

2. For admissions exceeding nineteen (19) days for a delivery, providers must submit a request for a continued stay in accordance with the policies and procedures provided by the appropriate UM/QIO.

D. Newborns

1. Well newborn services provided in the hospital must be billed separately from the mother's hospital claim.

   a) The hospital must notify the Division of Medicaid within five (5) calendar days of a

newborn's birth via the Newborn Enrollment Form located on the Division of Medicaid's website.

b) The Division of Medicaid will notify the provider within five (5) business days of the newborn's permanent Medicaid identification (ID) number.

2. The hospital must obtain a TAN for sick newborns requiring hospitalization whose length of stay is six (6) days or more. The baby's date of birth is the sick newborn's beginning date for certification. A sick newborn whose length of stay exceeds nineteen (19) days requires a concurrent review by the appropriate UM/QIO.

3. The hospital must obtain authorization for newborns delivered outside the hospital and newborns admitted to accommodations other than well baby.

Source: 42 USC § 1395f; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2015; Revised eff. 10/01/2012.

*Rule 1.4: Covered Services*

A. Covered inpatient services include:

1. Ancillary services.

2. Drugs, excluding take home drugs.

3. Supplies.

4. Oxygen.

5. Durable Medical Equipment.

6. The cost of implantable programmable baclofen drug pumps used to treat spasticity which are implanted in an inpatient hospital setting are reimbursed through the Mississippi Medicaid APR-DRG payment.

7. Newborn Hearing Screens - refer to Part 218.

8. Therapy Services

a) Therapeutic services ordinarily furnished to inpatients by the hospital, or by others under arrangements made by the hospital, are covered.

b) Inpatient services rendered by a psychologist or a therapist who is employed by the hospital, and whose services are normally included in the billing of the hospital, are covered in the same manner as the services of other non-physician hospital employees.

9. Inpatient Psychiatric Services are covered in the following settings as outlined:

   a) Acute Freestanding Psychiatric Facility

      1) Services available for children up to age twenty-one (21).

      2) Certification by the UM/QIO is required for the admission and for a continued stay after nineteen (19) days.

   b) Psychiatric Unit at a Medical Surgical Facility

      1) Services available to children or adults.

      2) Certification by the UM/QIO is required for the admission and for a continued stay after nineteen (19) days.

10. Inpatient or outpatient hospital services rendered to a beneficiary who leaves the hospital against medical advice.

11. Canceled or incomplete procedures related to the beneficiary's medical condition. Services performed before the surgical or other procedure is canceled or terminated before completion due to a change in the beneficiary's condition.

B. The division of Medicaid covers medically necessary inpatient procedures. Refer to Part 202, Chapter 5.

   1. Moved to Rule 5.3.

   2. Moved to Rule 5.6.

   3. Moved to Rule 5.4.

   4. Moved to Rule 5.1.

   5. Moved to Rule 5.2.

   6. Moved to Rule 5.5.

C. Hospitals with Multiple Accommodations:

   The Division of Medicaid does not specifically reimburse hospitals for the cost of accommodations. Billed charges do factor into the calculation of the APR-DRG outlier payments.

1. Private Room: When private room accommodations are furnished, the following rules will govern:

   a) Private Room/Critical Care Units – Medically Necessary – The reasonable cost/charges of a private room or other accommodations more expensive than semi-private are covered services when such accommodations are medically necessary. Private rooms will be considered medically necessary when the physician documents that the patient's condition requires him/her to be isolated for his/her own health or for the health of others. This includes the use of critical care units.

   b) Private Room – Not Medically Necessary – Based on Availability – When accommodations more expensive than semi-private are furnished, the assigned accommodations are considered medically necessary and cost/charges are covered by The Division of Medicaid if at the time of admission less expensive accommodations are not available (this includes hospitals with private rooms only.) The subsequent availability of semi-private or ward accommodations would offer to the hospital the right to transfer that patient to such accommodations or, at the express request of the patient, to allow him/her to continue occupancy of the private room as a private-room patient enjoying a personal comfort item and subject to be billed the room differential charge.

   c) Private Room – Requested by Beneficiary – When a private room is not medically necessary but is furnished at the beneficiary's request, the hospital may charge the patient no more than the difference between the customary charge for the accommodations furnished and the customary charge for the semi-private accommodations at the rate in effect at the time services are rendered. No such charge may be made to the patient unless he/she requested the more expensive accommodations with the knowledge that he/she would be charged the differential. The patient's account file, over the signature of an authorized hospital employee, should reflect the patient's knowledge that the differential charge will be expected.

   d) Deluxe Accommodations – The Division of Medicaid does not cover deluxe accommodations and/or deluxe services. These would include a suite/birthing suite, or a room substantially more spacious than is required for treatment, or specifically equipped or decorated, or serviced for the comfort and convenience of persons willing to pay a differential for such amenities. A room differential cannot be charged to the beneficiary when the differential is based on such factors as differences between older and newer wings, proximity to lounge, elevators or nursing stations, or a desirable view. Such rooms are standard on-bed units and not deluxe rooms for purposes of this instruction.

2. Semi-private Room – Two (2) beds per room – The Division of Medicaid will cover the reasonable cost/charges of semi-private accommodations.

3. Ward Accommodations – Three (3) or more beds per room – If less than semi-private accommodations are furnished, The Division of Medicaid will cover the cost/charges or

the accommodation furnished only if the patient requests such or when semi-private accommodations are not available. If less than semi-private accommodations are furnished because all semi-private rooms are filled, the patient should be transferred to semi-private accommodations as soon as one becomes available.

Source: Miss. Code Ann. §§ 43-13-117 (A)(1)(d)(e), 43-13-121: SPA 2012-008.

History: Revised Rule 1.4.B(1-6) eff. 10/01/2013: Rules 1.4A.8(a)(b), 1.4.A.9(a)(b), 1.4C. eff. 10/01/2012 to correspond with SPA 2012-008.

Chapter 5: Hospital Procedures

*Rule 1.5: Non-Covered Services*

A. Services provided in a geriatric psychiatric unit of a hospital.

B. Services rendered to a Medicaid beneficiary and billed by a physician employed by or contracted with the hospital.

C. Elective cancellation of procedures not related to the beneficiary's medical condition.

1. Surgical or other procedures canceled due to scheduling conflicts of the operating suite or physicians, beneficiary request, or other reasons not related to medical necessity.

2. Additional room and board days required due to rescheduling.

Source: Miss. Code Ann. § 43-13-121.

*Rule 1.6 - Refer to Chapter 5, Rule 5.1*

*Rule 1.7 - Refer to Chapter 5, Rule 5.2*

*Rule 1.8 - Refer to Chapter 5, Rule 5.3 and Rule 5.6*

*Rule 1.9 - Refer to Chapter 5, Rule 5.4*

*Rule 1.10 - Refer to Chapter 5, Rule 5.5*

*Rule 1.11: Documentation Requirements*

The hospital must maintain legible and auditable records that will substantiate the claim submitted to Medicaid. At a minimum, the records must contain the following on each patient:

A. Date of service.

B. A comprehensive history and physical assessment/report, including the patient's presenting

complaint.

C. Diagnosis(es) to substantiate the hospitalization and all treatments/procedures rendered during the hospitalization.

D. The specific name/type of all diagnostic studies, including lab, x-ray, and the like, and the medical indication and results/finding of the studies.

E. Documentation and consult reports to substantiate treatment/procedures rendered, the patient's response to the treatment/procedure; and the signature or initials of the appropriate health care worker providing the treatment/procedure, including but not limited to the physician, nurse, therapist, dietitian.

F. The name, strength, dosage, route, either IM, IV, PO, topical, enteral, intracatheter, date and time, indication for, and the administration of all medications administered to the patient.

G. Discharge planning and instructions, including the signature or initials of the health care worker performing the instruction; the name of the person being instructed; date and time of instruction; whether the instructions are given in writing, verbally, by telephone or other means; and how much instruction was comprehended by the beneficiary, including level of proficiency on return demonstration when a procedure is being taught.

H. Discharge orders for medications, treatments and procedures that indicate whether the orders/prescriptions are issued in writing, verbally, or by telephone, and to whom the orders are issued.

I. Signed physician orders for all medications, treatments, and procedures rendered to the patient.

J. All x-ray images, including films and digital images, films, and digital images must be of such quality that they can be clearly interpreted.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 424.13

*Rule 1.12: Disproportionate Share Hospital*

The Disproportionate Share Hospital (DSH) program and the qualifications for participation in the DSH program are defined in Attachment 4.19-A of the Medicaid State Plan.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 447.298

*Rule 1.13: Out-of-State Facilities*

A. Out-of-state hospitals are reimbursed under the APR-DRG payment methodology. The inpatient cost-to-charge ratios (CCRs) used to pay cost outlier payments for each out-of-state hospital are set annually using the Federal Register that applies to the federal fiscal year

beginning October 1 of each year, issued prior to the reimbursement period. The inpatient CCR is calculated using the sum of the statewide average operating urban CCR plus the statewide average capital CCR for each state.

B. For transplants not available in Mississippi, payment for transplant services performed outside of Mississippi is made under the MS APR-DRG payment methodology including a policy adjustor. If access to quality services is unavailable under the MS APR-DRG payment methodology, a case rate may be set as described in Part 202, Chapter 4, Rule 4.7.
C. For specialized services not available in Mississippi, the Division of Medicaid will make payment using the MS APR-DRG payment methodology. If MS APR-DRG payment limits access to care, the Division will reimburse what the domicile state pays for the service or a comparable payment other states reimburse under APR-DRG.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117(A)(1)(d); 42 CFR 431.52; 42 USC 1395f, also known as, Social Security Act § 1814

History: Revised - 01/01/2013, 10/01/2012

*Rule 1.14: Inpatient Hospital Payments*

A. For admissions dated October 1, 2012 and after, the Division of Medicaid reimburses all hospitals a per stay rate based on All Patient Refined Diagnosis Related Groups (APR-DRGs). APR-DRGs classify each case based on information contained on the inpatient Medicaid claim including diagnosis, procedures performed, patient age, patient sex, and discharge status. The APR-DRG payment is determined by multiplying the APR-DRG relative weight by the APR-DRG base rate. Medicaid uses a prospective method of reimbursement and will not make retroactive adjustments except as specified in the Title XIX Inpatient Hospital Reimbursement Plan.

