Title 23: Division of Medicaid

Part 202: Hospital Services

Chapter 1: Inpatient Services

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 1.4.A.8(a)(b), 1.4.A.9(a)(b), 1.4.C. to correspond with SPA 2012-008 (eff. 10/01/2012) eff. 10/01/2012.

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) eff. 10/01/2012.

Rule 5.6: Hysterectomy

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

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

History: Moved from Rule 1.6 and revised eff. 10/01/2013.