Title 23: Division of Medicaid

Part 225: Telemedicine

Chapter 1: Telehealth Services

Rule 1.1: Definitions

The Division of Medicaid defines telemedicine as a method which uses electronic information and communication equipment to supply and support health care when remoteness disconnects patients and links primary care physicians, specialists, providers, and beneficiaries which includes, but is not limited to, telehealth services, remote patient monitoring services, teleradiology services, store-and-forward and continuous glucose monitoring services.

A. The Division of Medicaid defines telehealth services as the delivery of health care by an enrolled Medicaid provider, through a real-time communication method, to a beneficiary who is located at a different site. The interaction must be:

    1. Live,

    2. Interactive, and

    3. Audiovisual.

B. The Division of Medicaid defines the originating site, also referred to as the spoke site, as the physical location of the beneficiary at the time the telehealth service is provided.

C. The Division of Medicaid defines the distant site, also referred to as the hub site, as the physical location of the provider delivering the telehealth service at the time the telehealth service is provided.

D. The Division of Medicaid defines the telepresenter as the healthcare provider at the originating site who introduces the beneficiary to the distant site provider for examination and assists the distant site provider with requested tasks and activities that are within the telepresenter's scope-of-practice and license.

Source: 42 CFR § 410.78; Miss. Code Ann. § 43-13-121; SPA 15-003.

History: New to correspond with SPA 15-003 (eff. 01/01/2015) eff. 07/01/2015.

Rule 1.2: General Provider Information

A. Providers of telehealth services must comply with all requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the provider specific requirements below:

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

2. Copy of current licensure card or permit, and

3. Verification of social security number using a social security card, military ID or a notarized statement signed by the provider noting the social security number. The name noted on the verification must match the name noted on the W-9.

B. Telehealth services must be delivered by an enrolled Medicaid provider acting within their scope-of-practice and license and in accordance with state and federal guidelines, including but not limited to, authorization of prescription medications at both the originating and distant site.

C. The following enrolled Medicaid providers are eligible to provide telehealth services at the distant site as a substitution for an in-person visit or encounter for consultations, office visits, and/or outpatient visits:

1. Physicians,

2. Physician Assistants,

3. Nurse Practitioners,

4. Psychologists,

5. Licensed Clinical Social Workers (LCSWs), and

6. Licensed Professional Counselors (LPCs).

D. The Division of Medicaid allows any enrolled Medicaid provider to provide telehealth services at the originating site.

E. A telepresenter at the originating site must:

1. Be employed by an enrolled Medicaid provider,

2. Perform tasks and activities within the telepresenter's scope-of-practice and license, and

3. Be physically present during the entirety of the telehealth visit or encounter.

F. The use and delivery of telemedicine services does not alter a covered provider’s privacy obligations under federal/and or state law and a provider or entity operating telehealth services that involve protected health information (PHI) must meet the same Health Insurance Portability and Accountability Act (HIPAA) requirements the provider or entity would for a service provided in person.

Source: 42 CFR § 410.78; The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (as amended by the Genetic Information Nondiscrimination Act (GINA) of 2008 and the Health Information Technology for Economic and Clinical Health Act (HITECH Act), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act (ARRA) 0f 2009) and its implementing regulations, including 45 C.F.R. Parts 160 and 164, Subparts A and E (Privacy Rule), and Subparts A and C (Security Rule); Miss. Code Ann. § 43-13-121; SPA 15-003.

History: Added Miss. Admin. Code Part 225, Rule 1.2.C.6. eff. 05/01/2016; New to correspond with SPA 15-003 (eff. 01/01/2015) eff. 07/01/2015.

Rule 1.3: Covered Services

A. The Division of Medicaid covers medically necessary telehealth services as a substitution for an in-person visit or encounter for consultations, office visits, and/or outpatient visits.

B. The Division of Medicaid requires that the audio and video equipment and technology be sufficient enough to provide real-time interactive communications that provide the same information as if the telehealth visit or encounter was performed in-person.