B. Medicaid may adjust APR-DRG rates pursuant to changes in federal and/or state laws or regulations or to obtain budget goals. All Plan changes must be approved by the federal grantor agency.

C. Extraordinarily costly cases in relation to other cases within the same DRG because of the severity of the illness or complicating conditions may qualify for a cost outlier payment. This is an add-on payment for expenses that are not predictable by the diagnoses, procedures performed, and other statistical data captured by the DRG grouper.

1. The additional payment for a cost outlier is determined by calculating the hospital's estimated loss. The estimated loss is determined by multiplying the covered charges by the hospital's inpatient cost-to-charge ratio minus the DRG base payment. If the estimated loss is greater than the DRG cost outlier threshold established by the Division of Medicaid, then the cost outlier payment equals the estimated loss minus the DRG cost outlier threshold multiplied by the DRG Marginal Cost Percentage. For purposes of this calculation, the DRG base payment is net of any applicable transfer adjustment.

2. Stays assigned to mental health DRGs are not eligible for cost outlier payments, but may qualify for a day outlier payment if the mental health stay exceeds the DRG Long Stay Threshold.

D. Cost-to-Charge Ratio (CCR) Used to Calculate Cost Outlier Payments

1. The Cost-to-Charge Ratios (CCRs) use to calculate cost outlier payments are calculated annually for each provider by performing a desk review program developed by the Division of Medicaid, using the most recent filed cost report. The Division accepts amended original cost reports if the cost report is submitted prior to the end of the reimbursement period in which the cost report is used for payment purposes. If the provider's inpatient cost-to-charge ratio used to pay cost outlier payments is changed as a result of the amended cost report, no retroactive adjustments are made to cost outlier payments using the amended cost-to-charge ratio. After the amended desk review is completed and the thirty (30) day appeal option has been exhausted the new inpatient cost-to-charge ratio is entered into the Mississippi Medicaid Management Information System and is in effect from the date of entry through the end of the current reimbursement period.

2. Out-of-state hospitals are reimbursed under the APR-DRG payment methodology. The inpatient cost-to-charge ratios (CCRs) used to pay cost outlier payments for each out-of-state hospital are set annually using the Federal Register that applies to the federal fiscal year beginning October 1 of each year, issued prior to the reimbursement period. The inpatient CCR is calculated using the sum of the statewide average operating urban CCR plus the statewide average capital CCR for each state.

3. A Mississippi facility which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the sale. The seller must file a final cost report with the Division of Medicaid from the date of the last cost report to the effective date of the sale. The filing of a final cost report may be waived by the Division, if the cost report is not needed for reimbursement purposes. The new owner must file a cost report from the date of change of ownership through the end of the Medicare cost report year end. The new owner must submit provider enrollment information required under the Division of Medicaid policy.

4. The inpatient cost-to-charge ratio of the old owner is used to pay cost outlier payments for the new owner. The new owner's inpatient cost-to-charge ratio used to pay cost outlier payments is calculated for the first rate year beginning October 1, for which the new owner's cost report is available. There are no retroactive adjustments to a new owner's inpatient cost-to-charge ratio used to pay cost outlier payments.

5. New Mississippi hospitals beginning operations during a reporting year must file an initial cost report from the date of certification to the end of the cost report year end. Each rate year the inpatient cost-to-charge ratio used to pay outlier payments for each Mississippi hospital is grouped by bed class of facilities and an average inpatient cost-to-charge ratio is determined for each class. The initial inpatient cost-to-charge ratio used to pay cost

outlier payments to a new hospital will be the average inpatient cost-to-charge ratio used for the bed class of Mississippi hospitals as of the effective date of the Medicaid provider agreement until the inpatient cost-to-charge ratio is recalculated based on the new hospital's initial cost report. There are no retroactive adjustments to a new hospital's inpatient cost-to-charge ratio used to pay cost outlier payments.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117 (A)(1)(d); Social Security Act § 1814 142 USC 1395f; 42 U.S.C. § 139 SWW. Also known as Social Security Act § 1886; 42 CFR § 447.325

History: Revised - 10/01/2012

*Rule 1.15: Cost Reports*

A. Facilities must submit a Uniform Cost Report to Medicaid following the close of their Medicare Title XVIII approved year end. Any deviations to the reporting year, such as a Medicare approved change in fiscal year end should be submitted to Division of Medicaid in writing. In cases where there is a change in the fiscal year end, the most recent cost report is used to perform the desk review. All other filing requirements shall be the same as those for Title XVIII, unless specifically outlined in the Hospital State Plan.

B. Cost reports must be submitted on or before the last day of the fifth ($5^{th}$) month following the close of the reporting period. Should the due date fall on a weekend, a State of Mississippi holiday, or a federal holiday, the due date shall be the first ($1^{st}$) business day following such weekend or holiday. Medicaid does not grant routine extensions for cost reports. Extensions of time to file may be granted due to unusual situations or to match a Medicare filing. Extraordinary circumstances are considered on a case-by-case basis. Extensions may only be granted by the Executive Director of the Division of Medicaid.

C. Cost reports that are either postmarked or hand delivered after the due date will be assessed a penalty in the amount of fifty dollars ($50.00) per day the cost report is delinquent.

D. Hospitals that do not file a cost report within six (6) calendar months after the close of its reporting period are subject to cancellation of its Provider Agreement at the discretion of Medicaid.

E. All cost reports are required to detail their entire reporting year making appropriate adjustments as required by the Hospital State Plan for determination of allowable costs. The cost report must be prepared in accordance with the methods of reimbursement and cost findings in accordance with Title XVIII (Medicare) Principles of Reimbursement except where further interpreted by the Provider Reimbursement Manual, Section 2414 or as modified by the State Plan.

F. All cost reports must be filed with DOM. When it is determined that a cost report has been submitted that is not complete enough to perform a desk review, the provider is notified. The provider must submit a complete cost report. When it is determined that certain information

is missing, providers are allowed a specified amount of time to submit the requested information. For cost reports which are submitted by the due date, ten (10) working days from the date of the provider's receipt of the request for additional information are allowed for the provider to submit the additional information. If requested additional information has not been submitted by the specified date, an additional request for the information is made. The provider is given five (5) working days from the date of the provider's receipt of the second request for information. Information that is requested that is not submitted following either the first or the second request may not be submitted for reimbursement purposes. Providers are not be allowed to submit the information at a later date, the cost report may not be amended in order to submit the additional information, and an appeal of the disallowance of the costs associated with the requested information may not be made. Adjustments may be made to the cost report by the Division of Medicaid to disallow expenses for which required documentation, including cost findings, is omitted.

G. For cost reports submitted after the due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If there is no response to the request, an additional five (5) working days will be allowed for submission of the requested information. Hospitals that do not respond will not be allowed to submit the information at a later date, the cost report may not be amended in order to submit the additional information, and an appeal of the disallowance of the costs associated with the requested information may not be made. Adjustments may be made to the cost report by the Division of Medicaid to disallow expenses for which required documentation, including cost findings, is omitted.

H. Cost reports that are incomplete will be subject to the penalty provisions for delinquent cost reports until the required additional information is submitted.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1886(f)(1)(A), § 1886(b), § 1815(a), § 1833(e); 42 CFR § 412.52; 413.20, 413.24, 413.40

History: Revised - 10/01/2012

*Rule 1.16: Split Billing*

A. Under DRG-based payment, hospitals cannot split bill Medicaid claims when a stay crosses a state fiscal year end, cost report year end, or under any other circumstance.

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

Source: Miss. Code Ann. § 43-13-121; § 43-13-117 (A)(1)(d)

History: Revised - 10/01/2012

*Rule 1.17: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)*

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

*Rule 1.18: Review for Medical Necessity and/or Independent Verification and Validation (IV&V)*

A. The Division of Medicaid defines Review for Medical Necessity and/or Independent Verification and Validation (IV&V) as the Utilization Management/Quality Improvement Organization (UM/QIO) or Division of Medicaid, or designee, review of services of Medicaid beneficiaries in the inpatient setting for including, but not limited to, the following:

    1. Meeting clinical guidelines for medical necessity. [Refer to Part 200, Rule 5.1 for definition of medical necessity],

    2. Appropriateness of setting and quality of care,

    3. Appropriate lengths of stay and services, and

    4. Correct All Patient Refined Diagnosis Related Groups (APR-DRG) assignment.

B. The inpatient hospital provider must submit the requested documentation to the UM/QIO or the Division of Medicaid, or designee, within the specified time frame in the Notice.

C. Inpatient hospital providers may request an Administrative Appeal when the provider is dissatisfied with final administrative decisions of the Division of Medicaid relating to disallowances as a result of a review for medical necessity or an IV&V decision described in Miss. Admin. Code Part 202, Rule 1.18.A.

D. Providers must comply with the appeal provisions in Miss. Admin. Code Part 300, Rule 1.1.

Source: 42 CFR Part 456; 45 CFR § 307.15(b)(10); Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New eff. 09/01/2014.

**Part 202 Chapter 2: Outpatient Services**

*Rule 2.1: General*

Medicaid provides financial assistance for outpatient hospital services. An outpatient is a person who is being provided services by a hospital other than on an inpatient basis or for whom laboratory or radiology services are performed for a referring physician. All rules set forth in Part 202, Chapter 1, are applicable to outpatient services in addition to those specifically outlined in this chapter.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 440.20(a)

*Rule 2.2: Outpatient Hospital Services*

A. Medicaid defines outpatient hospital services as preventative, diagnostic, therapeutic, rehabilitative, or palliative services provided by a licensed hospital to an outpatient by or under the direction of a physician or dentist.

1. Medically necessary outpatient hospital services are covered when all of the following criteria apply:

   a) Outpatient services are provided in a clinic or other facility that is not located inside the hospital.

   b) The clinic or other facility has been designated as an outpatient facility by the hospital.

   c) The clinic or other facility was in operation or under construction on July 1, 2009. and

   d) The costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report.

2. For hospital clinics not located inside the hospital and constructed after July 1, 2009 the Medicare thirty five (35) mile rule will apply.

3. Outpatient services must be provided by hospital salaried or contracted employees. For purposes of this rule, contracted services are defined as hospital services provided according to a written agreement between a hospital and the health care professional providing the hospital services.

4. Hospitals may bill only for services provided in the hospital's outpatient department as defined above.

B. Off Site Services are services provided off site and outside of the outpatient hospital departments by contracted or employed hospital employees are not covered as outpatient hospital services.

