MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 203
Physician Services

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Title 23: Division of Medicaid

Part 203: Physician Services

Part 203 Chapter 1: General

Rule 1.1: Provider Enrollment Requirements for Physicians, Osteopaths, Chiropractors, Podiatrists

Physician providers may participate in the Medicaid program upon compliance with the applicable provider enrollment requirements outlined in Miss. Admin. Code Title 23, Part 200, Chapter 4.
Source: Miss. Code Ann. § 43-13-121

History: Revised eff. 08/01/2026.

Rule 1.2: Physician Fees

Effective for dates of services on and after July 1, 2022, physicians' services are reimbursed at ninety percent (90%) of the Medicare Physician Fee Schedule.

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

History: Revised eff. 07/01/2022; Revised eff. 07/01/2021.

Rule 1.3: Medical Visit Editing

Medicaid does not provide separate reimbursement for most Evaluation and Management (E&M) services when a substantial diagnostic or therapeutic procedure is performed.

Source: Miss. Code Ann. § 43-13-121
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 203, 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.

E. The Division of Medicaid reimburses physician visits related to opioid treatment as part of a monthly bundle.

1. Physicians that are providing office based opioid treatment must be appropriately licensed and operating within the scope of their practice.

2. Physician visits provided as part of the office based opioid treatment bundle do not count toward the physician visit limit.

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

History: Revised eff. 01/01/2026. Revised eff. 04/01/2022; 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.

Rule 1.5: Hospital Inpatient Visits/ Consultations

A. An initial hospital visit for the beneficiary's attending physician is covered. A subsequent hospital visit by the attending physician is not covered on the same day as the initial visit.

B. Inpatient hospital physician visits are limited to one (1) per day, per specialty. An exception is made when the patient is in an Intensive Care Unit (ICU) or Coronary Care Unit (CCU) where the limit is two (2) visits per day, per specialty.

C. An initial inpatient consultation is covered for each consultant of a different specialty if the patient's condition justifies the medical necessity for multiple consultations. Only one (1) initial consultation is allowed per beneficiary, per consultant, per admission.

D. A subsequent hospital visit and a hospital discharge visit on the same date of service are not both covered; only the hospital discharge visit is a covered service.

Source: Miss.Code Ann. § 43-13-121.

History: Revised to correspond with MS SPA 25-0009 (05/01/2025) eff. 01/01/2026.

Rule 1.6: Locum Tenens/Reciprocal Billing Arrangements

A. Locum Tenens: For purposes of this rule a "locum tenens" arrangement is defined when the regular physician retains a substitute physician to take over the practice during an absence. A regular physician is the physician that is normally scheduled to see a patient. The regular physician usually pays the substitute physician a fixed amount per diem, with the substitute physician being an independent contractor rather than an employee.

B. Reimbursement shall be made to the patient's regular physician for covered services of a locum tenens physician who is not an employee of the regular physician and whose services for patients of the regular physician are not restricted to the regular physician's offices when all the following criteria are met:

1. The regular physician is unavailable to provide the services,

2. The regular physician pays the locum tenens for the services on a per diem or similar fee-for-time basis,

3. The Medicaid beneficiary has arranged or sought to receive services from the regular physician,

4. The substitute physician does not provide the services to the Medicaid beneficiary over a continuous period of longer than sixty (60) days,

5. The locum tenens physician is an enrolled Mississippi Medicaid provider with a valid Mississippi Medicaid provider number,

6. The regular physician identifies the services as substitute physician services,

7. The claim is billed with the National Provider Identifier (NPI) of the regular physician,

8. The regular physician keeps on file a record of each service provided by the substitute physician, and

9. The regular physician ensures that the locum tenens physician is properly licensed to practice medicine in the state of Mississippi; or, if the regular physician practices in another state, the state in which the regular physician is licensed to practice.

C. Reciprocal Billing Arrangement: Medicaid defines reciprocal billing arrangement when a regular physician or group has a substitute physician provide covered services to a Medicaid beneficiary on an occasional reciprocal basis. A physician can have reciprocal arrangements with more than one physician. The arrangements need not be in writing.

1. Medicaid covers reciprocal billing arrangements when the regular physician arranges to be provided by a substitute physician on an occasional reciprocal basis if all the following criteria are met:

   a) The regular physician is unavailable to provide the services,

   b) A reciprocal billing arrangement is typically an agreement among physicians that one will cover the other's practice when the regular physician is absent. Physicians can have reciprocal arrangements with more than one physician,

   c) The Medicaid beneficiary has arranged or sought services from the regular physician,

   d) The substitute physician does not provide the services to a Medicaid beneficiary over a continuous period of longer than sixty (60) days,

   e) The substitute physician is an enrolled Mississippi Medicaid provider with a valid Mississippi Medicaid provider number,

   f) The regular physician identifies the services as substitute physician on the appropriate claim form,

   g) The regular physician keeps on file a record of each service provided by the substitute physician, associated with the substitute physician's National Provider Identifier (NPI), and

   h) The regular physician ensures that the substitute physician is properly licensed to practice medicine in the state of Mississippi; or, if the regular physician practices in another state, the state in which the regular physician is licensed to practice.

2. Medicaid does not cover reciprocal services for substitution arrangements among physicians in the same medical group except when a group member provides services on

behalf of another group member who is the designated attending physician for a hospice patient.

D. Covered Visit Service - Medicaid covers the submission of claims for a medical group under reciprocal billing arrangements for the covered visit services of a substitute physician who is not a member of the group. Medicaid defines a continuous period of covered visit services that begins with the first day on which the substitute physician provides covered visit services to patients of the regular physician, and it ends with the last day on which the substitute physician provides these services to these patients before the regular physician returns to work. This period continues without interruption on days on which no covered visit services are provided to patients on behalf of the regular physician or are furnished by some other substitute physician on behalf of the regular physician. A new period of covered visit services can begin after the regular physician has returned to work.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Teaching Facilities' Billing for Resident Services

A. Medicaid does not apply Medicare policy related to billing for services performed by residents in a teaching facility. Medicaid does not cover services provided under the direction of the teaching physician.

B. Medicaid covers teaching physicians, who are supervising residents, but requires the teaching physician to physically be present in the room with the beneficiary and requires documentation in the teaching physician medical record that they were physically present in the room with the beneficiary when services were rendered by the resident.

Source: Miss. Code Ann. § 43-13-121

Rule 1.8: Casting, Splinting, or Strapping in Office Setting

A. Physicians, physician assistants, or nurse practitioners must bill the appropriate procedure evaluation and management code, fracture or dislocation codes, or application of casts and strapping code to be reimbursed professional fees for application of casts, splints, or strapping performed in the office setting. Providers must follow the procedure coding guidelines for selection of the appropriate code.

B. For casting, splinting, or strapping supplies provided by a physician, physician assistant, or nurse practitioner in the office setting, the provider must bill the procedure codes for the cost of the supplies.

C. The coding criteria listed above apply to replacement casts, splints, or strapping.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: Removal of Impacted Cerumen

A. Medicaid covers the removal of impacted cerumen only for symptoms directly related to the presence of impacted cerumen. Symptoms include, but are not limited to, the following:

    1. Earache,

    2. Itching of the ear,

    3. Feeling that the ear is plugged,

    4. Partial hearing loss,

    5. Ringing in the ear, or

    6. Otorrhea

B. Medicaid does not cover simple removal of non-impacted cerumen and is considered incidental to an evaluation and management service.

C. Medicaid requires documentation to support occlusion, impaction or blockage, of the external auditory canal secondary to cerumen. The presence of earwax, without symptoms, is not sufficient to support need for removal and symptoms of wax impaction.

Source: Miss. Code Ann. § 43-13-121

Rule 1.10: 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 Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Rule 1.11: Physician Verbal Orders

The Division of Medicaid defines physician verbal orders as physician orders that are verbally communicated by telephone, telehealth or face-to-face to authorized medical personnel regarding medications, treatments, interventions or other beneficiary care.

A. Providers are permitted to use physician verbal orders, as long as the verbal order is:

    1. Dated,

    2. Timed, and

3. Promptly documented by authorized medical personnel that is responsible for the beneficiary's care and authorized to receive verbal orders in accordance with State law.

B. Verbal orders must be signed by the ordering physician within fourteen (14) days of the date the verbal order was given except for:

1. Pharmacy verbal orders which must be signed in compliance with the Mississippi Pharmacy Practice Regulations.

2. Nursing facility verbal orders which must be signed:

a) Within thirty (30) days of the date the verbal order was given during the first ninety (90) days after admission.

b) Within sixty (60) days of the date the verbal order was given after the initial ninety (90) days from admission.

Source: 42 C.F.R. §§ 482.23, 482.24, 483.30; Miss. Code Ann. §§ 43-13-117, 43-13-121; Miss. Admin. Code Title 30, Part 3001.

