Title 23: Division of Medicaid

Part 202: Hospital Services

Part 202 Chapter 1: Inpatient Services

Rule 1.13: Out-of-State Facilities

A. Out-of-state hospitals are reimbursed under the APR-DRG payment methodology. The inpatient cost-to-charge ratios (CCRs) used to pay cost outlier payments for each out-of-state hospital are set using the Federal Register in effect as of July 1, 2021, that applies to the federal fiscal year beginning October 1, 2020, issued prior to the reimbursement period. The inpatient CCR is calculated using the sum of the statewide average operating urban CCR plus the statewide average capital CCR for each state.

B. For transplants not available in Mississippi, payment for transplant services performed outside of Mississippi is made under the MS APR-DRG payment methodology including a policy adjustor. If access to quality services is unavailable under the MS APR-DRG payment methodology, a case rate may be set as described in Part 202, Chapter 4, Rule 4.7.

C. For specialized services not available in Mississippi, the Division of Medicaid will make payment using the MS APR-DRG payment methodology. If MS APR-DRG payment limits access to care, the Division will reimburse what the domicile state pays for the service or a comparable payment other states reimburse under APR-DRG.

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

History: Revised eff. 07/01/2021; Revised - 01/01/2013, 10/01/2012

Rule 1.14: Inpatient Hospital Payments

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

B. The Division of Medicaid may adjust APR-DRG rates pursuant to changes in federal and/or state laws or regulations or to obtain budget goals. Effective July 1, 2021, all Plan changes must be authorized by the Mississippi Legislature and federal grantor agency, and rates shall not be increased, decreased or otherwise changed from the levels in effect on July 1, 2021, unless such changes are authorized by the Legislature.

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

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

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

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

1. The Cost-to-Charge Ratios (CCRs) used to calculate cost outlier payments are calculated for each provider by performing a desk review program developed by the Division of Medicaid, using the most recent filed cost report. The Division accepts amended original cost reports if the cost report is submitted prior to the end of the reimbursement period in which the cost report is used for payment purposes. If the provider's inpatient cost-to-charge ratio used to pay cost outlier payments is changed as a result of the amended cost report, no retroactive adjustments are made to cost outlier payments using the amended cost-to-charge ratio. After the amended desk review is completed and the thirty (30) day appeal option has been exhausted the new inpatient cost-to-charge ratio is entered into the Mississippi Medicaid Management Information System and is in effect from the date of entry through the end of the current reimbursement period. Effective July 1, 2021, the CCRs in effect as of July 1, 2021 will be used to calculate cost outlier payments.

2. Out-of-state hospitals are reimbursed under the APR-DRG payment methodology. The inpatient cost-to-charge ratios (CCRs) used to pay cost outlier payments for each out-of-state hospital are set using the Federal Register in effect as of July 1, 2021, that applies to the federal fiscal year beginning October 1, 2020, issued prior to the reimbursement period. The inpatient CCR is calculated using the sum of the statewide average operating urban CCR plus the statewide average capital CCR for each state.

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

Medicaid policy.

4. The inpatient cost-to-charge ratio in effect as of July 1, 2021, of the old owner is used to pay cost outlier payments for the new owner. There are no retroactive adjustments to a new owner's inpatient cost-to-charge ratio used to pay cost outlier payments.

5. New Mississippi hospitals beginning operations during a reporting year must file an initial cost report from the date of certification to the end of the cost report year end. Each rate year the inpatient cost-to-charge ratio used to pay outlier payments for each Mississippi hospital is grouped by bed class of facilities and an average inpatient cost-to-charge ratio is determined for each class. The initial inpatient cost-to-charge ratio used to pay cost outlier payments to a new hospital will be the average inpatient cost-to-charge ratio used for the bed class of Mississippi hospitals as of the effective date of the Medicaid provider agreement until the inpatient cost-to-charge ratio is recalculated based on the new hospital's initial cost report. There are no retroactive adjustments to a new hospital's inpatient cost-to-charge ratio used to pay cost outlier payments.

E. The Division of Medicaid reimburses for Graduate Medical Education (GME). Payment schedules and calculations are defined in Attachment 4.19-A of the Medicaid State Plan. The Division of Medicaid does not reimburse for indirect GME costs. To qualify for GME payments, Mississippi hospitals must meet the following criteria:

1. Be located in the state of Mississippi.

2. Have accreditation from the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) at the beginning of the state fiscal year in order to qualify for the quarterly payments during the payment year.

3. Have a Medicare approved teaching program for direct GME costs.

4. Be eligible for Medicare GME reimbursement.

5. Render services on the campus of the teaching hospital or at a participating hospital site.

   a) The participating site must be listed on the ACGME website.

   b) If the participating site uses the teaching hospital's ACGME accreditation, there must be a current affiliation agreement in place with the teaching hospital as of July 1st of the payment year.

   c) Only the teaching hospital or the participating hospital site is eligible for GME reimbursement.

6. Have full-time equivalents (FTEs) reported on Worksheet E-4, line 6, line 15 or line 16 columns 1 and 2 of the most recent Medicare cost report filed with DOM for the calendar

year immediately prior to the beginning of the fiscal year for sponsoring/participating hospitals.