C. Partial hospitalization programs or day treatment programs are not covered in an outpatient hospital setting. The Division of Medicaid defines partial hospitalization or day treatment programs as:

1. Those clearly billed as partial hospitalization/day treatment,

2. Those represented to the community as partial hospitalization programs or day treatment programs, or

3. Those billed to the Division of Medicaid using revenue and procedure codes reflecting multiple units or daily services.

D. Professional Fees are physician services performed in hospital owned physician clinics. Hospitals are covered and must be submitted under a physician group provider number.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 440.20(a)

*Rule 2.3: Emergency Department Outpatient Visits*

A. Emergency department services, also referred to as emergency room services, are allowed for all beneficiaries without limitations. Emergency department services provided by hospitals, except for Indian Health Services, are reimbursed using the outpatient prospective payment methodology.

B. Services provided during an emergency department visit resulting in an inpatient hospital admission must be included on the inpatient hospital claim.

1. The "Statement Covers Period From Date" on the inpatient hospital claim is the first date the beneficiary enters the emergency department.

2. The "Treatment Authorization Code" on the inpatient hospital claim is the Treatment Authorization Number (TAN) received from the Utilization Management and Quality Improvement Organization (UM/QIO) which corresponds with the date the physician documents the inpatient hospital admission in the physician's orders.

a) A TAN is not required for an emergency department visit directly preceding an inpatient admission.

b) A TAN issued by the UM/QIO is only required for an inpatient admission/continued stay.

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

History: Removed Rule 2.3.B language to correspond with SPA 2012-009 (eff. 09/01/2012) and added language for clarification with SPA 2012-008 (eff. 10/01/2012) eff. 11/01/2013, Revised eff. 01/01/2013, Revised eff. 11/01/2012, Revised eff. 09/01/2012.

*Rule 2.4: Outpatient (23-Hour) Observation Services*

A. Medicaid defines outpatient twenty-three (23) hour observation services as those services furnished on a hospital's premises, whether in an emergency department or a designated non-critical care area, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate a beneficiary's condition or determine the need for possible admission as an inpatient.

1. The terms “outpatient observation”, “twenty-three (23) hour observation”, and/or “day patient” are interchangeable.

2. The availability of outpatient observation services does not mean that services for which an overnight stay is anticipated may be performed and billed to the Division of Medicaid on an outpatient basis.

B. Outpatient observation services must be documented in the physician’s orders by a physician or other individual authorized by hospital staff bylaws to admit patients to the hospital or to order outpatient diagnostic tests or treatments. The decision for ordering outpatient hospital observation services or an inpatient hospital admission is solely the responsibility of the physician. Factors that must be taken into consideration by the physician or authorized individual when ordering outpatient observation are:

1. Severity of the beneficiary’s signs and symptoms,

2. Degree of medical uncertainty the beneficiary may experience an adverse occurrence,

3. Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the beneficiary to remain at the hospital for more than twenty-three (23) hours to assist in assessing whether the beneficiary should be admitted, and

4. Availability of diagnostic procedures at the time and location where the beneficiary seeks services.

C. Non-Covered Services

1. Medicaid does not cover more than twenty-three (23) consecutive hours in an observation period and only covers service that are appropriate to the specific medical needs of the beneficiary.

2. Medicaid considers the following as non-covered outpatient observation services:

a) Substitution of outpatient services provided in outpatient observation for physician-ordered inpatient hospital services.

b) Services not reasonable, necessary or cost effective for the diagnosis or treatment of a beneficiary.

c) Services provided solely for the convenience of the beneficiary, facility, family or the physician.

d) Excessive time and/or amount of services medically required by the condition of the beneficiary.

e) Services customarily provided in a hospital-based outpatient surgery center and not supported by medical documentation of the need for outpatient observation services.

f) Discharging beneficiaries receiving inpatient hospital services to outpatient observation services.

g) Services for routine preparation and recovery of a beneficiary following diagnostic testing or therapeutic services provided in the facility.

h) Services provided when an overnight stay is planned prior to, or following, the performance of procedures such as surgery, chemotherapy, or blood transfusions.

i) Services provided in an intensive care unit.

j) Services provided without a physician's order and without documentation of the time, date, and medical reason for outpatient observation services.

k) Services provided without clear documentation as to the unusual or uncommon circumstances that would necessitate outpatient observation services.

l) Complex cases requiring inpatient hospital services.

m) Routine post-operative monitoring during the standard recovery period.

n) Routine preparation services furnished prior to diagnostic testing in the hospital outpatient department and the recovery afterwards.

o) Outpatient observation services billed concurrently with therapeutic services such as chemotherapy or physical therapy.

D. Medical Records Documentation

1. The medical record must substantiate the medical necessity for observation including appropriateness of the setting. When the outpatient observation setting is non-covered, all services provided in the outpatient observation setting are also non-covered.

2. Documentation in the medical record must include:

a) Orders for outpatient observation services and the reason for outpatient observation services must be documented in the physician's orders and not the emergency department record and must specify "admit to observation." Only an original or electronic signature is acceptable.

b) Changes from "outpatient observation to "inpatient hospital" must be ordered by a physician or authorized individual.

c) Changes from outpatient observation services to inpatient hospital services must be supported by documentation of medical necessity.

d) A physician's order for inpatient hospital admission and discharge from outpatient observation.

e) Documentation a physician had face-to-face contact with the beneficiary at least once during outpatient observation.

f) The actual time of outpatient observation and the services provided.

E. Billing

1. Medicaid considers the twenty-three (23) hour outpatient observation stay as an outpatient service when the stay does not result in an inpatient hospital admission.

2. Services provided during outpatient observation resulting in an inpatient hospital admission must be included on the inpatient hospital claim.

   a) The "Statement Covers Period From Date" on the inpatient hospital claim is the first date the beneficiary received outpatient observation services.

   b) The "Treatment Authorization Code" on the inpatient hospital claim is the Treatment Authorization Number (TAN) received from the Utilization Management and Quality Improvement Organization (UM/QIO) which corresponds with the date the physician documents the inpatient hospital admission in the physician's orders.

      1) A TAN is not required for outpatient observation services directly preceding an inpatient admission.

      2) A TAN issued by the UM/QIO is only required for an inpatient admission/continued stay.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §§ 440.2(a) 482.24(c); SPA 2012-008.

History: Revised E.2. to correspond with SPA 2012-008 (eff. 10/01/2012) and added language for clarification to E.2. eff. 11/01/13.

*Rule 2.5: Outpatient Dialysis*

Services provided in hospital-based renal dialysis units (RDU) are covered and are not subject to any visit limitations.

Source: Miss. Code Ann. § 43-13-121, 43-13-117(2)

*Rule 2.6: Mental Health Services*

A. Mental Health services are covered when:

1. Provided in an outpatient department of a general hospital, and outpatient mental health services are not covered in acute freestanding psychiatric facilities.

2. Prior authorized through the Utilization Management and Quality Improvement Organization (UM/QIO). Failure to obtain prior authorization will result in denial of payment.

B. Outpatient hospital mental health services will be reimbursed using the same methodology as other outpatient hospital services.

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

*Rule 2.7: Out-of-State Facilities*

Out-of-state hospitals will be reimbursed using the same methodology as Mississippi hospitals.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117 (A)(2)(c); 42 CFR § 431.52

History: 9/1/2012

*Rule 2.8: Outpatient Rates*

A. Except as otherwise specified all outpatient hospital services for all hospitals except Indian Health Services will be reimbursed under a prospective payment methodology.

B. Hospital-based clinics may not bill facility fees unless they are a teaching hospital with a resident-to-bed ratio of 0.25 or greater.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117 (A)(2)(c); 42 CFR § 447.321

History: 9/1/2012

*Rule 2.9: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)*

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

*Rule 2.10: Phase II Cardiac Rehabilitation Services*

The Division of Medicaid defines Phase II Cardiac Rehabilitation services as a physician supervised program designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to their optimal functional status including their physiological, psychological, social, vocational and emotional status including, but not limited to:

1. Formal exercise sessions with continuous electrocardiographic (ECG) monitoring,

2. Risk factor education, and

3. Behavior modification counseling.

Providers must comply with all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to:

Being a current Mississippi Division of Medicaid provider,

Being located in the state of Mississippi, and

Holding a current certification from the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR).

C. The Division of Medicaid covers Phase II Cardiac Rehabilitation services for beneficiaries eighteen (18) and older for one (1) of the qualifying episodes:

1. Acute myocardial infarction within the preceding twelve (12) months,

2. Coronary artery bypass graft within six (6) months,

3. Percutaneous transluminal coronary angioplasty or percutaneous coronary intervention within six (6) months,

4. Heart valve repair/replacement within six (6) months,

5. Heart transplant within one (1) year, or

6. Stable angina positive stress test within six (6) months.

D. The Division of Medicaid covers up to thirty-six (36) Phase II Cardiac Rehabilitation sessions per twelve (12) months regardless of the number of qualifying episodes.

1. The twelve (12) month period begins with the initiation of Phase II Cardiac Rehabilitation.

2. Phase II Cardiac Rehabilitation is covered for only one (1) qualifying episode during the twelve (12) month period.

3. The thirty-six (36) Phase II Cardiac Rehabilitation sessions must occur within twelve (12) weeks from initiation of services unless a medical condition prevents the beneficiary from completing the thirty-six (36) sessions. Prior authorization for the extension must be obtained from the Utilization Management and Quality Improvement Organization (UM/QIO) up to an additional twelve (12) weeks.

E. Phase II Cardiac Rehabilitation Services must be:

Furnished in the outpatient hospital setting with physician supervision as required in compliance with AACVPR guidelines, and

2. Prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO).

F. The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: 42 CFR § 410.49; Miss. Code Ann. § 43-13-121.

History: New Rule eff. 02/01/2014.

*Rule 2.11: Refer to Part 200, Chapter 5, Rule 5.6*

**Part 202 Chapter 3: Swing Beds**

*Rule 3.1: Definition*

Swing bed services are extended care services provided in a hospital bed that has been designated as such. Services consist of one or more of the following:

A. Skilled nursing care and related services for patients requiring medical or nursing care,

B. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and

C. On a regular basis, health related care and services to individuals who, because of their medical status, require care and services above the level of room and board which can be made available to them only through institutional facilities.