History: New rule eff. 05/01/2020.

Part 203 Chapter 2: Physician-Administered Drugs and Implantable Drug System Devices

Rule 2.1: Covered Services

A. The Division of Medicaid covers medically necessary physician-administered drugs and implantable drug system devices defined as a drug other than vaccines, diagnostic or therapeutic radiopharmaceutical, contrast imaging agent, biological or implantable drug system device covered under the Social Security Act § 1927(k)(2) that:

1. Are administered by a medical professional in a physician's office or other outpatient clinical setting,

2. Are incident to physician services that are separately billed to the Division of Medicaid,

3. Qualifies for rebate in accordance with 42 USC § 1396r-8,

4. Are Food and Drug Administration (FDA) approved or follows medically accepted indications and dosing limits supported by one (1) or more of the official compendia as designated by the Centers for Medicare and Medicaid Services (CMS), and

5. Are not considered cosmetic, investigational, experimental or unproven.

B. The Division of Medicaid requires prior authorization for certain physician-administered drugs and implantable drug system devices as determined by the Division of Medicaid.

C. The Division of Medicaid reimburses for discarded drugs or biologicals up to the dosage amount indicated on the single-use vial or package label minus the administered dose(s) if:

1. The drug or biological is supplied in a single use vial or single–use package,

2. The drug or biological is actually administered to the beneficiary to appropriately address his/her condition and any unused portion is discarded,

3. The amount wasted is recorded in the beneficiary's medical record,

4. The provider has written policy and procedures regarding single-use drugs and biologicals and bills all payers in the same manner, and

5. The amount billed to the Division of Medicaid as a discarded drug is not administered to another beneficiary or patient.

D. The Division of Medicaid does not reimburse for discarded drugs or biologicals when:

1. A beneficiary misses an appointment,

2. A multi-use vial or package is used,

3. The actual dose of the drug or biological administered is less than the billing unit,

4. The drug or biological is administered during an inpatient stay, or

5. The extra amount of the drug is provided to account for wastage in a syringe hub.

E. The Division of Medicaid defines an implantable drug system device as an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent or other similar or related article, including a component part, or accessory which is:

1. Recognized in the official National Formulary, the United States Pharmacopoeia or any supplement to one of these, or

2. Intended for use in the diagnosing of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease.

F. The Division of Medicaid covers the insertion and removal of a Food and Drug Administration (FDA) approved implantable drug system device if it:

1. Is medically necessary,

2. Is in compliance with its approved uses, specifications and restrictions, and

3. Meets all other applicable coverage requirements.

G. The Division of Medicaid does not cover:

1. Services related to the use of a non-covered medical device, or

2. Implantable drug system devices that are considered experimental or investigational.

Source: 42 U.S.C. § 1396r-8; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2019; Added Miss. Admin. Code Part 203, Rule 2.1.A.5. eff. 05/01/2016. Emergency Filing eff. 03/02/2016. Revised eff. 07/01/2014.

Rule 2.2: Drug Rebates

A. In accordance with federal regulations, the Division of Medicaid collects Medicaid drug rebates from manufacturers on physician-administered drugs per the following:

1. Effective for all drugs administered on and after January 1, 2008, providers must submit the National Drug Code (NDC) of the drug administered in addition to the appropriate drug code for physician-administered drugs on claims.

a) An NDC is not required for vaccines or other drugs as specified by CMS.

b) The NDC of the drug administered must contain eleven (11) digits in the five (5) four (4) two (2) grouping and, if applicable, include "leading zeros (0)" to constitute an eleven (11) digit NDC code.

c) The NDC of the drug administered must be matched against a database to ensure its validity.

2. Providers reimbursed based on a fee-for-service must submit the NDC of the drug administered with the appropriate code(s) including, but not limited to, ambulances, independent radiology clinics, free-standing and hospital based dialysis facilities, nurse practitioners, optometrists, individual physicians, physician groups, physician assistants, and podiatrists.

3. Providers reimbursed based on a per diem, encounter or other type of rate are not required to submit the NDC or appropriate code(s) for drugs administered/dispensed by providers including, but not limited, to outpatient hospitals, federally qualified health centers (FQHC), rural health clinics (RHC), ambulatory surgical centers (ASC), home health agencies, nursing homes or other long term-term care facilities.

4. The Division of Medicaid only reimburses for physician administered drugs that are:

a) Subject to the federal rebate program, and

b) Not considered Drug Efficacy Study Implementation (DESI) drugs.

5. Providers participating in the 340B program must adhere to all the provisions in Miss. Admin. Code Part 200, Chapter 4, Rule 4.10.

B. The Division of Medicaid has the authority to recoup monies when an audit determines that the incorrect NDC number was billed.

Source: Deficit Reduction Act of 2005; 42 U.S.C. § 1396r–8; Miss. Code Ann. § 43-13-121.

History: Revised eff. 09/01/2015; Revised eff. 07/01/2014.

Rule 2.3: [Refer to Miss. Admin. Code Part 203, Rule 2.1]

Rule 2.4: [Refer to Miss. Admin. Code Part 203, Rule 2.1]

Rule 2.5: [Refer to Miss. Admin. Code Part 203, Rule 2.1]

Rule 2.6: [Refer to Miss. Admin. Code Part 203, Rule 2.1]

Rule 2.7: 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 Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 3: Anesthesia

Rule 3.1: Provider Enrollment

A. Providers of anesthesia services must meet the applicable requirements set forth in Part 200, Chapter 4.

B. Anesthesiologists must meet the physician requirements outlined in Part 203, Chapter 1, Rule 1.1.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2026.

Rule 3.2: Covered Services

A. Medicaid covers anesthesia services provided by an anesthesiologist/certified registered

nurse anesthetists (CRNA).

B. Medicaid covers CRNAs for anesthesia services for surgical procedures using the appropriate anesthesia codes.

C. Medicaid covers administration of anesthesia by a CRNA, without medical direction, at ninety percent (90%) of the calculated payment for anesthesiologists. The appropriate modifier must be used when billing for services that are not medically directed.

D. Medicaid covers medically directed CRNA services at fifty percent (50%) of the allowance for the anesthesiologist. The appropriate modifier should be used when billing for services that are medically directed.

Source: Miss. Code Ann. § 43-13-121

Rule 3.3: Criteria for Medical Direction of Resident

A. Medicaid covers an anesthesiologist who assumes full responsibility for a patient while the anesthesia is being administered by a resident in a teaching facility.

1. Medicaid only covers one anesthesiologist for the professional services.

2. Medicaid covers the appropriate modifier indicating that the anesthesiologist has assumed full responsibility for the patient while the anesthesia is being administered by a resident in a teaching facility.

3. The medical direction of residents is covered only in a teaching facility.

4. Medicaid covers the anesthesiologist to supervise no more than four (4) residents at any one time.

5. Medicaid does not cover medical direction by CRNAs.

B. Medicaid covers for the medical direction only if the following criteria are met:

1. Anesthesiologist must be present in the immediate area of the operating or delivery suite with the resident and available for immediate diagnosis and treatment.

2. Anesthesiologist must perform and assist the resident in a pre-anesthesia examination and evaluation.

3. Anesthesiologist must prescribe the anesthesia plan for/with the resident.

4. Anesthesiologist must personally participate in the most demanding procedures of the anesthesia plan, including induction and emergence with the resident.

5. Anesthesiologist must ensure that no procedures were performed by a non-qualified anesthetist.

6. Anesthesiologist must monitor the course of anesthesia with the resident.

7. Anesthesiologist must at all times supervise and assist the resident with any procedure being performed by the resident.

8. Anesthesiologist must provide indicated post-anesthesia care with the resident.

C. The anesthesiologist and the resident must sign the anesthesia report.

Source: Miss. Code Ann. § 43-13-121

Rule 3.4: Billing for Procedures

A. Medicaid defines one (1) anesthesia time unit as one (1) minute.

B. Medicaid defines anesthesia time as when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under post-operative supervision.

C. Medicaid does not cover additional modifying units for physical status, extreme age, utilization of total body hypothermia or controlled hypotension, or emergency conditions.

D. Medicaid covers additional coverage for the insertion of an arterial line, CVP line, or the insertion/placement of a flow directed catheter such as a Swan-Ganz when the procedures are personally performed by the anesthesiologist/CRNA in conjunction with anesthesia services for a surgical procedure.

Source: Miss. Code Ann. § 43-13-121

Rule 3.5: 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 Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 4: Surgery

Rule 4.1: Definitions

A. For purposes of this chapter Medicaid defines the following terms related to surgery as

follows:

1. Add-on codes are procedures performed in addition to the primary service/procedure and are never reported as a stand-alone code.

    a) Add-on codes describe additional intra-service work associated with the primary procedure.

    b) Add-on codes are exempt from multiple surgery rules.