Source: 42 CFR § 410.78; Miss. Code Ann. § 43-13-121; SPA 15-003.

History: New to correspond with SPA 15-003 (eff. 01/01/2015) eff. 07/01/2015.

Rule 1.4: Non-Covered Services

The Division of Medicaid does not:

A. Cover telehealth services in the inpatient setting.

B. Cover a separate reimbursement for the installation or maintenance of telehealth hardware, software and/or equipment, videotapes, and transmissions.

C. Consider the following as telehealth services:

1. Telephone conversations,

2. Chart reviews;

3. Electronic mail messages;

4. Facsimile transmission;

5. Internet services for online medical evaluations, or

6. Communication through social media.

D. Cover the installation or maintenance of any telecommunication devices or systems.

Source: 42 CFR § 410.78; Miss. Code Ann. § 43-13-121; SPA 15-003.

History: New to correspond with SPA 15-003 (eff. 01/01/2015) eff. 07/01/2015.

Rule 1.5: Reimbursement

A. The Division of Medicaid reimburses a provider delivering the medically necessary telehealth service at the distant site the current applicable Mississippi Medicaid fee for the service provided.

   1. If a service in an in-person setting is not covered by the Division of Medicaid, it is not covered if provided through telehealth.

   2. The provider must include the appropriate modifier on the claim indicating the service was provided through telehealth.

B. The Division of Medicaid reimburses the originating site the Mississippi Medicaid telehealth originating site facility fee for telehealth services per completed transmission.

   1. The following enrolled Medicaid providers are eligible to receive the originating site facility fee for telehealth services per transmission:

      a) The office of a physician or practitioner,

      b) An outpatient hospital, including a Critical Access Hospital (CAH),

      c) A Rural Health Clinic (RHC),

      d) A Federally Qualified Health Center (FQHC),

      e) A Community Mental Health/Private Mental Health Center,

      f) A Therapeutic Group Home,

      g) An Indian Health Service Clinic, and

      h) A school-based clinic.

   2. The telepresenter must be one (1) of the following for the originating site to receive the originating site facility fee:

      a) Physicians,

b) Physician Assistants,

c) Nurse Practitioners,

d) Psychologists,

e) Licensed Clinical Social Workers (LCSWs), and

f) Licensed Professional Counselors (LPCs).

3. The telehealth presenter must be physically present in the room at all times.

C. The originating site provider cannot bill for an encounter or Evaluation and Management (E&M) visit unless a separately identifiable service is performed.

Source: 42 CFR § 410.78; Miss. Code Ann. § 43-13-121; SPA 15-003.

History: Added Miss. Admin. Code Part 225, Rule 1.5.B.2.f) eff. 05/01/2016; New to correspond with SPA 15-003 (eff. 01/01/2015) eff. 07/01/2015.

Rule 1.6: Documentation

The provider must document the same information as for a comparable in-person service and be maintained at both the originating and distant site of the telehealth services provided including, but not limited to:

A. Signed consent for treatment using telehealth,

B. Medically appropriate reason telehealth was utilized to provide services,

C. Beneficiary's presenting diagnosis and symptoms,

D. Specific name/type of all diagnostic studies and results/findings of the studies, and

E. Plan of Care.

Source: Miss. Code Ann. § 43-13-121.

History: New to correspond with SPA 15-003 (eff. 01/01/2015) eff. 07/01/2015.

Part 225 Chapter 2: Remote Patient Monitoring Services

Rule 2.1: Definitions

A. The Division of Medicaid defines telemedicine as a method which uses electronic information and communication equipment to supply and support health care when remoteness disconnects patients and links primary care physicians, specialists, providers, and beneficiaries which includes, but is not limited to, telehealth services, remote patient monitoring services, teleradiology services, store-and-forward and continuous glucose monitoring services.