Source: Miss. Code Ann. § 43-13-121

*Rule 3.2: Certification of Providers/ Provider Enrollment*

A. The Division of Medicaid requires any hospital certified for participation in the Medicare swing bed program who wants to participate in the Medicaid program to become a provider. A separate provider number from the hospital is required for the swing bed.

B. Hospital providers, including swing bed providers applying for enrollment into the Medicaid program must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to submitting the following provider type specific requirements:

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

2. Written confirmation from the IRS confirming the provider's tax identification number and legal business name.

3. CLIA certificate and submit the completed certification form.

4. Joint Commission on Accreditation of Health Care Organization (JCAHO) for licensed hospitals.

5. Copy of current Medicare certification or Tie-In Notice. Explanation of Medicare Benefits (EOMB) is not acceptable.

6. Copy of outstanding claims, if applicable, for out-of state facility.

7. Copy of Hospital license:

   a. Copy of license/certification, in effect during the claims period for which they are billing for out-of state facility.

   b. In-state facility: A copy of letter from the Mississippi State Department of Health is acceptable for in-state facility.

   c. License in effect for the new owner for Hospital undergoing a Change of Ownership (CHOW).

Source: Miss. Code Ann. § 43-13-121

*Rule 3.3: Coverage Criteria*

A. Swing bed services are covered when all these criteria are met:

1. Services to be furnished are ordered by a physician, are consistent with the nature and severity of the beneficiary's illness or injury, medical needs, and accepted standards of medical practice, and are reasonable in duration and quantity,

2. The beneficiary requires daily and continuous (not intermittent) skilled nursing and/or rehabilitation services to prevent or minimize deterioration or to sustain health status,

3. The beneficiary does not require daily supervision of a physician but does require a

physician visit and evaluation at least every thirty (30) days while the beneficiary is in the swing bed setting,

4. A nursing facility bed is not available and the required services cannot be safely and effectively provided in the beneficiary's residence,

5. In addition to the need for skilled nursing and/or rehabilitation services, the beneficiary must require, at a minimum, assistance with at least three (3) activities of daily living (eating, toileting, personal hygiene, bathing, ambulation, dressing) which cannot be safely and cost-effectively provided in the beneficiary's residence and which must be performed by, or under the supervision of, registered nurses, licensed practical nurses, physical therapists, or occupational therapists.

6. Swing bed services may be covered as long as the beneficiary meets the coverage criteria and there is no available bed in a nursing facility. It is expected that the beneficiary will be discharged or transferred to a nursing facility when the beneficiary's condition allows or a nursing home bed becomes available.

B. Swing bed services are not covered when the beneficiary does not meet the coverage criteria in this Part. Examples include, but are not limited to, the following:

1. The primary service is oral medications.

2. The beneficiary is capable of independent ambulation, dressing, feeding, toileting, and hygiene.

3. Insulin injections are the only service a beneficiary is receiving, and prior to hospitalization, the beneficiary was on self-injections at the beneficiary's residence.

4. The beneficiary and/or primary caregiver are capable of being taught to safely perform the necessary treatment at the beneficiary's residence.

5. When services can be safely and more cost-effectively provided in the beneficiary's residence.

6. If the beneficiary needs intermittent rather than daily and continuous care.

7. If a beneficiary's condition requires an acute inpatient hospital level of care.

Source: Miss. Code Ann. § 43-13-121

*Rule 3.4: Reimbursement*

A. Individuals who are placed in swing beds in a hospital may have Medicare only, Medicare and Medicaid, or Medicaid only.

1. In all instances where a Medicaid beneficiary is covered by Medicare, Medicare is the primary payer for a swing bed stay.

2. Medicaid covers swing bed care for Medicare and Medicaid dual eligibles when:

   a) The Medicaid beneficiary's medical condition does not qualify for Medicare, or

   b) Medicare benefits are exhausted.

B. The methods and standards used to determine payment rates to hospital providers of nursing facility (NF) services furnished by a swing bed hospital provides for payment for the routine NF services at the average rate per patient day paid to NFs for routine services furnished during the previous calendar year.

C. Beneficiaries who have Part A Medicare are the responsibility of the Medicare program when in a swing bed. Medicaid will cover the Medicare coinsurance after the 20th consecutive day in a swing bed for Medicare/Medicaid beneficiaries through day one hundred (100) or the last day covered by Medicare, whichever comes first.

D. The swing bed facility must provide and pay for all services and supplies required by the plan of care and ordered by a physician. During the course of a covered Medicaid stay, the facility may not charge a resident for the following items and services:

1. Nursing services,

2. Specialized rehabilitative services,

3. Dietary services,

4. Activity programs,

5. Room/bed maintenance services,

6. Routine personal hygiene items and services,

7. Personal laundry, or

8. Drugs not covered by the Medicaid Pharmacy program.

E. Any items or service not covered in the per diem rate must be billed outside the per diem rates and include:

1. Items and services covered by Medicare Part B or any other third party.

2. Any service or supply billed directly to Medicaid for swing bed residents including:

a) Lab services,

b) X-rays,

c) Drugs covered as specified in Part 214,

d) Therapy services as specified in Part 213, or

e) Durable Medical Equipment as specified in Part 209.

Source: Miss. Code Ann. § 43-13-121; Omnibus Budget Reconciliation Act of 1987 (OBRA 87) Pub. L. 97-35, Section 2153

*Rule 3.5: Documentation Requirements*

A. The Division of Medicaid requires providers of swing bed services to maintain auditable records that substantiate the services provided. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3. At a minimum, the records must contain the following on each beneficiary:

1. Date of service,

2. History and physical exam, with update if necessary,

3. Physician's progress notes,

4. Medical indication,

5. Results and finding of all diagnostic and lab procedures,

6. Treatment rendered,

7. Provider's signature or initials,

8. Documentation of services consisting of skilled nursing care and related services for patients requiring medical or nursing care,

9. Documentation of rehabilitation services for the rehabilitation of injured, disabled or sick persons, and

10. Frequent documentation of health related care and services to individuals who, because of their medical status, require care and services above the level of room and board which can be made available only through institutional facilities.

Source: Miss. Code Ann. § 43-13-121, 43-13-117, 43-13-118

**Part 202 Chapter 4: Organ Transplants**

*Rule 4.1: Transplant Procedures*

A. Medicaid covers benefits for transplants listed in Rules 4.9 – 4.18 in this Chapter if the transplant facility obtains prior approval (PA), when required, and satisfies all criteria listed in the Rule.

B. Requests for prior approval must be sent to Medicaid's Utilization Management/Quality Improvement Organization (UM/QIO). Providers should submit requests as soon as it is determined that the beneficiary may be a potential candidate for transplant.

C. Transplant benefits are dependent on all of the following:

1. The beneficiary must be eligible for Mississippi Medicaid.

2. The beneficiary's prior authorization request for the transplant must be approved by the UM/QIO.

3. Prior authorization is required for Medicaid hospital inpatient transplant admissions.

4. A transplant beneficiary whose length of stay exceeds nineteen (19) days requires concurrent review by the UM/QIO.

5. All conditions of third party liability procedures must be satisfied.

6. All providers must complete requirements for participation in the Mississippi Medicaid program.

7. All claims must be submitted according to the requirements of the Mississippi Medicaid program.

8. All charges, both facility and physician, relating to procurement/storage must be billed by the transplant facility on the current UB claim form with the appropriate revenue code(s).

9. The transplant facility must provide appropriate medical records, progress or outcome reports as requested by Medicaid, the UM/QIO or the fiscal agent.

10. The transplant procedure must be performed at the facility requesting transplant approval.

D. Transplant procedures/services subject to denial include, but are not limited to, the following:

1. Transplant procedures/services when medical necessity has not been proven.

2. Transplant procedures/services still in clinical trials and/or investigative or experimental

in nature.

3. Transplant procedures/services performed in a facility not approved by Medicaid.

4. Inpatient or outpatient admissions for transplant procedures/services that have not been certified/re-certified by the UM/QIO.

E. Pancreas transplants are not covered by Medicaid. Pancreas transplants done in conjunction with another covered transplant procedure will only be covered for those charges related to the covered transplant procedure.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117 (A)(1)(e); 42 CFR 441.35; 42 CFR 482.90 - 482.104

History: Revised - 10/01/2012

*Rule 4.2: Organ Acquisition*

A. Medicaid covers all charges, facility and physician, relating to acquisition, whether cadaveric or living donor, to the transplant facility using the appropriate revenue codes.

B. Donor related charges may include the following:

1. A search for matching tissue, bone marrow, or organ.

2. Donor's transportation.

3. Charges for removal, withdrawal, and preservation/storage

4. Donor's hospitalization.

C. Medically necessary follow-up care outside of the transplant admission for the living donor is covered only if the donor is a Mississippi Medicaid beneficiary and is reimbursed as routine benefits under the APR-DRG payment method.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117 (A)(1)(d); § 43-13-117 (A)(2)(c); 42 CFR 441.35; 42 CFR 482.90 – 482.104

History: Revised - 10/01/2012

*Rule 4.3: Fundraising*

A. Fundraisers may be used to obtain funds needed for transplant costs not normally covered by Medicaid program.

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. 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. Mixed funds could be counted as income or an asset which could result in a loss or reduction of Medicaid benefits.

5. Legible documentation of 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.

6. The beneficiary must report all sources of income to the source of eligibility. Donated funds for the purpose of payment of medical services are considered a third party source.

7. Transplant facilities/providers cannot participate in fundraising for beneficiaries to raise additional funds to pay for the transplant procedure and/or related services.

Source: Miss. Code Ann. § 43-13-121

*Rule 4.4: Prior Approval*

A. Medical necessity for transplants, except those listed below, must be prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), regardless of the age of the beneficiary.

   1. Kidney transplants,

   2. Cornea transplants, or

   3. Bone marrow/peripheral stem cell transplants.

B. Prior authorization for **all** hospital transplant admissions is required from the UM/QIO.

C. Transplants on beneficiaries with Medicare coverage do not require prior approval.

D. Prior authorization from the UM/QIO is required on transplants when the beneficiary has

third party coverage and the hospital intends to bill Medicaid for any transplant related hospital charges.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.35; 42 CFR 482.90 - 482.104

History: Revised - 10/01/2012

*Rule 4.5: Facility Criteria*

A. Medicaid requires organ transplant procedures to be performed in a Medicare approved transplant facility, unless otherwise authorized by Medicaid.