2. Assistant surgeon is a licensed physician who actively assists the physician in charge of a case in performing a surgical procedure.

3. Bilateral procedures are exact procedures identified by the same procedure codes which are performed on anatomically bilateral sides of the body during the same operative session.

4. Co-surgeons are two (2) surgeons, each usually in a different specialty, who are required to perform specific procedures during the same operative setting. Co-surgery also refers to surgical procedures involving two (2) surgeons performing the parts of the procedure simultaneously, such as bilateral knee replacements.

5. Endoscopic procedure is the performance of a procedure on interior organs and cavities of the body through an endoscope.

6. An endoscope is a flexible fiber optic instrument used to visualize the interior of a body cavity or organ.

7. Incidental procedure is a procedure carried out at the same time as a primary procedure, is clinically integral to the performance of the primary procedure or requires little additional physician resources.

8. Multiple deliveries are two (2) or more infants delivered from one (1) pregnancy.

9. Multiple surgeries are separate procedures performed by the same physician on the same patient at the same operative setting. Medicaid applies multiple surgery rules to certain procedure codes except for certain procedures exempt from multiple surgery rules.

10. Mutually exclusive procedures are the separate billing for two (2) or more procedures that are usually not performed for the same patient on the same date of service.

11. Team surgeon is a team of surgeons, more than two (2) surgeons of different specialties, required to perform a specific procedure.

12. Unbundled procedures are the use of two (2) or more procedure codes to describe a procedure or event when a single procedure code exists that comprehensively describes

the surgery performed.

Source: Miss. Code Ann. § 43-13-121

Rule 4.2: Assistant Surgeon

A. Medicaid covers an assistant surgeon during major surgery, including all surgical cases performed under spinal or regional anesthesia if the nature of the surgery requires the assistance of a second physician or surgeon. Medicaid covers only one (1) assistant surgeon for any case.

B. Medicaid does not cover interns, residents, fellows, physician assistants, and nurses, including nurse practitioners, as an assistant surgeon.

C. Medicaid covers the services of an assistant surgeon when the following criteria are met:

1. The operation must be a covered surgical procedure, and

2. The operation must be of sufficient difficulty and complexity to require an assistant surgeon, and

3. The assistant surgeon must actively assist in the surgery.

a) Medicaid defines actively assist as the assistant surgeon must assist in the actual performance of the surgical procedure, and

b) The assistant surgeon, in the event the surgeon is unable to continue, must be able to complete the surgery.

D. Medicaid covers the assistant surgeon's services at sixteen percent (16%) of the surgical fee for that particular surgery.

E. The appropriate modifier in conjunction with the procedure code for services rendered is required to identify an assistant surgeon's services.

F. Medicaid does not cover an assistant surgeon in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and which has a qualified resident available, unless one (1) of the following circumstances exists:

1. The assistant surgeon certifies that his services were medically necessary and no qualified resident was available to perform the services. There may be some instances when no qualified residents are available to assist in surgery due to a number of factors that include, but are not limited to, involvement in other activities, complexity of the surgery, number of residents in the program, or other valid reasons.

2. Exceptional medical circumstances, including emergency, life-threatening situations such

as multiple traumatic injuries requiring immediate treatment.

3. The primary surgeon has an across-the-board policy on never involving residents in the preoperative, operative, or postoperative cares of his/her patients.

Source: Miss. Code Ann. § 43-13-121

Rule 4.3: Co-Surgeons

A. Medicaid covers the individual skills of two (2) or more surgeons when required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery.

B. Medicaid covers co-surgeons at sixty two and one half percent (62.5%) of the Medicaid coverage for co-surgeon procedures.

C. Medicaid covers the services of two (2) surgeons of the same specialty without regard to the two (2) specialty requirement when the services are justified by medical documentation.

D. Medicaid covers the services of two (2) surgeons in different specialties when performing a specific procedure.

1. This is also applicable when the different procedures are performed through the same incision.

2. Each surgeon must report the procedure he/she performed.

E. The appropriate modifier in conjunction with the procedure code for services rendered is required to identify a co-surgeon's services.

Source: Miss. Code Ann. § 43-13-121

Rule 4.4: Team Surgeons

A. Medicaid covers two (2) or more surgeons to perform surgery on the same patient during the same operative session.

B. Medicaid covers the surgeons of different specialties performing a different procedure, even if the procedures are performed through the same incision.

C. The appropriate modifier in conjunction with the procedure code for services rendered is required to identify a co-surgeon's services.

Source: Miss. Code Ann. § 43-13-121

Rule 4.5: Multiple Surgeries

A. Part 203, Chapter 4 Rule 4.5.A, B is applicable for assistant surgeon, team surgeon, or co-surgeon services.

B. Medicaid reimburses for the primary procedure at the highest reimbursement rate from the Medicaid Physician Fee Schedule. The primary surgical procedure must be billed first and other procedures must be billed on subsequent lines on the claim.

C. Medicaid covers multiple surgical procedures performed by the same surgeon on the same patient and on the same date of service. The surgical procedures must be billed together on the same claim unless one (1) claim does not accommodate all of the procedures.

D. For multiple surgeries performed on the same day, Medicaid covers the following:

1. Multiple surgical procedures performed at the same operative setting through a single opening are reimbursable at the Medicaid rate for the procedure with the greatest reimbursement. The additional surgeries through this same opening are not reimbursable unless a second surgical procedure adds significant time, risk, or complexity to patient care which Medicaid will reimburse as follows:

    a) The surgery with the greater Medicaid allowed amount will be reimbursed at the full amount.

    b) The second surgery will be reimbursed at one half the Medicaid allowance.

    c) The secondary procedure must be billed with the appropriate modifier.

    d) No additional benefits are paid toward incidental, mutually exclusive, or unbundled procedures.

2. Multiple surgical procedures performed at the same operative setting through separate incisions are covered as follows:

    a) The surgery with the greater Medicaid allowance amount will be reimbursed at the full amount.

    b) Secondary surgeries, will be paid at one half (1/2) of the Medicaid allowance.

        1) These procedures must be identified with the appropriate modifier.

        2) No benefits are provided for incidental, mutually exclusive, and unbundled procedures.

3. Secondary procedures must meet all of the following criteria:

a) The secondary procedure is to correct a separate pathological condition,

b) That pathological condition would have required intervention had an incision not already been present, and

c) The degree of difficulty, operative time and risk were significantly increased by the secondary procedure.

4. If, after a surgical procedure has been completed, it becomes necessary to return and perform a subsequent surgical procedure that same day, Medicaid will cover the full-allowed amount for each surgical setting in accordance with multiple surgery criteria.

E. Medicaid covers designated add on codes and other exempt codes from multiple surgery rules and coverage for multiple surgeries do not apply to these codes.

Source: Miss. Code Ann. § 43-13-121

Rule 4.6: Bilateral Procedures

A. Medicaid covers bilateral procedures performed during an operative setting, when reported with the appropriate procedure code and modifier. One (1) procedure will be paid at one hundred percent (100%) of the Medicaid allowable and the second procedure will be paid at fifty percent (50%) of the Medicaid allowable.

B. If the bilateral procedures are both secondary procedures to a primary procedure, the bilateral secondary procedures will each be paid at fifty percent (50%) of the Medicaid allowable.

Source: Miss. Code Ann. § 43-13-121

Rule 4.7: Surgical Modifiers

A. The applicable modifiers for bilateral procedures, multiple procedures, co-surgeons, surgical teams, and assistant surgeons must be utilized on claims for surgery.

B. Medicaid reimburses for surgical care only at eighty-five percent (85%) of the Medicaid allowable. The applicable modifier for this service must be reported with the appropriate surgery procedure codes.

C. Medicaid reimburses for postoperative management only at fifteen percent (15%) of the Medicaid allowable. The applicable modifier for this service must be reported with the appropriate surgery procedure codes.

1. Medicaid requires a documented agreement for the transfer of care when one (1) physician performs a patient's surgical service and another provides the postoperative management.

2. The agreement must be in the form of a letter, discharge summary, chart notation, or other

written documentation and be retained in each physician' beneficiary's medical record.

D. No separate benefits are allowed for preoperative management as it is inclusive in the allowance for surgical care.

Source: Miss. Code Ann. § 43-13-121

Rule 4.8: Endoscopic Procedures

A. Medicaid considers the following incidental and not covered:

1. A diagnostic scope and a surgical scope in the same setting,

2. A diagnostic scope with biopsy and a surgical scope,

3. A diagnostic scope with or without biopsy done with an endoscope and an open surgical procedure in the same anatomic area, or

4. A diagnostic scope and diagnostic scope with biopsy unless the verbiage distinguishes the procedure as "with biopsy" versus "without biopsy".

