Title 23: Division of Medicaid

Part 203: Physician Services

Chapter 1: General

Rule 1.4: Physician Office Visits

A. The Division of Medicaid covers a combined total of sixteen (16) non-psychiatric physician office and hospital outpatient department visits per state fiscal year whether occurring during or after office hours or provider established office hours. [Refer to Miss. Admin. Code, Part 200, Rule 9.5 for psychiatric physician office and hospital outpatient department visits.]

B. The Division of Medicaid:

1. Defines regularly scheduled office hours as the hours between 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding Saturday, Sunday and federal and state holidays, referred to in Rule 1.4 as "office hours".

2. Permits providers to set regularly scheduled office hours outside of the Division of Medicaid's definition of office hours, referred to in Rule 1.4 as "provider established office hours".

3. Requires providers to maintain records indicating the provider's established office hours and any changes including:

a) The date of the change,

b) The provider established office hours prior to the change, and

c) The new provider established office hours.

C. The Division of Medicaid reimburses a fee in addition to the appropriate Evaluation and Management (E&M) code for a physician office visit when the visit:

1. Occurs during the provider established office hours which are set outside of the Division of Medicaid's definition of office hours, or

2. Occurs outside of office hours or provider established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or provider established office hours.

D. The Division of Medicaid reimburses only the appropriate E&M code for a physician office visit scheduled during office hours or provider established office hours but not occurring until after office hours or provider established office hours.

Source: 42 C.F.R. § 440.230; Miss. Code Ann. § 43-13-117, 43-13-121.

History: Revised to correspond with SPA 18-0020 (eff. 01/01/2019) eff. 06/01/2019; Removed Miss. Admin. Code Part 203, Rule 1.4.E. with the approval of SPA 2013-032 on 08/08/2014, and SPA 2013-033 on 08/05/2014, eff. 06/01/2015.

Chapter 9: Psychiatric Services

Rule 9.5: Service Limits

A. The Division of Medicaid defines service limits as the maximum quantity of services per beneficiary that are eligible for reimbursement by the Division of Medicaid within a given time frame, either daily or yearly.

B. The following daily service limits apply to beneficiaries, regardless of the setting, hospital/residential or community-based, in which the services are provided:

1. Individual and Family Therapy - No more than one (1) service in any of the categories of individual psychotherapy or family psychotherapy is eligible for reimbursement by Medicaid on any given day.

2. Group Therapy

a) Generally, one (1) service of group therapy can be billed per day.

b) Two (2) services in group psychotherapy may be eligible for reimbursement on any given day when the following criteria are met:

1) Two (2) distinct sessions, each having mutually exclusive goals and objectives, are provided, and

2) Two (2) sessions per day are medically necessary, and

3) Two (2) sessions per day are appropriate and in accordance with the standards of medical practice, and

4) Documentation in the clinical record substantiates that the above criteria were met.

C. The following yearly service limits apply to non-EPSDT-eligible beneficiaries:

1. The Division of Medicaid covers a combined total of sixteen (16) psychiatric physician office and hospital outpatient department visits per state fiscal year (July 1-June 30). [Refer to Miss. Admin. Code, Part 200, Rule 9.5 for non-psychiatric physician office and hospital outpatient department visits.]

2. Hospital Inpatient Services

   a) Inpatient hospital psychiatric services are reimbursed under the APR-DRG methodology and are available only if the services are determined to be medically necessary by the Utilization Management/Quality Improvement Organization (UM/QIO). Day outlier payments may be made for mental health long lengths of stay for exceptionally expensive cases.

   b) Prior authorization is required upon admission and for lengths of stay greater than nineteen (19) days.

   c) One (1) covered psychiatric service/procedure is eligible for reimbursement per beneficiary per certified day in a general hospital or acute freestanding psychiatric facility.

Source: 42 C.F.R. § 440.230; Miss. Code Ann. § 43-13-117, 43-13-121.

History: Revised to correspond with SPA 18-0020 (eff. 01/01/2019) eff. 06/01/2019; Revised - 10/01/2012.