B. Bone marrow/peripheral stem cell transplant facilities must meet the following medical, experience and administrative criteria:

1. Medical Criteria

a) The facility must have written criteria for transplant candidate selection and a written implementation plan.

b) The facility must have a written transplant candidate management plan/protocol that includes both evaluative and therapeutic procedures for the waiting period, in-hospital period, and post-transplant phases of treatment.

c) The facility must make a sufficient commitment of resources and planning to the transplant program to demonstrate the importance of the program at all levels. Indications of this commitment must be broadly evident throughout the facility. The facility must use a multidisciplinary team that includes representatives with expertise in the appropriate organ specialty (ex: hepatology, cardiology, or pulmonology) and the following general areas: transplant surgery, vascular surgery, anesthesiology, immunology, infectious diseases, pathology, radiology, nursing, blood banking, and social services.

2. Experience Criteria

a) The facility's volume of transplants and survival rates must demonstrate both experience and success with bone marrow and/or peripheral stem cell transplantation. The facility staff must have performed a reasonable number of successful transplants for each transplant type for which Medicaid approval is sought.

b) The facility must provide documentation to support the current competence of its transplant physicians and transplant surgeons, and, if requested, its transplant-specific and general clinical staff. The qualifications and transplant experience of transplant physicians and surgeons specified by UNOS (UNOS bylaws Appendix B – III (2): Liver; (4): Heart; and (5): Lung and Heart-Lung) will be considered appropriate for each specified transplant program.

3. Administrative Criteria

a) The facility must make an active member of the Organ Procurement and Transplant Network (OPTN) and abide by its approved rules. The facility must also have an agreement with an Organ Procurement Organization (OPO).

b) The facility must make available, either directly or by specified arrangements, all laboratory services needed to meet the needs of transplant candidates/recipients.

c) The facility must agree to maintain and, when requested, periodically submit clinical data, including pre-certification, concurrent review, and other requested information to Medicaid or to the UM/QIO.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 121; 42 CFR § 482.90 – 482.104; 42 CFR 482.12

History: Revised - 10/01/2012

*Rule 4.6: Documentation Requirements*

Providers of transplant services must document and maintain records in accordance with requirements set forth in Part 200, Chapter 1, Rule 1.3. Medicaid requires at a minimum, transplant medical record documentation must contain the following on each beneficiary:

A. Comprehensive history and physical.

B. Treatments rendered that were unable to prevent progressive disability and/or death.

C. Use of tobacco, alcohol, and/or illegal drugs currently or within the last six (6) months.

D. Absence of severe and irreversible organ dysfunction in organ(s) other than the organ(s) being transplanted.

E. Relevant diagnostic studies (ex: x-rays, lab reports, EKG reports, pulmonary function studies, psychosocial reports, nutritional evaluation, performance status) and the results of the studies.

F. Reports, consults or other documentation to substantiate the transplant including documentation of transplant approval by the center's transplant review team.

G. Copy of signed informed consent form.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 42 CFR § 482.90 -104

*Rule 4.7: Reimbursement*

A. All transplants performed in the state of Mississippi are paid under the APR-DRG payment methodology including a policy adjustor.

B. For transplant services not available in Mississippi, payment for transplant services performed outside of Mississippi is made under the MS APR-DRG payment methodology including a policy adjustor. If access to quality services is unavailable under the MS APR-DRG payment methodology, a case rate may be set.

1. A case rate is set at forty percent (40%) of the sum of billed charges for transplant services as published in the most current *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion*.

2. The *Milliman* categories comprising the sum of billed charges include outpatient services received thirty (30) days pre-transplant, procurement, hospital transplant inpatient admission, physician services during transplant and one-hundred eighty (180) days post (transplant) discharge. Outpatient immuno-suppressants and other prescriptions are not included in the case rate.

3. For beneficiaries enrolled in a Coordinated Care Organization (CCO), the CCO is responsible for reimbursement of outpatient services received thirty (30) days pre-transplant and one-hundred eighty (180) days post (transplant) discharge. These billed charges are not included in the case rate.

4. If the transplant stay exceeds the hospital length of stay published by *Milliman*, an outlier per-diem payment will be made for each day that exceeds the hospital length of stay.

5. Reimbursement for transplant services cannot exceed one-hundred percent (100%) of the sum of *Milliman's* billed charges for the categories listed in Rule 4.7, B.2 or B.3.

6. Provisions listed in Part 202, Chapter 4, Rule 4.7 apply to Transplant Services on or after October 1, 2012.

7. For transplant services not available in Mississippi and not listed in the most current *Milliman U.S. Organ and Tissue Transplant Cost Estimates and Discussion*, the Division of Medicaid will make payment using the MS APR-DRG payment methodology. If MS APR-DRG payment limits access to care, the Division will reimburse what the domicile state pays for the service. The Division of Medicaid is responsible for payment of transplant services listed in 4.7 B.2. with the CCO responsible for payment of transplant services listed in 4.7 B.3 for beneficiaries enrolled in a CCO.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117 (A)(1)(d); § 43-13-117 (A)(2)(c); § 43-13-117 (A)(1)(e)

History: Revised – 01/01/2013, 10/01/2012

*Rule 4.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)*

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

*Rule 4.9: Cornea Transplant*

Medicaid covers cornea transplants for all beneficiaries and does not require prior authorization for medical necessity from the UM/QIO.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 482.90 – 104

History: Revised - 10/01/2012

*Rule 4.10: Heart Transplant*

A. Prior authorization is required.

B. Heart transplants are covered when all the following criteria are met:

1. Candidate is less than sixty-six (66) years of age.

2. New York Heart Association (NYHA) Class III or IV on maximal medical therapy.

3. Meets transplanting facility's blood and tissue-type compatibility standards.

4. Infections are controlled for at least forty-eight (48) hours prior to transplant.

5. Pulmonary Functions studies of FEV1 of >1.5 liter, PVR of <3 Wood units (if >3, prior to vasodilators, <3 after), Pulmonary artery systolic pressure <65-70 mm Hg.

6. Absence of irreversible and severe end organ dysfunction, such as hepatic, renal, peripheral vascular, or cerebrovascular, as well as, refractory hypertension, or uncontrolled malignancy.

7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

9. The candidate has been approved by the transplant review team.

10. Required serology studies have been completed for HIV, Hepatitis A, B, and C, Cytomegalovirus (CMV), and Varicella.

11. Immunizations have been administered as follows:

    a) All immunizations for children age two (2) to six (6) are up-to-date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP),

    b) Hepatitis A, if serology does not indicate immunity,

    c) Hepatitis B, if serology does not indicate immunity,

    d) Pneumococcal, and

    e) Influenza, annually.

12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated,

    b) Candidate's social support system has been evaluated and found to be adequate, and

    c) Candidate has no previous history of significant non-compliance to medical treatment.

13. Specific diagnostic inclusion criteria include the following conditions if expected to limit the candidate's survival rate to less than twelve (12) months:

    a) Congestive, restrictive, or ischemic cardiomyopathy,

    b) Valvular, congenital and other organic heart disease,

    c) Recurrent and refractory life-threatening ventricular dysrhythmias, or

    d) Refractory severe angina pectoris.

14. The facility is approved for heart transplants.

C. Transplants are not covered when the candidate has one (1) of the following:

1. Active chemical dependency, drugs or alcohol, within the preceding six (6) months.

2. Gastrointestinal hemorrhage.

3. Severe and irreversible pulmonary, for instance FEV1 < 1 liter, or other non-cardiac organ dysfunction.

4. Recent or unresolved pulmonary infarction, not embolism.

5. Uncorrectable absence of an essential psychosocial support system.

6. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.

7. HIV.

8. Hepatitis B or Hepatitis C.

9. Systemic malignancy.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 482.90 -104; 52 FR 10935

*Rule 4.11: Heart/Lung Transplant*

A. Prior authorization is required.

B. Heart/lung transplants are covered when the following criteria are met:

1. Candidate is less than fifty-six (56) years of age.

2. NYHA Class III or IV with rehabilitation potential.

3. Preserved nutritional state.

4. Meets facility's blood and tissue-type compatibility standards.

5. Infections controlled for at least forty-eight (48) hours prior to transplant, unless the infection is limited to the lung to be removed.

6. Absence of irreversible and severe end organ dysfunction, including hepatic, gastrointestinal, renal, peripheral vascular, or cerebrovascular, or uncontrolled malignancy.

7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

9. The candidate has been approved by the center's transplant review team.

10. Required serology studies have been completed for HIV, Hepatitis (A, B, and C), Cytomegalovirus (CMV), and Varicella.

11. Immunizations have been administered as follows:

    a) All immunizations for children age two (2) to six (6) are up-to-date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

    b) Hepatitis A, if serology does not indicate immunity.

    c) Hepatitis B, if serology does not indicate immunity.

    d) Pneumococcal.

    e) Influenza, annually.

12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated.

    b) Candidate's social support system has been evaluated and found to be adequate.

    c) Candidate has no previous history of significant non-compliance to medical treatment.

13. Specific Diagnostic Inclusion Criteria

    a) End-stage fibrotic lung disease unresponsive to alternative therapy with FVC <65% of predicted.

    b) End-stage obstructive lung disease with FVC <25% of predicted.

    c) End-stage pulmonary hypertension, either primary or secondary – without significant right heart dysfunction, unless heart-lung transplant planned.

    d) Cystic fibrosis with FVC <40% and FEV1 <30% of predicted.

e) Bronchiectasis.

f) Bronchopulmonary dysplasia.

g) Obliterative bronchiolitis.