B. The Division of Medicaid defines remote patient monitoring as using digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to healthcare providers in a different location for interpretation and recommendation.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 2.2: General Provider Information

A. Providers of remote patient monitoring services must comply with all requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the provider specific requirements below:

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

    2. Copy of current licensure card or permit, and

    3. Verification of social security number using a social security card, military ID or a notarized statement signed by the provider noting the social security number. The name noted on the verification must match the name noted on the W-9.

B. Remote patient monitoring services must be delivered by an enrolled Medicaid provider acting within their scope-of-practice and license and in accordance with state and federal guidelines.

C. The use and delivery of remote patient monitoring services does not alter a covered provider's privacy obligations under federal/and or state law and a provider or entity operating telehealth services that involve protected health information ("PHI") must meet the same HIPAA requirements the provider or entity would for a service provided in person.

D. Providers of remote patient monitoring services must have protocols in place to address all of the following:

    1. A mechanism for monitoring, tracking and responding to changes in a beneficiary's clinical condition, and

2. A process for notifying the prescribing physician of significant changes in the beneficiary's clinical signs and symptoms.

Source: The Health Insurance Portability and Accountability Act ("HIPAA") of 1996 (as amended by the Genetic Information Nondiscrimination Act ("GINA") of 2008 and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act ("ARRA") 0f 2009) and its implementing regulations, including 45 C.F.R. Parts 160 and 164, Subparts A and E ("Privacy Rule"), and Subparts A and C ("Security Rule"); Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 2.3: Covered Services

A. The Division of Medicaid covers remote patient monitoring of devices when medically necessary, ordered by a physician, physician assistant or nurse practitioner which includes, but not limited to:

   1. Implantable pacemakers,

   2. Defibrillators,

   3. Cardiac monitors,

   4. Loop recorders, and

   5. External mobile cardiovascular telemetry.

B. The Division of Medicaid covers remote patient monitoring, for disease management when medically necessary, prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO), Division of Medicaid or designee, ordered by a physician, physician assistant, or nurse practitioner for a beneficiary who meets the following criteria:

   1. Has been diagnosed with one (1) or more of the following chronic conditions:

      a) Diabetes,

      b) Congestive Heart Failure (CHF), or

      c) Chronic Obstructive Pulmonary Disease (COPD).

   2. Has had two (2) or more hospitalizations in the previous twelve (12) months for one (1) of the chronic conditions listed above,

   3. Hospitalizations for two (2) different chronic conditions cannot be combined to satisfy

the two (2) or more hospitalizations requirement, and

4. Is capable of using the remote patient monitoring equipment and transmitting the necessary data or has a willing and able person to assist in completing electronic transmission of data.

C. Remote patient monitoring services must be provided in the beneficiary's private residence.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 2.4: Non-Covered Services

The Division of Medicaid does not cover remote patient monitoring for disease management as outlined in Miss. Admin. Code Part 225, Rule 2.3.B. for a beneficiary who is a resident of an institution that meets the basic definition of a hospital or long-term care facility.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 2.5: Reimbursement

A. The Division of Medicaid reimburses for remote patient monitoring:

1. Of devices when billed with the appropriate code, and

2. For disease management:

a) A daily monitoring rate for days the beneficiary's information is reviewed.

b) Only one (1) unit per day is allowed, not to exceed thirty-one (31) days per month.

c) An initial visit to install the equipment and train the beneficiary may be billed as a set-up visit.

d) Only one set-up is allowed per episode even if monitoring parameters are added after the initial set-up and installation.

e) Only one (1) daily rate will be reimbursed regardless of the number of diseases/chronic conditions being monitored.