B. Mutually exclusive relationships to endoscopic procedures are based on the following:

1. Complete versus partial,

2. With versus without, and

3. Extensive versus limited.

C. If endoscopic and open surgical procedures are both performed at the same surgical setting, Medicaid covers the clinically more intense procedure.

1. An endoscopic and an open surgical procedure in the same anatomic area are not covered by Medicaid for separate reimbursement.

2. Medicaid covers endoscopic-assisted, open surgical procedures performed on the same anatomic area during the same operative session when additional time, skill, and physician resources are required with the two (2) approaches, rather than a longer, more invasive open procedure, that can minimize morbidity, patient recovery, and scarring.

D. If multiple endoscopic procedures are performed during the same operative session, Medicaid covers the most complex procedure.

Source: Miss. Code Ann. § 43-13-121

Rule 4.9: Post-Operative Pain Management

A. The surgeon is responsible for daily post-operative pain management services except under extraordinary circumstances.

B. Medicaid covers post-operative pain management provided by several means, including, but not limited to:

    1. Oral and parenteral administration,

    2. Patient controlled analgesia (PCA), and

    3. Epidural.

C. Providers must maintain proper and complete documentation to verify the services provided. The provider has full responsibility for maintaining documentation to justify the services provided.

    1. At a minimum, the medical record must include, but is not limited to, the following:

        a) The medical necessity of providing the service.

        b) The daily services provided by the surgeon.

        c) The name, strength, dosage, route, date and time, indication for, and the administration of medications administered to the patient.

        d) Documentation supporting failure of conservative management.

        e) Relevant clinical signs and symptoms.

    2. Documentation must be legible and medical records must be available to Medicaid, the fiscal agent, and/or the Utilization Management/Quality Improvement Organization (UM/QIO) upon request.

Source: Miss. Code Ann. § 43-13-121

Rule 4.10: Abdominal Panniculectomy

A. Medicaid covers abdominal panniculectomy (abdominoplasty, abdominodermatolipectomy) only when there is medical documentation that demonstrates the procedure is:

    1. Medically necessary,

    2. Reconstructive,

3. Performed to alleviate the patient's symptomatology, and

4. Performed to improve function.

B. Abdominal panniculectomy performed in conjunction with a primary abdominal surgical procedure will be considered as part of the primary surgery. No additional reimbursement will be made toward the abdominal panniculectomy.

C. Medicaid recognizes the performance of abdominal panniculectomy as appropriate and medically necessary when performed to relieve clinical signs and symptoms resulting from redundant skin following a massive weight loss, symptomatology related to panniculitis, and/or the facilitation of abdominal surgery for those persons defined as morbidly obese. The surgeon's documentation must include presenting or past occurrences of any of the following signs and symptoms including, but not limited to:

1. Pain to abdominal pannus and/or lower back,

2. Impaired ambulation,

3. Interference with personal hygiene,

4. Signs and symptoms of panniculitis,

5. Large redundant fold of skin and fat hanging below the groin,

6. Recurrent intertrigo to the overhanging pannus resulting in skin infections,

7. Body Mass Index greater than thirty (30),

8. Presence of lymphedema, abscesses or hernias, and

9. Documentation of size and configuration of pannus as evidenced in photographs.

D. Prior approval for abdominal panniculectomy is not required.

1. The surgeon must retain all documentation supporting medical necessity in the medical record.

2. The final determination of medical necessity will be made by the surgeon based on the criteria listed in this Rule.

Source: Miss. Code Ann. § 43-13-121

Rule 4.11: Blepharoplasty

A. Medicaid covers a surgical blepharoplasty when performed by a general surgeon, plastic

surgeon or ophthalmologist in the physician's office, inpatient or outpatient facility or an ambulatory surgical center.

B. Medicaid defines:

1. Blepharoplasty as any surgery of the eyelid performed to improve abnormal functions or reconstruct deformities.

2. Cosmetic blepharoplasty as surgery performed to reshape normal structures of, or surrounding, the eye solely for the purpose of improving the patient's appearance or self-esteem.

3. Reconstructive blepharoplasty as surgery performed to correct visual impairment and/or restore normalcy to a structure that has been altered by trauma, infection, inflammation, degeneration, neoplasia or developmental errors.

C. Prior authorization is not required. The determination of medical necessity will be made by the surgeon based on Medicaid's coverage criteria. Documentation of visual fields showing un-taped upper vision at twenty-five (25) degrees or better is interpreted as normal and is considered cosmetic.

D. Medicaid covers blepharoplasty and/or repair of blepharoptosis procedures when performed for the following functional indications. Any indication other than the following are deemed not medically necessary and will be considered cosmetic and non-covered procedures.

1. Lower eyelid blepharoplasty is considered medically necessary when documentation:

a) Supports horizontal lower eyelid laxity of medial and lateral canthus resulting in ectropion, dacrystenosis and infection, and/or

b) Supports massive lower eyelid edema.

2. Upper eyelid blepharoplasty and/or brow lift is considered medically necessary when:

a) Clinical notes and visual field testing support a decrease in peripheral vision and/or upper field vision,

b) Photographs document obvious dermatochalasis, ptosis or brow ptosis compatible with the visual field determinations, and

c) Documentation of visual fields must show upper eyelid taped improvement to greater than twenty-five (25) degrees.

3. Repair of brow ptosis and blepharoptosis are considered medically necessary for the following functional indications:

a) Clinical notes and visual field testing support a decrease in peripheral vision and/or upper field vision,

b) Photographs document obvious dermatochalasis, ptosis, or brow ptosis compatible with the visual field determinations, and

c) Documentation of visual fields must show upper eyelid taped improvement to greater than twenty five (25) degrees.

4. Ptosis Repair is considered medically necessary when:

a) Pre-operative ptosis results in an eyelid covering of one fourth (1/4) of the pupil or one (1) to two (2) millimeters (mm) above the midline of the pupil, and

b) Documentation of the visual fields must show upper eyelid taped improvement to greater than twenty five (25) degrees.

E. The medical record must, at a minimum, include:

1. Complete opthalmological history and physical.

2. Documentation of patient complaints which justify functional surgery and are commonly found in patients with ptosis, pseudoptosis or dermatochalasis.

a) This may include interference with vision or visual field, difficulty reading due to upper eyelid drooping, looking through the eyelashes or seeing the upper eyelid skin or chronic blepharitis.

b) Both photographic and visual field testing are required.

3. Photographs must demonstrate one or more of the following:

a) The upper eyelid margin approaches to within two and one half (2.5) mm (of the diameter of the visible iris) of the corneal light reflex,

b) The upper eyelid skin rests on the eyelashes, or

c) The upper eyelid indicates the presence of dermatitis.

4. Photographs must be prints, not slides, and must include a frontal and lateral view.

a) The head must be perpendicular, not tilted, to the focal plane of the camera to demonstrate a skin rash or position of the true eyelid margin or the pseudo-eyelid margin.

b) The photos must be of sufficient clarity to show a light on the cornea.

c) If redundant skin coexists with true eyelid ptosis, additional photos must be taken with the upper eyelid skin retracted to show the actual position of the true eyelid margin.

d) Oblique photos may be needed to demonstrate redundant skin on the upper eyelashes when this is the only indication for surgery.

5. Visual field testing must be recorded using either a Goldmann Perimeter (III 4-E object) or a programmable automated perimeter (equivalent to a screening field with a single intensity strategy using a 10db stimulus) to test a superior (vertical) extend of fifty (50) to sixty (60) degrees above fixation with targets presented at a minimum four (4) degree vertical separation starting at twenty four (24) degrees above fixation while using no wider than a ten (10) degree horizontal separation.

6. Each eye must be tested with the upper eyelid at rest and repeated with the eyelid elevated to demonstrate an expected surgical improvement meeting or exceeding the criteria.

Source: Miss. Code Ann. § 43-13-121

Rule 4.12: Circumcisions

A. Medicaid does not cover circumcisions unless medical necessity is documented in the medical record according to the criteria listed below.

1. A diagnosis which justifies the medical necessity for circumcision including, but not limited to, recurrent balanoposthitis or recurrent urinary tract infections; the diagnosis of phimosis alone is not sufficient documentation of medical necessity,

2. Failure of the patient to respond to conservative treatment; documentation of conservative treatment must include, but not limited to, teaching about appropriate hygiene and listing of appropriate drug therapy used to treat the condition, and

3. The recurrent nature of the medical condition.

C. The medical documentation must be included either in the surgeon's report or a beneficiary's attending physician records to justify medical necessity. A pathology report alone is not sufficient as documentation of medical necessity.

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

E. Medically necessary circumcisions may be performed in the inpatient hospital setting subject to precertification of all inpatient days, the outpatient hospital setting, the ambulatory surgical center, or a physician's office.