14. Facility must be approved for heart and lung transplants by Medicaid.

C. Heart/Lung transplants are not covered when the candidate has one (1) of the following:

1. Active chemical dependence, drugs or alcohol within the preceding six (6) months,
2. Steroid therapy >20mg/day, and must be off steroids or weanable from them,
3. Bone marrow failure of any stem line: RBC, WBC, platelets,
4. Severe osteoporosis,
5. Severe chest wall deformity
6. Cachexia, a body weight <70% of ideal for height, or obesity, body weight >120% of ideal for height, in candidates with Cystic Fibrosis,
7. Recent pulmonary embolism or current deep venous thrombosis,
8. Viral hepatitis, in candidates with Cystic Fibrosis,
9. HIV,
10. Uncorrectable absence of an essential psychosocial support system, or
11. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 482.90 – 104

*Rule 4.12: Kidney Transplant*

Medicaid covers kidney transplants for all beneficiaries and does not require prior authorization for medical necessity from the UM/QIO.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 482.90 – 104

History: Revised - 10/01/2012

*Rule 4.13: Liver Transplant*

A. Prior authorization is required.

B. Liver transplants are covered when the following criteria are met:

1. Candidate is less than sixty-five (65) years of age.

2. Model for End Stage Liver Disease (MELD) score.

3. Pediatric End Stage Liver Disease (PELD) score.

4. Meets transplant facility's blood and tissue-type compatibility standards.

5. Infection controlled for at least forty-eight (48) hours prior to transplant.

6. Absence of severe and irreversible end organ dysfunction, either cardiac, pulmonary, renal, peripheral vascular, or cerebrovascular, or uncontrolled extrahepatic malignancy.

7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

9. The candidate has been approved by the transplant review team.

10. Required serology studies have been completed for HIV, Hepatitis A, B, and C, Cytomegalovirus (CMV), and Varicella.

11. Immunizations have been administered as follows:

    a) All immunizations for children age two (2) to six (6) are up-to-date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP),

    b) Hepatitis A, if serology does not indicate immunity,

    c) Hepatitis B, if serology does not indicate immunity,

    d) Pneumococcal, and

e) Influenza, annually.

12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated.

    b) Candidate's social support system has been evaluated and found to be adequate.

    c) Candidate has no previous history of significant non-compliance to medical treatment.

13. Specific Diagnostic Inclusion Criteria

    a) Chronic progressive liver disease, not otherwise correctable, including cirrhosis due to: alcoholism, if abstinent at least the prior six (6) months, chronic hepatitis C, primary or secondary biliary disease, sclerosing cholangitis, inborn error of metabolism, or other causes.

    b) Non-cirrhotic liver failure due to: biliary atresia, fulminant liver failure, submassive hepatic necrosis, hepatoblastoma, Budd-Chiari syndrome, an obstruction of the hepatic veins – if associated with a treatable disorder.

    c) Hepatocellular carcinoma, in conjunction with chemotherapy, if there is no evidence of extrahepatic metastases.

14. Facility is approved for liver transplants by the Division of Medicaid.

B. Liver transplants are not covered when the candidate has one (1) of the following.

1. Active chemical dependency, drugs or alcohol within the preceding six (6) months.

2. Acute alcoholic hepatitis.

3. Uncorrectable hemodynamic instability.

4. Extensive and uncorrectable portal vein thrombosis precluding portal inflow to graft.

5. Extrahepatic malignancy or hepatic malignancy with extrahepatic metastases.

6. Severe terminal diabetic and organ disease.

7. HIV.

8. Uncorrectable absence of an essential psychosocial support system.

9. Unmanageable psychiatric disorder felt to significantly compromise compliance with the

post-transplant regimen.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 482.90 – 104; 56 FR 15006

*Rule 4.14: Single Lung Transplant*

A. Prior authorization is required.

B. Single lung transplants are covered when the following criteria are met:

1. Candidate is less than sixty-six (66) years of age.

2. NYHA Class III or IV with rehabilitation potential.

3. Preserved nutritional state.

4. Meets facility's blood and tissue-type compatibility standards.

5. Infections controlled for at least forty-eight (48) hours prior to transplant, unless the infection is limited to the lung to be removed.

6. Absence of irreversible and severe end organ dysfunction, either hepatic, gastrointestinal, renal, peripheral vascular, or cerebrovascular, or uncontrolled malignancy

7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

9. The candidate has been approved by the center's transplant review team.

10. Required serology studies have been completed for HIV, Hepatitis A, B, and C, Cytomegalovirus (CMV), and Varicella.

11. Immunizations have been administered as follows:

a) All immunizations for children age two (2) to six (6) are up-to-date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP)

b) Hepatitis A, if serology does not indicate immunity.

c) Hepatitis B, if serology does not indicate immunity.

d) Pneumococcal.

e) Influenza, annually

12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

a) Candidate's psychiatric disorders, if present, are being treated.

b) Candidate's social support system has been evaluated and found to be adequate.

c) Candidate has no previous history of significant non-compliance to medical treatment.

13. Specific Diagnostic Inclusion Criteria

a) End-stage fibrotic lung disease unresponsive to alternative therapy with FVC <65% of predicted.

b) End-stage obstructive lung disease with FVC <25% of predicted.

c) End-stage pulmonary hypertension, either primary or secondary – without significant right heart dysfunction, unless heart-lung transplant planned.

d) Cystic fibrosis with FVC <40% and FEV1 <30% of predicted.

e) Bronchiectasis.

f) Bronchopulmonary dysplasia.

g) Obliterative bronchiolitis.

14. Facility must be approved for lung transplants by the Division of Medicaid.

C. Single lung transplants are not covered when the candidate has one (1) of the following:

1. Active chemical dependence, drugs or alcohol, within the preceding six (6) months.

2. Steroid therapy >20mg/day, must be off steroids or weanable from them.

3. Bone marrow failure of any stem line: RBC, WBC, platelets.

4. Severe osteoporosis.

5. Severe chest wall deformity.

6. Cachexia, body weight <70% of ideal for height, or obesity, body weight >120% of ideal for height, in candidates with Cystic Fibrosis

7. Recent pulmonary embolism or current deep venous thrombosis.

8. Viral hepatitis in candidates with Cystic Fibrosis.

9. HIV.

10. Uncorrectable absence of an essential psychosocial support system.

11. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 482.90 - 104

*Rule 4.15: Bilateral Lung Transplant*

A. Prior Authorization is required.

B. Bilateral lung transplants are covered when the following criteria are met:

1. Candidate is less than sixty-one (61) years of age.

2. NYHA Class III or IV with rehabilitation potential.

3. Preserved nutritional state.

4. Meets facility's blood and tissue-type compatibility standards.

5. Infections controlled for at least forty-eight (48) hours prior to transplant, unless the infection is limited to the lung to be removed.

6. Absence of irreversible and severe end organ dysfunction, either hepatic, gastrointestinal, renal, peripheral vascular, or cerebrovascular), or uncontrolled malignancy.

7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

9. The candidate has been approved by the center's transplant review team.

10. Required serology studies have been completed for HIV, Hepatitis (A, B, and C), Cytomegalovirus (CMV), and Varicella.

11. Immunizations have been administered as follows:

    a) All immunizations for children age two (2) to six (6) are up-to-date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

    b) Hepatitis A, if serology does not indicate immunity.

    c) Hepatitis B, if serology does not indicate immunity.

    d) Pneumococcal.

    e) Influenza, annually.

12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated.

    b) Candidate's social support system has been evaluated and found to be adequate.

    c) Candidate has no previous history of significant non-compliance to medical treatment.

13. Specific Diagnostic Inclusion Criteria:

    a) End-stage fibrotic lung disease unresponsive to alternative therapy with FVC <65% of predicted.

    b) End-stage obstructive lung disease with FVC <25% of predicted.

    c) End-stage pulmonary hypertension, either primary or secondary – without significant right heart dysfunction, unless heart-lung transplant planned

    d) Cystic fibrosis with FVC <40% and FEV1 <30% of predicted.

    e) Bronchiectasis.

    f) Bronchopulmonary dysplasia.

g) Obliterative bronchiolitis.

14. Facility is approved for lung transplants by Medicaid.

C. Bilateral lung transplants are not covered when the candidate has one of the following:

1. Active chemical dependence, drugs or alcohol within the preceding six (6) months.

2. Steroid therapy >20mg/day, must be off steroids or weanable from them.

3. Bone marrow failure of any stem line: RBC, WBC, platelets.

4. Severe osteoporosis.

5. Severe chest wall deformity

6. Cachexia, body weight <70% of ideal for height, or obesity, body weight >120% of ideal for height, in candidates with Cystic Fibrosis.

7. Recent pulmonary embolism or current deep venous thrombosis.

8. Viral hepatitis in candidates with Cystic Fibrosis.

9. HIV.

10. Uncorrectable absence of an essential psychosocial support system.

11. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.

Source**:** Miss. Code Ann. § 43-13-121; 42 CFR 482.90 -104

*Rule 4.16: Bone Marrow Transplant*

A. Medicaid covers bone marrow transplants as noted below and does not require prior authorization for medical necessity from the UM/QIO.

B. Bone marrow transplants (BMT), Autologous, Syngeneic, or Allogeneic, are covered for inpatient and outpatient when the following criteria are met:

1. Candidate is less than fifty-six (56) years of age for allogeneic, < sixty-six (66) if fully matched sibling donor.

2. Candidate is less than seventy (70) years of age for autologous.

3. Karnofsky >70 or ECOG <3.

4. Allogeneic HLA-MLC match, 1 antigen mismatch accepted.

5. Infections controlled for forty-eight (48) hours prior to transplant.

6. Left ventricular ejection fraction >40%.

7. FEV1 of >50% of predicted.

8. Dlco >60% of predicted.

9. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

10. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

11. The candidate has been approved by the transplant review team.

12. The candidate's immunization history and HIV status has been obtained.

13. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated.

    b) Candidate's social support system has been evaluated and found to be adequate.

    c) Candidate has no previous history of significant non-compliance to medical treatment.

14. Specific Diagnostic Inclusion Criteria (Allogeneic BMT or PSCT)

    a) Severe aplastic anemia.

    b) Pure erythrocyte aplasia.

    c) Myelodysplasia.

    d) Severe hemoglobinopathy, including sickle cell, thalassemia.

    e) Selected immunodeficiency syndrome including SCID, Wiskott-Aldrich, Chediak-Higashi

    f) Genetic storage disease, including Hurler's, Morquio's.

g) Primary amyloidosis.

h) Paroxysmal nocturnal hemoglobinuria.

i) Severe platelet dysplasia.

j) Acute lymphocytic leukemia, in first remission if high risk, at early relapse, or in second remission.

k) Acute myelogenous leukemia, in same clinical states as listed for acute lymphocytic leukemia.

l) Chronic lymphocytic leukemia.

m) Chronic myelogenous leukemia.

n) Hodgkin's lymphoma, failed first line therapy or failed at least one standard chemotherapy regimen.

o) Non-Hodgkin's lymphoma failed or responsive to first line therapy or high risk during first remission.

p) Familial hemophagocytic lymphohistiocytosis (FHL) also known as familial erythrophagocytic.

q) Lymphohistiocytosis (FEL).