B. The Division of Medicaid does not reimburse for the duplicate transmission or interpretation of remote patient monitoring data.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

2.6: Documentation

The provider must document the remote patient monitoring service the same as for a comparable in person service which includes, but is not limited to:

A. The monitoring equipment meets all of the following requirements:

   1. Capable of monitoring any data parameters included in the plan of care,

   2. Food and Drug Administration (FDA) Class II hospital-grade medical device, and

   3. Capable of accurately measuring and transmitting beneficiary glucose and/or blood pressure data.

B. Qualified staff installed the remote patient monitoring equipment necessary to monitor and transmit the data according to the beneficiary's care plan.

C. Clinical data was provided to the beneficiary's primary care physician or his/her designee.

D. Monitoring of the beneficiary's clinical data was not duplicated by any other provider.

E. Beneficiary's home environment has the necessary space and connections for installation and transmission of data.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Par 225 Chapter 3: Teleradiology Services

Rule 3.1: Definitions

The Division of Medicaid defines telemedicine as a method which uses electronic information and communication equipment to supply and support health care when remoteness disconnects patients and links primary care physicians, specialists, providers, and beneficiaries which includes, but is not limited to, telehealth services remote patient monitoring services, teleradiology services, store-and-forward and continuous glucose monitoring services.

A. The Division of Medicaid defines store-and-forward as telecommunication technology for the transfer of medical data from one (1) site to another through the use of a camera or similar device that records or stores an image which is transmitted or forwarded via telecommunication to another site for teleconsultation and includes, but is not limited to,

teleradiology services.

B. The Division of Medicaid defines a:

1. Teleradiology service as the electronic transmission of radiological images, known as store-and-forward images, from one (1) location to another for the purposes of interpretation.

2. Consulting provider as a licensed physician who interprets the radiological image, at the distant site and who must be licensed in the state within the United States in which he/she practices.

3. Distant site, also referred to as a hub site, as the location of the teleradiology consulting provider.

4. Referring provider as a licensed physician, physician assistant, or nurse practitioner who orders the radiological service and who must be licensed in the state within the United States in which he/she practices.

5. Originating site, also referred to as the spoke site, as the location where the beneficiary is receiving the teleradiology service.

A. Store-and-forward as telecommunication technology for the transfer of medical data from one (1) site to another through the use of a camera or similar device that records or stores an image which is transmitted or forwarded via telecommunication to another site for teleconsultation and includes, but is not limited to, teleradiology.

7. The transmission cost as the cost of the line charge incurred during the time of the transmission of a telehealth service.

Source: Miss. Code Ann. § 43-13-121.

History: Moved from Miss. Admin. Code Part 220, Rule 1.4. eff. 07/01/2015.

Rule 3.2: General Provider Information

A. Providers of teleradiology services must comply with all requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the provider specific requirements below:

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

2. Copy of current licensure card or permit, and

3. Verification of social security number using a social security card, military ID or a notarized statement signed by the provider noting the social security number. The name noted on the verification must match the name noted on the W-9.

B. Teleradiology services must be delivered by an enrolled Medicaid provider acting within their scope-of-practice and license and in accordance with state and federal guidelines.

C. The use and delivery of teleradiology services does not alter a covered provider's privacy obligations under federal/and or state law and a provider or entity operating telehealth services that involve protected health information ("PHI") must meet the same HIPAA requirements the provider or entity would for a service provided in person.

D. The teleradiology service provider must ensure:

1. Images are provided without clinically significant loss of data from image acquisition through transmission to final image display to enable the consulting provider to accurately interpret the image,

2. Equipment used provides image quality appropriate to the clinical need.

3. The radiologic examination at the originating site be performed at the originating site by qualified personnel:

a) Trained in the performance of the specified radiological service,

b) Operating within the licensure requirements of the state in which the service is being performed, and

c) Under the supervision of a qualified licensed physician.

4. Teleradiology systems provide network and software security protocols to protect the confidentiality of a beneficiary's identification and imaging data with measures implemented to safeguard the data and to ensure data integrity against intentional or unintentional corruption of the data.