F. Reimbursement for hospital inpatient procedures will be included in the per diem rate of the facility and may be included in the cost report.

1. Facility charges for procedures performed in the outpatient department of the hospital will be reimbursed according to established Medicaid rates for outpatient hospital services.

2. Facility charges for procedures performed in an ambulatory surgical center are paid according to the Medicaid Ambulatory Surgical Center procedure schedule.

3. Physician fees are reimbursed based on the Medicaid Physician Fee Schedule.

G. Appropriate anesthesia, which is considered the standard of care, is covered in accordance with the Division of Medicaid's rules for anesthesia services. Refer to Part 203, Chapter 3.

Source: Miss. Code Ann. § 43-13-121

Rule 4.13: [Refer to Miss. Admin. Code Part 203, Rule 2.1]

Rule 4.14: [Refer to Miss. Admin. Code Part 203, Rule 2.1]

Rule 4.15: Keloids

A. Medicaid covers the initial evaluation consultation to diagnose the condition and/or develop a plan of treatment.

B. Medicaid covers treatment only when there is medical documentation that demonstrates any of the following signs and symptoms:

1. Pain,

2. Persistent itching and/or burning sensation,

3. Ulceration and bleeding,

4. Limitation of movement of the head or a digit or extremity,

5. Obstruction of a bodily orifice,

6. Infection, or

7. Fast growth.

C. Medicaid covered Keloid treatments include the following:

1. Intralesional injection, including cortisone injections,

2. Topical treatment,

3. Excision (surgery), and

4. Radiation therapy.

D. Medicaid does not require prior approval for treatment of keloids.

1. The physician must retain all documentation supporting medical necessity in the record.

2. Documentation must include size, location and severity of symptoms.

3. Photographs may also be used to support medical necessity.

Source: Miss. Code Ann. § 43-13-121

Rule 4.16: Male Gynecomastia

A. Medicaid covers mastectomy, including reconstruction if necessary, for gynecomastia when considered medically necessary when the following criteria are met:

1. The tissue removed is glandular breast tissue and not the result of obesity, adolescence, or reversible effects of a drug treatment which can be discontinued (this would include drug-induced gynecomastia remaining unresolved six (6) months after cessation of the causative drug therapy),

2. Appropriate diagnostic evaluation has been done for possible underlying etiology,

3. Pain or tenderness directly related to the breast tissue has been refractory to a trial of analgesics, anti-inflammatory agents, etc., for a time period adequate to assess therapeutic effects,

4. The excessive breast tissue development is not caused by non-covered therapies or illicit drug usage such as marijuana, anabolic steroids, etc.,

5. The beneficiary has a physician documented history of two (2) years or more of gynecomastia that has been refractory to conservative treatments,

6. Unclothed preoperative photographs from the chin to the waist, including standing frontal and side views with arms straight down at sides, and

7. The beneficiary is over eighteen (18) years of age, or eighteen (18) months after the end of puberty.

B. Medicaid does not consider mastectomy for gynecomastia to be medically necessary under

certain circumstances. Examples of such circumstances Medicaid does not cover include, but are not limited to, the following:

1. The beneficiary has pseudogynecomastia, which is excess adipose tissue in the male breast, but with no increase in glandular tissue,

2. The procedure is for cosmetic purposes, or

3. Only liposuction is used as the surgical procedure.

C. Medical record documentation of medical necessity must include all of the following:

1. A summary of the medical history and last physical exam, including the information specified in Part 203, Chapter 4 Rule 4.15.A,

2. All prior treatments used to manage the beneficiary's medical symptoms,

3. Results from any diagnostic tests pertinent to the diagnosis taken within the last six months,

4. Photo documentation confirming breast hypertrophy taken within the last six months with the beneficiary's name and date on each photo,

5. A surgical treatment plan that outlines the amount of tissue to be removed from each breast and the prognosis for improvement of clinical signs and symptoms pertinent to the diagnosis, and

6. Other pertinent clinical information that Medicaid may request.

D. Providers must maintain proper and complete documentation to verify the services provided. The provider has full responsibility for maintaining documentation to justify the services provided.

Source: Miss. Code Ann. § 43-13-121

Rule 4.17: Otoplasty

A. Medicaid covers otoplasty for the correction of ears that protrude more than twenty (20) millimeters (mm) and at an angle greater than thirty five (35) degrees from the occipital scalp when the following criteria is meet:

1. For the correction of an external ear deformity associated with an abnormality of the external ear canal such as stenosis.

2. When the procedure is intended to improve a hearing impairment.

3. When performed as part of a staged reconstruction for an absent or inadequate external ear.

4. When the reconstruction involves a cochlear implant and the procedure is required for proper functioning of the device.

B. Medicaid does not cover otoplasty when performed solely for the purpose of improving or altering appearance or self-esteem, or to treat psychological symptomatology or psychosocial complaints related to one's appearance. Conditions for which Medicaid considers otoplasty cosmetic include:

1. Prominent/protruding ears defined by Medicaid as minor deformities that are considered an anatomic variance and do not meet the measurements listed under Part 203, Chapter 4, Rule 4.16.A.,

2. Lop ears,

3. Cupped ears, or

4. Constricted ears.

C. Medicaid does not cover otoplasty for children under the age of five (5).

D. The medical record must include the relevant history and physical finding indicating the coverage criteria, and must include the following:

1. Photographs of frontal, lateral, and oblique ear positions. The name of the patient and the date of the photograph must be marked on each photograph.

2. Detailed medical history,

3. Hearing evaluation and test results, if performed, and

4. Physical examination.

Source: Miss. Code Ann. § 43-13-121

Rule 4.18: Reduction Mammoplasty

A. The Division of Medicaid covers reduction mammoplasty only when there is medical documentation that demonstrates the procedure is:

1. Medically necessary,

2. Reconstructive, and

3. Performed as a last means of attempting to alleviate a beneficiary's symptomatology and dysfunction due to the excessive breast size.

B. The Division of Medicaid covers reduction mammoplasty only when there is documentation that the beneficiary meets all of the following:

1. If under the age of eighteen (18), and has been evaluated by the primary care provider,

2. The primary care provider has documented that the beneficiary:

a) Is appropriate for this procedure, and

b) Has reached the age of sixteen (16) and Tanner Stage V of the Tanner Staging of Sexual Maturity Rating.

3. The primary care provider agrees that the beneficiary is appropriate for a surgical evaluation for reduction mammoplasty.

C. Justification for reduction mammoplasty must be based on the probability of relieving clinical signs and symptoms of macromastia. The surgeon's documentation must include the following criteria:

1. A complete and accurate beneficiary history that includes complaints of pain and restriction of normal activity for the past two (2) years.

2. Medical necessity for the removal of a minimum of five hundred (500) grams of tissue from each breast. If the removal of the amount of breast tissue is less than five hundred (500) grams, the surgeon must provide full documentation in the medical record that justifies reduction mammoplasty with removal of less than five hundred (500) grams.

3. Supra sternal notch to nipple measurement of twenty-eight (28) cm or greater.

D. In addition to the criteria listed in Miss. Admin. Code Part 203, Chapter 4, Rule 4.18.C., documentation of the following may support the determination of medical necessity:

1. A history of intertrigo under or between breasts,

2. A psychological assessment, and/or

3. Documentation of deep grooves over the shoulders from bra straps.

E. The surgeon must retain all documentation supporting medical necessity in the medical record.

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

History: Revised eff. 05/01/2026. Revised eff. 03/01/2019.

Rule 4.19: Skin Tag Removal

A. Medicaid does not cover removal of benign skin tags that do not pose a threat to health or function.

B. Medicaid covers the removal of skin tags when there is medical documentation that one or more of the following conditions exist:

1. The skin tag has one or more of the following characteristics: bleeding, itching, pain,

2. The skin tag has physical evidence of inflammation such as purulence, oozing, edema, erythema,

3. The skin tag obstructs an orifice,

4. The skin tag clinically restricts vision,

5. There is clinical uncertainty as to the likely diagnosis, particularly where malignancy is a realistic consideration based on the skin tag appearance, or

6. A prior biopsy suggests or is indicative of malignancy.

C. Medicaid requires documentation to include the patient's signs and symptoms and skin tag physical findings including size, location, appearance, number, duration and changes over time, tissue diagnosis report, operative note with detail to support the surgical procedure performed.