15. Specific Diagnostic Inclusion Criteria (Autologous BMT or PSCT)

a) Acute lymphocytic leukemia in first remission if high risk, at early relapse, or in second remission.

b) Acute myelogenous leukemia in same clinical states as listed for acute lymphocytic leukemia.

c) Chronic lymphocytic leukemia.

d) Chronic myelogenous leukemia.

e) Hodgkin's lymphoma, for failed first line therapy or if failed at least one standard chemotherapy regimen.

f) Multiple Myeloma-a single autologous BMT/SCT transplant will be considered for beneficiaries with Durie-Salmon stage II or stage III disease if the following criteria is met. Newly diagnosed disease or responsive multiple myeloma. This includes

beneficiaries with previously untreated disease, those with at least a partial response to prior chemotherapy, which is defined as 50% decrease in either measurable serum and/or urine paraprotein or in bone marrow infiltration, sustained for at least one (1) month, and those in responsive relapse with adequate renal, pulmonary, and hepatic function.

16. Tandem BMT/SCT for multiple myeloma is specifically excluded from coverage.

    a) Non-Hodgkin's lymphoma, either failed or responsive to first line therapy or, if high risk, during first remission

    b) Neuroblastoma.

    c) Nephroblastoma.

17. Transplant facilities must meet Medicaid facility criteria.

C. Bone marrow transplants are not covered if the candidate has one (1) of the following:

1. Active chemical dependency, drugs or alcohol, within the preceding six (6) months

2. HIV.

3. Breast cancer.

4. Uncorrectable absence of an essential psychosocial support system.

5. Unmanageable psychiatric disorder felt to significantly compromise the candidate's compliance with the post-transplant regimen.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 482.90 – 104

History: Revised - 10/01/2012

*Rule 4.17: Peripheral Stem Cell Transplant*

A. No prior authorization is required.

B. Peripheral Hematopoietic Stem Cell Transplants (PSCT), Autologous, Syngeneic, or Allogeneic, are covered for inpatient and outpatient when the following criteria are met:

1. Candidate is less than fifty-six (56) years of age for allogeneic, < sixty-six (66) if fully matched sibling donor.

2. Candidate is less than seventy (70) years of age for autologous.

3. Karnofsky >70 or ECOG <3.

4. Allogeneic HLA-MLC match, 1 antigen mismatch accepted.

5. Infections controlled for forty-eight (48) hours prior to transplant.

6. Left ventricular ejection fraction >40%.

7. FEV1 of >50% of predicted.

8. Dlco >60% of predicted.

9. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

10. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

11. The candidate has been approved by the transplant review team.

12. The candidate's immunization history and HIV status has been obtained.

13. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated.

    b) Candidate's social support system has been evaluated and found to be adequate.

    c) Candidate has no previous history of significant non-compliance to medical treatment.

14. Specific Diagnostic Inclusion Criteria (Allogeneic PSCT)

    a) Severe aplastic anemia.

    b) Pure erythrocyte aplasia.

    c) Myelodysplasia.

    d) Severe hemoglobinopathy, including sickle cell, thalassemia.

    e) Selected immunodeficiency syndrome, including SCID, Wiskott-Aldrich, Chediak-Higashi.

f) Genetic storage disease, including Hurler's, Morquio's.

g) Primary amyloidosis.

h) Paroxysmal nocturnal hemoglobinuria.

i) Severe platelet dysplasia.

j) Acute lymphocytic leukemia, in first remission if high risk, at early relapse, or in second remission.

k) Acute myelogenous leukemia, in same clinical states as listed for acute lymphocytic leukemia.

l) Chronic lymphocytic leukemia.

m) Chronic myelogenous leukemia.

n) Hodgkin's lymphoma, failed first line therapy or failed at least one standard chemotherapy regimen.

o) Non-Hodgkin's lymphoma, failed or responsive to first line therapy or high risk during first remission.

p) Familial hemophagocytic lymphohistiocytosis (FHL) also known as familial erythrophagocytic.

q) Lymphohistiocytosis (FEL).

15. Specific Diagnostic Inclusion Criteria (Autologous PSCT).

a) Acute lymphocytic leukemia, in first remission if high risk, at early relapse, or in second remission.

b) Acute myelogenous leukemia, in same clinical states as listed for acute lymphocytic leukemia.

c) Chronic lymphocytic leukemia.

d) Chronic myelogenous leukemia.

e) Hodgkin's lymphoma, for failed first line therapy or if failed at least one standard chemotherapy regimen.

f) Multiple Myeloma single autologous BMT/SCT transplant will be considered for beneficiaries with Durie-Salmon stage II or stage III disease if this is a newly

diagnosed disease or responsive multiple myeloma. This includes beneficiaries with previously untreated disease, those with at least a partial response to prior chemotherapy which is defined as 50% decrease in either measurable serum and/or urine paraprotein or in bone marrow infiltration, sustained for at least one (1) month, and those in responsive relapse with adequate renal, pulmonary, and hepatic function.

g) Recurrent solid tumors.

16. Tandem BMT/SCT for multiple myeloma is specifically excluded from coverage.

a) Non-Hodgkin's lymphoma, either failed or responsive to first line therapy or, if high risk, during first remission.

b) Neuroblastoma.

c) Nephroblastoma.

17. Transplant facilities must meet Medicaid facility criteria.

C. Peripheral stem cell transplants are not covered when the candidate has one of the following:

1. Active chemical dependency, drugs or alcohol, within the preceding six (6) months.

2. HIV.

3. Breast cancer.

4. Uncorrectable absence of an essential psychosocial support system.

5. Unmanageable psychiatric disorder felt to significantly compromise the candidate's compliance with the post-transplant regimen.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 482.90 - 104

History: Revised – 04/01/2013, 10/01/2012

*Rule 4.18: Small Bowel Transplant*

A. Prior authorization is required.

B. Medicaid covers small bowel transplants meeting the following criteria for small bowel (or intestinal) transplantation, whether performed as a solitary procedure (SBT); or performed in conjunction with liver (SB/LT); or with stomach, duodenum, and pancreas, with or without liver (SB/MVT) transplantation:

1. The loss or absence of sufficient absorptive capacity of the intestinal tract to support life;

and

2. The demonstrated failure of total parenteral nutrition (TPN).

C. Concomitant liver or multivisceral transplantation can only be medically justified by documentation of severe and irreversible damage to the individual organ(s) to be replaced. Concomitant live or multivisceral transplants must meet the following criteria:

1. Candidate is less than sixty-five (65) years of age.

2. Meets transplanting facility blood and tissue-type compatibility standards.

3. Infections controlled for at least forty-eight (48) hours prior to transplant

4. Absence of severe and irreversible end organ dysfunction, to include cardiac, central nervous system, pulmonary, renal, peripheral vascular or cerebrovascular.

5. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

6. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

7. The candidate has been approved by the transplant review team.

8. Required serology studies have been completed for HIV, Hepatitis A, B, and C, Cytomegalovirus (CMV), and Varicella.

9. Immunizations have been administered as follows:

a) All immunizations for children age two (2) to six (6) are up-to-date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

b) Hepatitis A, if serology does not indicate immunity.

c) Hepatitis B, if serology does not indicate immunity.

d) Pneumococcal.

e) Influenza, annually.

10. A psychosocial evaluation has been performed for the adult candidate or, if the candidate

is a child, for the family, with the following results:

a) Candidate's psychiatric disorders, if present, are being treated.

b) Candidate's social support system has been evaluated and found to be adequate.

c) Candidate has no previous history of significant non-compliance to medical treatment.

11. Specific Diagnostic Inclusion Criteria

a) Severe and irreversible intestinal insufficiency, congenital or acquired, including, but not limited to the following causes:

1) Intestinal atresia.

2) Splanchnic vascular occlusive disease.

3) Gastroschisis.

4) Inflammatory bowel disease.

5) Microvillus involution disease, intractable diarrhea of infancy.

6) Post-traumatic, including surgical short bowel syndrome.

7) Volvulus.

8) Necrotizing enterocolitis.

9) Chronic intestinal pseudo-obstruction.

10) Radiation enteritis.

b) Failure of Total Parenteral Nutrition (TPN) as documented by:

1) Overt or impending liver failure due to TPN-induced hepatic injury,

2) Thrombosis of two or more central venous channels: jugular, subclavian, femoral,

3) Two or more episodes of TPN catheter-induced sepsis in a year or a single episode of line-related fungemia, or

4) Frequent episodes of dehydration due to uncontrollable and high volume loss of fluids through the gastrointestinal tract.

12. Facility is approved for small bowel transplants by Medicaid.

D. Small bowel transplants are not covered when the candidate has one (1) of the following:

1. Active chemical dependency, drugs or alcohol within the preceding six (6) months.

2. Profound and progressive neurological dysfunction, like Tay-Sachs.

3. Non-correctable non-gastrointestinal disease with a lethal prognosis.

4. Congenital immunodeficiency syndrome.

5. Active tuberculosis or active sepsis.

6. Uncorrectable absence of an essential psychosocial support system.

7. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.

8. HIV.

9. Systemic malignancy.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 482.90 – 104.

**Part 202 Chapter 5: Hospital Procedures**

*Rule 5.1: Hyperbaric Oxygen Therapy*

A. Hyperbaric Oxygen Therapy (HBOT) is covered in an inpatient or outpatient hospital setting in accordance with current standards of medical practice when the following criteria are met:

1. The patient's entire body must be placed into the hyperbaric chamber. Note that topical application of oxygen with portable chambers is not covered.

2. HBOT must be performed in the hospital setting, either inpatient or outpatient.

3. A physician must order HBOT treatments, document medical necessity, and establish the plan of care specifying the goals for hyperbaric oxygen therapy to accomplish and an estimated number of treatments, with revisions made as appropriate and justification for extending treatments.

4. A cardiopulmonary resuscitation team and a fully equipped emergency cart must be immediately available where the hyperbaric chamber is located when a patient is receiving HBOT in the event of a complication.