Source: The Health Insurance Portability and Accountability Act ("HIPAA") of 1996 (as amended by the Genetic Information Nondiscrimination Act ("GINA") of 2008 and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act ("ARRA") 0f 2009) and its implementing regulations, including 45 C.F.R. Parts 160 and 164, Subparts A and E ("Privacy Rule"), and Subparts A and C ("Security Rule"); Miss. Code Ann. § 43-13-121.

History: Moved with Revisions from Miss. Admin. Code Part 220, Rule 1.4. eff. 07/01/2015.

Rule 3.3: Covered Services

The Division of Medicaid covers:

A. One (1) technical and one (1) professional component for each teleradiology procedure only for providers enrolled as a Mississippi Medicaid provider and when there are no geographically local radiologist providers to interpret the images.

B. The technical component of the radiological service is covered at the originating site.

C. The professional component of the radiological service is covered at the distant site.

Source: Miss. Code Ann. § 43-13-121.

History: Moved with Revisions from Miss. Admin. Code Part 220, Rule 1.4. eff. 07/01/2015.

Rule 3.4: Non-Covered Services

The Division of Medicaid does not cover:

A. The transmission cost or any other associated cost of teleradiology,

B. Both the technical and professional component of teleradiology services for one (1) provider, or

C. One (1) provider billing for services performed by another provider.

Source: Miss. Code Ann. § 43-13-121.

History: Moved from Miss. Admin. Code Part 220, Rule 1.4. eff. 07/01/2015.

Rule 3.5: Reimbursement

A. The Division of Medicaid reimburses for:

    1. The technical component of the radiological service at the originating site for only providers enrolled as a Mississippi Medicaid provider.

    2. The professional component of the radiological service at the distant site only for providers enrolled as a Mississippi Medicaid provider.

B. If a hospital chooses to bill for purchased or contractual teleradiology services, the service must be billed under a physician group provider number only.

Source: Miss. Code Ann. § 43-13-121.

History: Moved from Miss. Admin. Code Part 220, Rule 1.4. eff. 07/01/2015.

Rule 3.6: Documentation

A. Teleradiology documentation must include, but not limited to:

1. At the originating site:

   a) The reason teleradiology was utilized to deliver the service including there was no local radiologists to interpret the images,

   b) Date(s) of service,

   c) Beneficiary demographic information,

   d) Signed consent for treatment, if applicable,

   e) Medical history,

   f) Beneficiary's presenting complaint,

   g) Diagnosis, and

   h) Specific name/type of all diagnostic studies and results/findings of the studies.

2. At the distant site:

   a) Date(s) of service,

   b) Beneficiary demographic information,

   c) Medical history,

   d) Beneficiary's presenting complaint,

   e) Diagnosis,

   f) Specific name/type of all diagnostic studies and results/findings of the studies, and

   g) Radiological images.

Source: Miss. Code Ann. § 43-13-121.

History: Moved from Miss. Admin. Code Part 220, Rule 1.4. eff. 07/01/2015.

Part 225 Chapter 4: Continuous Glucose Monitoring Services

Rule 4.1: Definitions

A. The Division of Medicaid defines telemedicine as a method which uses electronic information and communication equipment to supply and support health care when remoteness disconnects patients and links primary care physicians, specialists, providers, and beneficiaries which includes, but is not limited to, telehealth services remote patient monitoring services, teleradiology services, store-and-forward, and continuous glucose monitoring services.

B. The Division of Medicaid defines a continuous glucose monitoring service as:

1. The download, retrospective review and interpretation of blood glucose values by a physician, physician's assistant or nurse practitioner when captured for more than seventy-two (72) hours on a continuous glucose monitor system, and

2. Adjunct monitoring, not an alternative, to traditional self-monitoring of blood glucose levels, supplying additional information on glucose trends that are not available from self-monitoring.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 4.2: General Provider Information

A. Providers of continuous glucose monitoring services must comply with all requirements set forth in Miss. Admin. Code Part 200, Rule 4.8 for all providers in addition to the provider specific requirements below:

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

2. Copy of current licensure card or permit, and

3. Verification of social security number using a social security card, military ID or a notarized statement signed by the provider noting the social security number. The name noted on the verification must match the name noted on the W-9.