Source: Miss. Code Ann. § 43-13-121

Rule 4.20: Uvulopalatopharyngoplasty (UPPP/UP3)

Medicaid covers uvulopalatopharyngoplasty for the treatment of obstructive sleep apnea syndrome if all of the following are present:

A. Documented obstructed sleep apnea (OSA) with apnea hypopnea index (AHI) or respiratory disturbance index (RDI) which meets the following parameters in a) or b) below:

1. UPPP/UP3 as sole procedure: with AHI/RDI greater than fifteen (15) and less than forty (40), or AHI/RDI ten (10) to fifteen (15) with one (1) or more of the conditions listed below:

a) Hypertension,

b) Cardiac arrhythmias predominately during sleep,

c) Pulmonary hypertension,

d) Documented ischemic heart disease,

e) Impaired cognition or mood disorders,

f) History of stroke, or

g) Excessive daytime sleepiness, as documented by either a score of greater than ten (10) on the Epworth Sleepiness Scale or inappropriate daytime napping such as during driving, conversation, or eating, or sleepiness that interferes with daily activities.

2. UPPP/UP3 as part of a planned staged or combined surgery aimed at also relieving retro lingual obstruction such as genioglossal advancement, hyoid myotomy and suspension: with AHI/RDI greater than fifteen (15), or AHI/RDI ten (10) to fifteen (15) with one (1) or more of the conditions listed below:

a) Hypertension,

b) Cardiac arrhythmias predominately during sleep,

c) Pulmonary hypertension,

d) Documented ischemic heart disease,

e) Impaired cognition or mood disorders,

f) History of stroke, or

g) Excessive daytime sleepiness, as documented by either a score of greater than ten (10) on the Epworth Sleepiness Scale or inappropriate daytime napping, (e.g., during driving, conversation, or eating) or sleepiness that interferes with daily activities.

B. Continuous positive airway pressure (CPAP) has been tried with well-supported follow-up and clearly failed or is not tolerated.

C. Pre-operative evaluation including fiber optic endoscopy suggest retro-palatal narrowing is the primary source of airway obstruction if UPPP/UP3 is the sole procedure or a combined surgery aimed at also relieving retro lingual obstruction.

Source: Miss. Code Ann. § 43-13-121

Rule 4.21: Ventricular Assist Devices (VAD)

A. Medicaid covers medically necessary procedures for the insertion or removal of FDA-approved ventricular assist devices (VAD) in accordance with its FDA approved uses as follows:

1. Post-cardiotomy procedures for insertion/removal of a VAD performed during the period following open-heart surgery.

2. Bridge-to-transplant procedures for insertion/removal of a VAD performed during the period prior to heart transplant when the patient is at imminent risk of dying before donor heart procurement.

3. Destination therapy procedures for insertion/removal of a VAD performed as a permanent mechanical cardiac support for individuals with severe New York Heart Association (NYHA) Class IV heart failure, and who are not eligible for heart transplantation.

B. Medicaid does not cover procedures using non-FDA approved devices and/or done for indications other than those approved by the FDA including, but not limited to:

1. Procedures using devices that are considered experimental, investigational, or part of clinical trials.

2. Procedures for replacement of the human heart with an artificial heart.

C. Medicaid does not allow separate reimbursement for the ventricular devices.

Source: Miss. Code Ann. § 43-13-121

Rule 4.22: 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 Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Rule 4.23: Gastric Electrical Stimulation (GES)

A. The Division of Medicaid covers Gastric Electrical Stimulation (GES) when used for the treatment of chronic intractable (drug-refractory) nausea and vomiting secondary to gastro-paresis of diabetic or idiopathic etiology. The Food and Drug Administration has approved the GES device through a humanitarian exemption.

B. The beneficiary's medical record must contain documentation that the implanting facility's institutional review board (IRB) or equivalent governing body has approved the implantation of the GES for the specific indications listed in Rule 4.23 A.

C. GES is considered medically necessary if a beneficiary has a diagnosis of gastroparesis and meets all of the following criteria:

1. Is refractory or intolerant of two (2) out of three (3) classes of prokinetic medications and two (2) out of three (3) antiemetic medications,

2. Has significantly delayed gastric emptying as documented by standard scintigraphic imaging of solid food,

3. Has a poor nutritional status and enteral feedings or total parental nutrition (TPN) is medically necessary, and

4. Is age eighteen (18) through seventy (70).

D. All other indications including, but not limited to, the treatment of obesity, are considered investigational and not medically necessary.

E. GES is not covered for beneficiaries who are:

1. Pregnant,

2. Suffering from chemical dependency,

3. Undergoing peritoneal dialysis, or

4. Terminal with a limited life expectancy based on a diagnosis of cancer.

F. Prior authorization by the UM/QIO is required.

Source: Miss. Code Ann. § 43-13-121

History: 04\01\2013

Part 203 Chapter 5: Chiropractor

Rule 5.1: Covered Services

A. Medicaid covers chiropractic services for manual manipulation of the spine to correct a subluxation.

B. An x-ray must demonstrate that a subluxation exists and if the subluxation has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment.

Source: Miss. Code Ann. § 43-13-121

Rule 5.2: Reimbursement

The fee for chiropractic manipulation shall be reimbursed per the fee schedule and shall not exceed seven hundred dollars ($700) per fiscal year (July 1 - June 30) per beneficiary.

Source: Miss. Code Ann. § 43-13-121

Rule 5.3: Coverage Criteria

A. A chiropractor must use the appropriate procedure code for manual manipulation of the spine to correct subluxation. Medicaid coverage will be provided for one (1) procedure code that encompasses the entire treatment for any given day.

B. Necessity of treatment must be documented by use of the appropriate diagnosis code to report all of the following:

    1. Treatment area as denoted by the appropriate primary diagnosis code.

    2. Symptoms associated with subluxation as denoted by the appropriate second diagnosis code.

    3. Complicating factors as denoted by the appropriate third diagnosis code.

C. An x-ray is required to demonstrate that a subluxation exists unless the patient is:

    1. Pregnant,

    2. Suspects pregnancy which has not yet been confirmed, or

    3. A child age twelve (12) years or less.

D. The date of the x-ray or the exception(s) must be properly documented in the medical record including the:

    1. Date of the x-ray which must be within twelve (12) months of the date of service.

    2. Expected date of delivery if the patient is pregnant.

    3. Date of last menstrual period if pregnancy is suspected but not confirmed.

    4. Child's date of birth when the child is twelve (12) years of age or less. The x-ray is at the discretion of the chiropractor.

E. Medicaid applies the appropriate procedure codes for chiropractic services and x-ray procedures toward the seven hundred dollars ($700) per fiscal year (July 1 - June 30) per beneficiary.

Source: Miss. Code Ann. § 43-13-121

Rule 5.4: Dual Eligibles

A. For beneficiaries covered under Medicare and Mississippi Medicaid (dual eligibles), chiropractic providers must not file a claim with Medicaid for the manipulation of the spine procedures not covered by Medicare. Mississippi Medicaid benefits are not available for services that do not satisfy Medicare's medical necessity criteria.

B. For beneficiaries covered under Medicare and Medicaid (dual eligibles), chiropractic providers may file a claim with Medicaid for those specified codes not covered by Medicare.

C. The six (6) month timely filing limitation for filing crossover claims is applicable with no exceptions.

Source: Miss. Code Ann. § 43-13-121

Rule 5.5: Documentation Requirements

The chiropractor must maintain auditable records that substantiate the services provided. At a minimum, the records must contain the following on each patient:

A. The dates of services provided.

B. The patient's presenting complaint.

C. Date of the x-ray which must be within twelve (12) months of the date of service.

D. Expected date of delivery if the patient is pregnant.

E. Date of last menstrual period if a pregnancy is suspected but not confirmed.

F. Child's date of birth when the child is twelve (12) years of age or less. (The x-ray is at the discretion of the chiropractor).

G. The results/findings of all diagnostic studies.

H. The patient's history and physical findings.

I. The treatment rendered, including:

1. Frequency,

2. Proposed length,

3. Progress, and

4. Prognosis.

J. The chiropractor's signature.

Source: Miss. Code Ann. § 43-13-121

Rule 5.6: 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 Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 6: Podiatry

Rule 6.1: Covered Services

Medicaid covers the following podiatry services:

A. Laboratory services required for care of a systemic condition are covered only to the MD/DO supervising the systemic condition or to a laboratory to which the MD/DO has referred the specimen.

B. Physical therapy services that are medically necessary and appropriate for the treatment of the foot condition.

C. Radiology services provided in an office setting that are medically necessary and include both the technical and professional components of the service if provided.

D. Foot care required as a result of or associated with systemic conditions limited to once every sixty (60) days.

E. Surgical treatment of ingrown toenails. Localized pathology of the soft tissue surrounding the nail must demonstrate that it is severe enough to require professional intervention.

F. Debridement if gross contamination requires prolonged cleansing.

G. Surgical debridement of mycotic nails with a manual or electric grinder method if the following conditions exists:

1. Clinical evidence of mycosis of the toenail.

2. Documentation of the severity of the condition and if patient ambulatory have marked

limitation of ambulation, pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate and for non-ambulatory patients must suffer pain or secondary infection resulting from the thickening and dystrophy of the infected toenail plate.