Title 23: Division of Medicaid

Part 203: General Provider Information

Chapter 1: General

Rule 1.4: Physician Office Visits

A. The Division of Medicaid covers ~~twelve~~ a combined total of sixteen (16~~2~~) non-psychiatric physician office and hospital outpatient department visits per state fiscal year whether occurring during or after office hours or provider established office hours. [Refer to Miss. Admin. Code, Part 200, Rule 9.5 for psychiatric physician office and hospital outpatient department visits.]

B. The Division of Medicaid:

1. Defines regularly scheduled office hours as the hours between 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding Saturday, Sunday and federal and state holidays, referred to in Rule 1.4 as "office hours".

2. Permits providers to set regularly scheduled office hours outside of the Division of Medicaid's definition of office hours, referred to in Rule 1.4 as "provider established office hours".

3. Requires providers to maintain records indicating the provider's established office hours and any changes including:

a) The date of the change,

b) The provider established office hours prior to the change, and

c) The new provider established office hours.

C. The Division of Medicaid reimburses a fee in addition to the appropriate Evaluation and Management (E&M) code for a physician office visit when the visit:

1. Occurs during the provider established office hours which are set outside of the Division of Medicaid's definition of office hours, or

2. Occurs outside of office hours or provider established office hours only for a condition which is not life-threatening but warrants immediate attention and cannot wait to be treated until the next scheduled appointment during office hours or provider established office hours.

D. The Division of Medicaid reimburses only the appropriate E&M code for a physician office visit scheduled during office hours or provider established office hours but not occurring until after office hours or provider established office hours.

Source: 42 C.F.R. § 440.230; Miss. Code Ann. § 43-13-117, 43-13-121.

History: Revised to correspond with SPA 18-0020 (eff. 01/01/2019) eff. 06/01/2019; Removed Miss. Admin. Code Part 203, Rule 1.4.E. with the approval of SPA 2013-032 on 08/08/2014, and SPA 2013-033 on 08/05/2014, eff. 06/01/2015.

Chapter 9: Psychiatric Services

Rule 9.5: Service Limits

A. The Division of Medicaid defines service limits as the maximum quantity of services per beneficiary that are eligible for reimbursement by the Division of Medicaid within a given time frame, either daily or yearly.

B. The following daily service limits apply to beneficiaries, regardless of the setting, hospital/residential or community-based, in which the services are provided:

1. Individual and Family Therapy - No more than one (1) service in any of the categories of individual psychotherapy or family psychotherapy is eligible for reimbursement by Medicaid on any given day.

2. Group Therapy

a) Generally, one (1) service of group therapy can be billed per day.

b) Two (2) services in group psychotherapy may be eligible for reimbursement on any given day when the following criteria are met:

1) Two (2) distinct sessions, each having mutually exclusive goals and objectives, are provided, and

2) Two (2) sessions per day are medically necessary, and

3) Two (2) sessions per day are appropriate and in accordance with the standards of medical practice, and

4) Documentation in the clinical record substantiates that the above criteria were met.

C. The following yearly service limits apply to non-EPSDT-eligible-beneficiaries~~adult beneficiaries aged twenty-one (21) years and older~~:

1. The Division of Medicaid covers a combined total of sixteen (16) ~~P~~psychiatric physician office and hospital ~~O~~outpatient department visits ~~Services - Beneficiaries are limited to twelve (12) covered psychiatric services/procedures~~ per state fiscal year (July 1-June 30). [Refer to Miss. Admin. Code, Part 200, Rule 9.5 for non-psychiatric physician office and hospital outpatient department visits.]

2. Hospital Inpatient Services

   a) Inpatient hospital psychiatric services are reimbursed under the APR-DRG methodology and are available only if the services are determined to be medically necessary by the Utilization Management/Quality Improvement Organization (UM/QIO). Day outlier payments may be made for mental health long lengths of stay for exceptionally expensive cases.

   b) Prior authorization is required upon admission and for lengths of stay greater than nineteen (19) days.

   c) One (1) covered psychiatric service/procedure is eligible for reimbursement per beneficiary per certified day in a general hospital or acute freestanding psychiatric facility.

Source: 42 C.F.R. § 440.230; Miss. Code Ann. § 43-13-117, 43-13-121.

History: Revised to correspond with SPA 18-0020 (eff. 01/01/2019) eff. 06/01/2019; Revised - 10/01/2012.