B. Continuous glucose monitoring services must be delivered by an enrolled Medicaid provider acting within their scope-of-practice and license and in accordance with state and federal guidelines.

C. The use and delivery of continuous glucose monitoring services does not alter a covered provider's privacy obligations under federal/and or state law and a provider or entity operating telehealth services that involve protected health information ("PHI") must meet the same HIPAA requirements the provider or entity would for a service provided in person.

Source: The Health Insurance Portability and Accountability Act ("HIPAA") of 1996 (as amended by the Genetic Information Nondiscrimination Act ("GINA") of 2008 and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), Title XIII of Division A, and Title IV of Division B of the American Recovery and Reinvestment Act ("ARRA") 0f 2009) and its implementing regulations, including 45 C.F.R. Parts 160 and 164, Subparts A and E ("Privacy Rule"), and Subparts A and C ("Security Rule"); Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 4.3: Covered Services

A. The Division of Medicaid covers:

1. A continuous glucose monitoring service when using an FDA approved minimally invasive glucose monitoring system when medically necessary, prior authorized by the UM/QIO, Division of Medicaid or designee, ordered by the physician who is actively managing the beneficiary's diabetes and the beneficiary meets all of the following criteria:

    a) Has an established diagnosis of type I diabetes mellitus that is poorly controlled as defined below:

        1) Unexplained hypoglycemic episodes,

        2) Nocturnal hypoglycemic episode(s),

        3) Hypoglycemic unawareness and/or frequent hypoglycemic episodes leading to impairments in activities of daily living,

        4) Suspected postprandial hyperglycemia,

        5) Recurrent diabetic ketoacidosis, or

        6) Unable to achieve optimum glycemic control as defined by the most current version of the American Diabetes Association (ADA).

    b) Has documented self-monitoring of blood glucose at least four (4) times per day.

    c) Requires insulin injections three (3) or more times per day or requires the use of an insulin pump for maintenance of blood glucose control.

2. One (1) retrospective review and interpretation of blood glucose values per month.

3. A one (1) time device hook-up which includes beneficiary education.

B. The Division of Medicaid does not require the provider to have a face-to-face office visit with the beneficiary to download, review and interpret the blood glucose data.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 4.4: Non-Covered Services

The Division of Medicaid does not cover continuous glucose monitoring for:

A. Non-diagnostic or personal use at home, or

B. Beneficiaries with type II diabetes mellitus.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 4.5: Reimbursement

A. The Division of Medicaid reimburses for:

1. One (1) retrospective review and interpretation of blood glucose values per month, and

2. A one (1) time device hook-up which includes beneficiary education.

B. The Division of Medicaid does not reimburse for a separate Evaluation and Management (E&M) visit unless a separately identifiable service is performed.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.

Rule 4.6: Documentation

Continuous glucose monitoring service documentation must include, but is not limited to:

A. The beneficiary and/or care giver is capable of operating the continuous glucose monitoring system,

B. The beneficiary:

1. Has an established diagnosis of type I diabetes mellitus that is poorly controlled as defined in Miss. Admin. Code Part 225, Rule 4.3.A.1.a),

2. Requires three (3) insulin injections per day, or use of an insulin pump, for maintenance of blood glucose control,

3. Is compliant with the physician ordered diabetic treatment plan including, but not limited to:

   a) Regular self-monitoring of at least four (4) times a day, and

   b) Multiple alterations in insulin administration orders.

C. The monitoring equipment is Food and Drug Administration (FDA) Class II hospital-grade medical device and is capable of accurately measuring and transmitting beneficiary blood data.

Source: Miss. Code Ann. § 43-13-121.

History: New eff. 07/01/2015.