H. Debridement of mycotic nails once every sixty (60) days.

I. Correction of hammertoe.

J. Definitive treatment of viral or plantar warts.

K. Medical or surgical treatment of subluxation of the ankle joint (talocrural joint). Services that are medical or surgical, diagnosis, or treatment for medical conditions that have resulted from or associated with partial displacement of structures.

L. Treatment of paronychia for stages A and B when avulsion or debridement is provided.

M. Foot care in the presence of metabolic, peripheral, or neurological disease including the following:

1. Diabetes Mellitus,

2. Arteriosclerosis obligerans,

3. Buerger's disease,

4. Chronic thrombophlebitis, or

5. Peripheral neuropathies involving feet that are associated with malnutrition, alcoholism, malabsorption, or pernicious anemia, peripheral neuropathies

Source: Miss. Code Ann. § 43-13-121

Rule 6.2: Non-covered services

Medicaid does not cover the following:

A. Identification of culture of fungi in the toenail clippings is not covered.

B. Local anesthesia, digital blocks, or topical anesthesia done with a specific surgical procedure.

C. Cast applications/strapping/splinting charged separately from the initial surgery or fracture care on same day as initial surgery or fracture care.

D. Removal of casts/straps/splints.

E. Ultrasound on patients with diabetes.

F. Foot massage.

G. Whirlpool for mycotic nail treatment.

H. Surgical trays.

I. Supplies.

J. Biopsies performed in conjunction with a surgical procedure.

K. Services for treatment of flat foot.

L. Services not medically necessary for the diagnosis and treatment of the condition of the foot.

M. Laboratory services performed by the DPM (Doctor of Podiatric Medicine) or referred to an independent laboratory by the DPM.

N. Services performed for conditions above the ankle unless within the scope of the podiatrist license.

O. Office visits with routine foot care procedures.

P. Routine foot examinations on all patients in a skilled nursing facility on a routine basis for screening purposes.

Q. Orthopedic shoes, any other type shoe, and/or supportive devices.

R. Routine foot care with debridement of nails on same date of service. Routine foot care may not be substituted for debridement of nails when the once every sixty day limit has been utilized.

S. Doppler (other than hand held Doppler), non-vascular diagnostic testing pertaining to a systemic disease.

T. Evaluation and advice for proper care of feet when the only service rendered for the management of paronychia. Debridement and avulsion may not be done on the same date of service.

U. Surgical or nonsurgical treatments provided for the sole purpose of correcting a subluxated structure in the foot as an isolate entity.

V. Palliative treatment of viral or plantar warts.

W. Routine foot care, in the absence of systemic conditions, including the following:

1. The cutting or removal or corns or calluses,

2. The trimming of nails, including the cutting, clipping, or debridement of ingrown toenails, club nails, or mycotic nails,

3. Fungal infections of the nail plates or mycotic nails with little or no symptomatology,

4. Avulsing small chips after trimming of the thickened/elongated nails that are painful, under the diagnosis of ingrown toenail,

5. Other hygienic and preventive maintenance care and any other service provided in the absence of localized illness, injury, or symptoms involving the foot, or

6. Routine soaking and application of topical medication.

Source: Miss. Code Ann. § 43-13-121

Rule 6.3: Anesthesia

A. Medicaid does not cover local infiltration, metacarpal/ metatarsal/ digital blocks, or topical anesthesia outside the specific surgical procedure performed.

B. Medicaid covers the cost of drugs used for IV sedation and must be billed with the appropriate HCPCS code

Source: Miss. Code Ann. § 43-13-121

Rule 6.4: Documentation

Medicaid requires podiatry providers to maintain auditable records that will substantiate the services provided. At a minimum, the records must contain the following on each patient:

A. Date(s) of service,

B. Patient's presenting complaint(s),

C. Patient's history and physical findings,

D. Treatment rendered, including: frequency of treatment, proposed length of treatment, and progress reports documenting the patient's progress with the treatment, and prognosis,

E. Narrative or operative report specific for procedure, type of anesthesia used for the procedure,

F. Clinical evidence of all conditions,

G. Accurate diagnosis codes to reflect all conditions,

H. X-rays ordered or obtained,

I. Full name and address of the MD/DO treating patient for a systemic condition and date of last visit with that MD/DO and must be within last six (6) months. Medical necessity must document the local pathology of the foot that requires professional intervention, identify complicating factors,

J. Full description of the clinical symptoms of the systemic condition,

K. Site of each wart, size, method of treatment or surgical removal,

L. Medical necessity of therapy, specific modality, or procedure, frequency of therapy, proposed length of therapy, and progress reports of patient's therapy,

M. Complicating conditions of the nail that limits ambulation, pain, or secondary infection result in thickening and dystrophy of the infected toenail plate,

N. Warts removed by cautery must include the number of lesions removed, their location, size and type of cautery used. If removed by surgical excision the operative note and pathology report on the excised tissue including number of specimens, their location, size, and any/all microscopic findings,

O. Nerve block injections must be reasonable and medically necessary and must indicate that a more conservative therapy has not been effective, must describe patient's clinical state, history , physical findings, laboratory and other tests, identification of the problem, including diagnosis, precipitating events, quantity and quality of pain, test results, response to previous therapy, the procedure performed, including area injected, the substance(s) injected, and the dosage of the substance(s),

P. Diagnosis(es) to substantiate all treatments/procedures,

Q. The name, strength, dosage, route (intramuscular, intravenous, subcutaneous, oral, and topical, etc.), date and time, indication for, and the administration of all medications administered to the patient,

R. Patient's or guardian's refusal of services, if applicable,

S. Photographs, if applicable, must be prints, not slides, and include the patient's name and date of service, to document severe paronychia, persistent, recurrent infections, clinical evidence of systemic conditions related to the foot, mycotic nails, severity of ulcers of the foot and progression of ulcer(s), deformities such as hammertoe, traumatic injuries, severity of ingrown toenails or ingrown toenail condition on toes other than big toe,

T. Description(s) of wound(s), ulcer(s), etc., if applicable, including size, appearance, and location for each date of service, and

U. Podiatrist signature.

Source: Miss. Code Ann. § 43-13-121

Rule 6.5: 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 Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 7: Nurse Practitioner

Rule 7.1: Provider Enrollment

A. Advanced Practice Registered Nurses (APRNs), also referred to as Nurse Practitioners (NPs), certified by the state in which they practice may participate in the Mississippi Medicaid Program upon compliance with the applicable provider enrollment requirements outlined in Part 200, Chapter 4.

Source: 42 C.F.R. Part 455, Subpart E; Miss. Code Ann. §§ 43-13-117, 43-13-121, 73-15-20.

History: Revised eff. 08/01/2026. Revised eff. 12/01/2019.

Rule 7.2: Nurse Practitioner Services and Reimbursement

The Division of Medicaid covers services provided by Advanced Practice Registered Nurses (APRNs), also referred to as Nurse Practitioners (NPs), certified by the state in which they practice, for services rendered within the scope of practice allowed by their protocol.

NPs must bill the appropriate Current Procedure Terminology (CPT) code for services rendered and follow the same rules and guidelines as physician services.

The Division of Medicaid reimburses NPs at ninety percent (90%) of the physician fee for the service.

The Division of Medicaid does not reimburse for:

1. An NP as an assistant surgeon,

2. Multiple providers when a service is performed simultaneously with another provider, or

3. NP services if the collaborating physician is not a Mississippi Medicaid enrolled provider or an Ordering, Referring or Prescribing (ORP) physician.

Source: 42 C.F.R. § 440.166; Miss. Code Ann. §§ 43-13-117, 43-13-121, 73-15-20.

History: Revised eff. 12/01/2019

Rule 7.3: 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 Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 8: Physician Assistant

Rule 8.1: Physician Assistant Enrollment Requirements

A. Physician assistants (PAs), who are licensed by the Mississippi State Board of Medical Licensure and are practicing with physician supervision under regulations adopted by the board, may participate in the Mississippi Medicaid Program upon compliance with the applicable provider enrollment requirements outlined in Part 200, Chapter 4.

B. The PA's supervising/collaborating physician must be enrolled with Mississippi Medicaid as:

    1. A Medicaid provider, or

    2. An Ordering, Referring or Prescribing (ORP) physician.

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

History: Revised eff. 08/01/2026. Revised eff. 12/01/2019.
Rule 8.2: Physician Assistant Services and Reimbursement

A. Physician assistants (PAs) may bill the Division of Medicaid for the covered services within the scope of practice allowed by their protocol.

B. PAs must bill the appropriate Current Procedure Terminology (CPT) code for services rendered and follow the same rules and guidelines as physician services.