B. Hyperbaric oxygen therapy is covered for the following medical diagnoses only:

1. Acute carbon monoxide intoxication,

2. Decompression illness (Caisson disease),

3. Air (gas) embolism,

4. Gas gangrene,

5. Acute traumatic peripheral ischemia, as adjunctive treatment to accepted standard therapeutic measures when function, life, or limb is threatened,

6. Crush injuries and suturing of severed limbs, as adjunctive treatment to accepted standard therapeutic measures when function, life, or limb is threatened,

7. Progressive necrotizing infections - necrotizing fasciitis or meleney ulcer also known as pyoderma gangrenosum,

8. Acute peripheral arterial insufficiency,

9. Preparation and preservation of compromised skin grafts,

10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management,

11. Osteoradionecrosis, as an adjunct to conventional treatment,

12. Soft tissue radionecrosis, as an adjunct to conventional treatment,

13. Cyanide poisoning, and

14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment.

C. Physician must be in constant personal attendance where the hyperbaric oxygen chamber is located while the patient is receiving HBOT and must not delegate administration of HBOT to hospital staff. Physician's absence during the entire HBOT treatment shall result in reimbursement to the facility only.

D. Documentation of Medical Necessity:

1. Documentation must be legible and available for review if requested.

2. Documentation must include the following:

a) Specific written record that HBOT was performed in a hospital setting, inpatient or outpatient, utilizing a full body hyperbaric chamber;

b) A written physician order, comprehensive history, and physical report detailing the condition/diagnosis(es) requiring HBOT, including prior treatments and their results and additional treatments being rendered concurrently with HBOT;

c) Physician progress notes and consultation reports that describe the patient's response to treatment;

d) Established goals for hyperbaric oxygen therapy to accomplish and an estimated number of treatments, with revisions made as appropriate and justification for extending treatments;

e) Wound description, if applicable, including wound size and appearance, for each day of service billed;

f) Radiology and laboratory reports, including culture and sensitivity studies, to support the diagnosis when applicable;

g) Specific written record of the physician's constant personal attendance where the hyperbaric chamber is located while the patient is undergoing HBOT; and

h) Specific written record of the availability of a cardiopulmonary resuscitation team and a fully equipped emergency cart where the hyperbaric chamber is located while the patient is undergoing HBOT.

Source: Miss. Code Ann. § 43-13-121; Social Security Act §§ 1862(a)(1)(A), 1833(e); 42 CFR §§ 410.26(a)(2), 410.27(f), 410.32(b)(3)(ii).

History: Moved from Rule 1.5 and revised Rule 5.1.A. eff. 10/01/2013.

*Rule 5.2: Chelation Therapy*

A. The Division of Medicaid covers only Food and Drug Administration (FDA)-approved chelation in an inpatient or outpatient hospital setting in accordance with current standards of medical practice.

B. Conditions which may be treated with chelation include:

1. Lead poisoning,

2. Iron overload,

3. Metallic mercury poisoning,

4. Copper poisoning,

5. Arsenic poisoning,

6. Gold poisoning,

7. Cystinuria,

8. Wilson's disease, and

9. Severe, active rheumatoid arthritis that has failed to respond to an adequate trial of conventional therapy.

C. Documentation in the medical records of symptoms and/or laboratory tests must support one (1) of the listed diagnoses. Chelation therapy for the treatment of any other conditions is not a covered service.

Source: Miss. Code Ann. § 43-13-121; 21 CFR § 312.

History: Moved from Rule 1.7 and revised Rule 5.2.A. eff. 10/01/2013.

*Rule 5.3: Sterilization*

A. The Division of Medicaid covers sterilization procedures in an inpatient or outpatient hospital setting in accordance with current standards of medical practice for beneficiaries who:

1. Are male or female,

2. Are non-institutionalized,

3. Are twenty-one (21) years of age or older at the time of consent, and

4. Are mentally competent, able to understand the nature and consequences of the procedure, knowingly and voluntarily request the procedure, and give informed consent to be sterilized.

B. The informed consent form for sterilization:

1. Must be accurate and complete with all required signatures,

2. Must be voluntarily and knowingly signed by the beneficiary,

3. Must be signed by the beneficiary, defined as the individual to be sterilized and not the personal or legal representative,

4. Is valid for one hundred eighty (180) days from the date it is signed by the beneficiary, and

5. Must comply with 42 CFR § 441 *et al*.

C. At least thirty (30) days but not more than one hundred eighty (180) days must have passed between the date of the beneficiary signature on the informed consent form and the date the sterilization will be performed except in the case of premature delivery or emergency abdominal surgery.

1. In the case of premature delivery, defined as a delivery prior to the expected due date, informed consent must have been given at least thirty (30) days before the expected date of delivery.

2. A beneficiary may be sterilized at the time of premature delivery or emergency abdominal surgery if at least seventy-two (72) hours have passed since signing the informed consent form for the sterilization. A Caesarean delivery is not routinely considered emergency abdominal surgery.

3. The physician must justify and describe the circumstance for any premature delivery or emergency abdominal surgery and document the expected date of delivery for premature deliveries in the medical record and further certify that at least thirty (30) days have passed between the date of the beneficiary's signature on the informed consent form and the date the sterilization was performed.

D. The Division of Medicaid covers a subsequent sterilization that is due to a previously failed sterilization. Documentation in the beneficiary's medical record must reflect the date of the first sterilization and the reason for the procedure failure.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 50.207; 42 CFR §§ 441.251-259; 43 Fed. Reg. 52171.

History: Moved from Rule 1.8 and revised Rule 5.3.A.4, B.3, C.1, C.2, C.3 eff. 10/01/2013.

*Rule 5.4: Abortions*

A. Notwithstanding any other provision of law to the contrary, no public funds that are made available to any institution, board, commission, department, agency, official, or employee of the State of Mississippi, or of any local political subdivision of the state, whether those funds are made available by the government of the United States, the State of Mississippi, or a local governmental subdivision, or from any other public source, shall be used in any way for, to assist in, or to provide facilities for abortion, except:

1. When the abortion is medically necessary to prevent the death of the mother, or

2. When the abortion is being sought to terminate a pregnancy resulting from an alleged act

of rape or incest, or

3. When there is a fetal malformation that is incompatible with the baby being born alive.

B. Medicaid coverage for abortion services is governed by federal law under the Hyde Amendment, which provides that abortion services are reimbursable under Medicaid in an inpatient or outpatient hospital setting in accordance with current standards of medical practice as follows:

1. When the abortion is medically necessary to prevent the death of the mother, or

2. When the abortion is being sought to terminate a pregnancy resulting from an alleged act of rape or incest.

C. The physician is required to maintain sufficient documentation in the medical record that supports the medical necessity for the abortion for one of the reasons outlined in Rule 5.4.B.(a)(b).

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 441, Subpart E; Consolidated Appropriations Act, 2008 (H.R. 2764), signed into law Dec. 26, 2007, (Public Law 110-161) Sections 507-508.

History: Moved from Rule 1.9 and revised Rule 5.4. B. eff. 10/01/2013.

*Rule 5.5: Trauma Team Activation/Response*

Trauma team activation/response payments are covered under the Mississippi Medicaid Program in an outpatient hospital setting in accordance with current standards of medical practice according to the following criteria:

A. The billing hospital must have a complete designation as a Level I, II, III, or IV trauma center through the Mississippi State Board of Health, Office of Emergency Planning and Response; or if out of state, through the responsible governing body of the state in which the beneficiary received services.

B. Payment will be made in accordance with the reimbursement methodology of the Division of Medicaid's inpatient or outpatient hospital services.

C. Trauma activation fees for beneficiaries who are "drive by," or arrive by private vehicle without notification from pre-hospital caregivers, are not covered. The patient must arrive by ambulance and the hospital must be pre-notified by pre-hospital caregivers.

D. Documentation must be maintained in the patient's medical record that supports provision of an organized trauma team response that meets the criteria for the Level I, II, III, or IV service. A facility must not bill and cannot be paid for a level of care above the one (1) which they have been designated by the Mississippi State Department of Health.

E. All patients must have a primary diagnosis that falls within the appropriate International Classification Of Disease (ICD) diagnosis code range plus documentation in the medical record of one (1) of the following situations:

1. Transfer between acute care facilities, in or out,

2. Admission to critical care unit, no minimum,

3. Hospitalization for three (3) or more calendar days,

4. Death after receiving any evaluation or treatment,

5. Admission directly from Emergency Department to Operating Room for major procedure, excluding plastics or orthopedics procedures on patients that do not meet the three day hospitalization criteria,

6. Triaged, in accordance with regional trauma protocols, to a trauma hospital by pre-hospital care regardless of severity, or

7. Treated in the Emergency Department by the trauma team regardless of severity of injury.

Source: Miss. Code Ann. §§ 43-13-117(A)(2)(c), 43-13-121(A)(1)(d), SPA 2012-008.

History: Moved from Rule 1.10 and revised 5.5 eff. 10/01/2013; Revised to correspond with SPA 2012-008 eff. 10/01/2012.

*Rule 5.6: Hysterectomy*

A. The Division of Medicaid defines a hysterectomy as the surgical removal of the uterus.

B. The Division of Medicaid covers a hysterectomy when medically necessary in an inpatient or outpatient setting in accordance with current standards of medical practice and when:

1. Prior to the hysterectomy:

a) The person who secured authorization to perform the hysterectomy has informed the beneficiary and guardian/legal representative, if any, orally and in writing that the hysterectomy will make the beneficiary permanently incapable of reproducing, and

b) The beneficiary or guardian/legal representative, the person that secured authorization for the hysterectomy, and the physician who performs the hysterectomy have completed and signed the appropriate section(s) of the Hysterectomy Acknowledgement Form;

2. The beneficiary is already sterile before the hysterectomy and the physician certifies in

writing on the Hysterectomy Acknowledgement Form that the beneficiary was already sterile at the time of the hysterectomy, and states the cause of sterility; or

3. The beneficiary requires a hysterectomy because of a life-threating emergency situation in which the physician determines that prior acknowledgement is not possible, and the physician certifies in writing on the Hysterectomy Acknowledgement Form that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgement was not possible and documents a description of the nature of the emergency.

C. The Division of Medicaid does not cover a hysterectomy when:

1. It is performed solely for the purpose of rendering a beneficiary permanently incapable of reproducing, or

2. There was more than one (1) purpose to the hysterectomy and it would not have been performed but for the purpose of rendering the beneficiary permanently incapable of reproducing.

Source: 42 CFR § 441.255; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2015; Added Rule 5.6.A., B.1-3, C, D eff. 05/01/2014; Moved from Rule 1.6 and revised eff. 10/01/2013.