C. The Division of Medicaid reimburses PAs at ninety percent (90%) of the physician fee for the service.

D. The Division of Medicaid does not reimburse for:

    1. A PA as an assistant surgeon,

2. Multiple providers when a service(s) is (are) performed simultaneously with another provider, or

3. PA services if the supervising physician is not a Mississippi Medicaid enrolled provider or an Ordering, Referring or Prescribing (ORP) physician.

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

History: Revised eff. 12/01/2019.

Rule 8.3: 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 Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 9: Psychiatric Services

Rule 9.1: Provider Qualifications

Psychiatric services described in this chapter must be provided by a licensed physician (medical doctor or doctor of osteopathy) who is board-certified in psychiatry or by a licensed Psychiatric Mental Health Nurse Practitioner (PMHNP). Rules included in this chapter do not apply to psychologists.

Source: Miss. Code Ann. § 43-13-121

Rule 9.2: General Requirements

A. All services must be personally and directly provided by the psychiatrist or PMHNP who requests reimbursement for the service.

B. Services must be based on beneficiary need and not the convenience of the beneficiary, the beneficiary's family or the provider.

C. A provider may bill only for the actual time spent in service delivery.

Source: Miss. Code Ann. § 43-13-121

Rule 9.3: Covered Services

The following psychiatric services are eligible for reimbursement by Medicaid only when they have been personally and directly provided by a licensed physician (medical doctor or doctor of osteopathy) who is board-certified in psychiatry or by a licensed Psychiatric Mental Health

Nurse Practitioner (PMHNP):

A. Evaluative Services which include a psychiatric interview ok an interactive psychiatric interview.

B. Therapeutic Services which include individual, family, and group psychotherapy.

C. Other psychiatric services/procedures including

    1. Medication evaluation, and

    2. Electroconvulsive therapy.

Source: Miss. Code Ann. § 43-13-121

Rule 9.4: Non-Covered Services

A. Services are not eligible for reimbursement unless they are personally and directly provided by the servicing provider.

B. Educational interventions of an academic nature are not eligible for Medicaid reimbursement.

C. Medicaid will not reimburse more than once for the same service provided to any beneficiary on any given date, regardless of the setting(s) in which the service was provided. It is the provider's responsibility to coordinate services with the beneficiary and/or his/her family member to ensure that services are not duplicated.

Source: Miss. Code Ann. § 43-13-121

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. Daily service limits apply to beneficiaries, regardless of the setting, hospital/residential or community-based, in which the services are provided.

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 eff. 07/01/2021; Revised to correspond with SPA 18-0020 (eff. 01/01/2019) eff. 06/01/2019; Revised - 10/01/2012.

Rule 9.6: Documentation

A. Physicians are required to maintain auditable records that will verify any or all services provided and billed under the Medicaid program.

1. Records must, be made available to representatives of the Division of Medicaid or Office of the Attorney General in substantiation of claims.

2. Records must be maintained for a minimum of five (5) years in order to comply with all state and federal regulations and laws. Refer to Maintenance of Records Part 200, Chapter 1, Rule 1.3.

B. It is expected that the initial psychiatric service provided to any beneficiary must be of an evaluative nature. Documentation of the evaluation must be in the case record and must include, at a minimum:

1. Dates, including beginning and ending session times, and the amount of time spent,

2. Chief complaint,

3. Referral source,

4. History of present illness,

5. Past psychiatric history,

6. Past medical history,

7. List of the beneficiary's current medications including prescription, non-prescription and over-the-counter,

8. Social and family history,

9. Comprehensive mental health status examination,

10. Treatment plan formulation/prognosis,

11. Assessment of the patient's ability to adhere to the treatment plan,

12. A multi-axial diagnosis,

13. Identification of the clinical problems that are to be the focus of treatment,

14. Treatment modalities and/or strategies that will be employed or are recommended to address each problem. If medications are prescribed, documentation must include the name of the drug, strength and dosage. The method of administration must be included for injectable medications. Medication prescriptions must be identified as issued in writing, electronically, or by telephone, and

15. The signature of the person who provided and documented the service. Any note that is "signed" by computer must be initialed by hand.

C. A treatment plan must be developed and implemented for each beneficiary no later than the date of the third (3rd) therapy session.

1. The treatment plan must include, at a minimum:

a) A multi-axial diagnosis,

b) Identification of the beneficiaries' and/or family's strengths,

c) Identification of the clinical problems, or areas of need, that is to be the focus of treatment,

d) Treatment goals for each identified problem,

e) Treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement,

f) Specific treatment modalities and/or strategies that will be employed to reach each objective, and

g) Date of implementation and signatures of the provider and the beneficiary or

parent/legal guardian.

2. Treatment plans must be kept in the case record and must be reviewed and revised as needed, or at least every three (3) months. Each review must be verified by the dated signatures of the provider and beneficiary/parent/legal guardian. The physician, nurse practitioner, psychologist, and clinical social worker must sign the treatment plan for the services each will provide to the beneficiary.

D. A clinical note for each therapeutic service provided must be in the case record and must:

1. Include the date of service, type of service provided, the length of time spent delivering the service, who received or participated in it, as well as a brief summary of what transpired. If medications are prescribed, documentation must include the name of the drug, strength and dosage. The method of administration must be included for injectable medications. Medication prescriptions must be identified as issued in writing, electronically, or by telephone.

2. Indicate whether Evaluation and Management services are provided.

3. Relate to the problems identified in clinical record.

4. Identify whether the service occurs in an inpatient or outpatient setting.

5. Be authenticated by the signature of the person who provided and documented the service. Any note that is "signed" by computer must be initialed by hand.

Source: Miss. Code Ann. § 43-13-121

Rule 9.7: 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 Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 203 Chapter 10: Implantable Medical Devices

Rule 10.1: Skin and Soft Tissue Substitutes

A. The Division of Medicaid defines skin and soft tissue substitutes as types of wound coverage materials composed of human tissue, non-human tissue, synthetic materials, or a composite of these materials which mimic or substitute for some aspect of the skin's structure, either permanently or temporarily, for the treatment of acute and chronic non-healing wounds and soft tissue grafting.

B. The Division of Medicaid covers skin and soft tissue substitute procedures, products, and services for medically accepted conditions and indications approved by the Food and Drug Administration (FDA) when medically necessary and when the procedures, products, and services are:

1. Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs,

2. Safely applied within the scope of FDA indications and according to manufacturer's instructions, and

3. No equally effective or more conservative or less costly treatment is available statewide.

C. The Division of Medicaid covers skin and soft tissue substitutes for the following, including, but not limited to:

1. Acute wounds,

2. Chronic non-healing wounds,

3. Soft tissue grafting,

4. Second and third degree burns,

5. Dermatological conditions which involve large areas of skin breakdown,

6. Post-surgical states in which skin coverage is inadequate or ability to heal is compromised,

7. Diabetic foot ulcers, and

8. Venous stasis ulcers.

D. The Division of Medicaid does not cover skin and soft tissue substitutes for experimental, investigational uses or clinical trials or for the following conditions or circumstances, including, but not limited to:

1. Infected ulcers,

2. Wounds or ulcers healing with traditional wound care dressings and treatment,

3. Underlying osteomyelitis,

4. Surrounding cellulitis,

5. Uncontrolled diabetes,

6. Vasculitis,

7. Eschar or any necrotic material,

8. Wound bed with exposed bone,

9. Uncontrolled rheumatoid arthritis, rheumatoid ulcers, or both,

10. Known hypersensitivity to:

    a) Collagen,

    b) Bovine-derived products, or

    c) Porcine-derived products,

11. Active Charcot's arthropathy of the ulcer extremity,

12. Arterial disease with an ankle brachial index (ABI) of less than .65 in respect to venous stasis ulcers or a lack of pedal pulses in respect to diabetic foot ulcers,

13. Ulcers with sinus tracts or tunnels,

14. Uncontrolled collagen vascular diseases,

15. Radiation and/or chemotherapy treatment within the month immediately preceding proposed skin substitute treatment, or

16. Current treatment with high-dose corticosteroids or immunosuppressants.

E. The provider must maintain auditable records that substantiate the services provided which must include, but are not limited to, the following:

    1. The diagnosis supporting medical necessity,

    2. Previous conservative wound management which has failed to induce healing,

    3. Exact location, size, including width, length, circumference, and depth, of the wound prior to initial treatment and prior to each subsequent treatment,

4. Response to wound treatment,

5. Appropriate adjunctive wound care measures,

6. The handling, application, and immobilization of the product in accordance with the manufacturer's instructions,

7. Amount of skin or soft tissue product used and wasted, and

8. Manufacturer's serial/lot/batch or other unit identification number of graft material, or documentation sufficient to demonstrate that the manufacturer does not supply unit identification.

Source: Social Security Act §§ 1862(a)(1)(A) and (D); 21 CFR Part 1271.

History: New Rule eff. 10/01/2014.