7. Any hospital which is a newly accredited sponsoring/participating hospital or is within the five (5) year resident cap building period for the newly accredited sponsoring/participating hospital must be in operation as of July 1 of the payment year and must submit:

    a) Documentation of accreditation,

    b) Medicare's most recent interim rate letter, and

        (1) The number of residents used to calculate medical education payments during cap building years will be the number of FTEs as reported on the Medicare interim rate letter.

        (2) If the number of FTEs reported on the Medicare interim rate letter does not cover the entire cost reporting period, the reported FTEs will be annualized and used to calculate medical education payments,

    c) Start date of the GME accredited sponsoring/participating hospital prior to the July 1 calculation of the payments.

8. Has GME eligibility determined each year with the submission of the following annually:

    a) Documentation of accreditation,

    b) Medicare's most recent interim rate letter,

    c) Number of filled resident positions,

    d) Start date of the GME program prior to the July 1 calculation of the payments, and

    e) Documentation that the program was in operation as of July 1 of the payment year.

F. Outpatient services provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital, within the three (3) days prior to an inpatient hospital admission that are related to the reason for the inpatient hospital stay must be included in the APR-DRG payment for the inpatient hospital stay. This is referred to as the three (3) day payment window rule.

1. The inpatient hospital claim must include the following:

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

    b) Therapeutic (non-diagnostic) services related to an inpatient hospital admission and

provided to a beneficiary within three (3) days prior to and including the date of the inpatient admission.

2. If outpatient services are provided more than three (3) days prior to admission to a beneficiary by the admitting hospital, or an entity wholly owned or operated by the admitting hospital, and the outpatient service dates span to days outside of the three (3) day window the hospital must:

   a) Split bill for the outpatient services provided outside of the three (3) day window on a claim separate from the inpatient claim, and

   b) Include the outpatient services provided that are related to the reason for the inpatient hospital stay within the three (3) day window on the inpatient hospital claim.

3. Maintenance renal dialysis services are excluded from the three (3) day window payment rule.

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

Source: 42 U.S.C. § 1395f; 42 C.F.R. § 447.325; Miss. Code Ann. §§ 43-13-121, 43-13-117; SPA 20-0018; SPA 19-0019.

History: Revised eff. 07/01/2021; Revised to correspond with SPA 19-0019 (eff. 10/01/2019) and SPA 20-0018 (eff. 07/01/2020) eff. 12/01/2020; Revised eff. 03/01/2019; Revised - 10/01/2012.

Rule 1.15: Cost Reports

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

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

C. Cost reports and related information must be uploaded electronically to the cost report data base as designated by the Division of Medicaid. Cost reports uploaded after the due date will

be assessed a penalty in the amount of fifty dollars ($50.00) per day the cost report is delinquent.

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

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

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

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

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

Source: Social Security Act § 1886(f)(1)(A), § 1886(b), § 1815(a), § 1833(e); 42 CFR §§ 412.52; 413.20, 413.24, 413.40; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2021; Revised - 10/01/2012

Rule 1.16: Split Billing

A. Under Diagnosis Related Groups (DRG)-based payment, hospitals cannot split bill inpatient hospital Medicaid claims when a stay crosses a state fiscal year end, cost report year end, or under any other circumstance unless otherwise specified by the Division of Medicaid.

B. For Mississippi Medicaid, the seventy-two (72) hour observation stay is not considered a split bill.

C. Refer to Miss. Admin. Code Part 202, Rule 1.14.E. for split billing of claims for services subject to the three (3) day window rule.

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

History: Revised eff. 07/01/2021; Revised eff. 03/01/2019; Revised - 10/01/2012.

Part 202 Chapter 2: Outpatient Services

Rule 2.3: Emergency Department Outpatient Visits

A. Emergency department services, also referred to as emergency room services, are allowed for all beneficiaries without limitations. Emergency department services provided by hospitals, except for Indian Health Services (IHS), are reimbursed using the outpatient prospective payment methodology. Effective as of July 1, 2021 all rates and/or fees for services will remain the same as those in effect July 1, 2021.

B. The date of service for evaluation and management procedure code line items for outpatient hospital emergency department claims must be the date the beneficiary enters the emergency department even if the beneficiary's encounter spans multiple dates of service.

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

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

2. The Treatment Authorization Number (TAN) on the inpatient hospital claim is received from the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid, or a designated entity which corresponds with the date the physician documents the inpatient hospital admission in the physician's orders.

    a) A TAN is not required for an emergency department visit.

b) A TAN issued by the UM/QIO, the Division of Medicaid, or a designated entity is only required for an inpatient admission or continued stay.

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

History: Revised eff. 07/01/2021; Revised eff. 09/01/2018. Removed Rule 2.3.B language to correspond with SPA 2012-009 (eff. 09/01/2012) and added language for clarification with SPA 2012-008 (eff. 10/01/2012) eff. 11/01/2013, Revised eff. 01/01/2013, Revised eff. 11/01/2012, Revised eff. 09/01/2012.

Rule 2.4: Outpatient (72-Hour) Observation Services

A. Medicaid defines outpatient seventy-two (72) hour observation services as those services furnished on a hospital's premises, whether in an emergency department or a designated non-critical care area, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate a beneficiary's condition or determine the need for possible admission as an inpatient.

1. The terms "outpatient observation", "seventy two (72) hour observation", and/or "day patient" are interchangeable.

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

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

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

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

3. Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the beneficiary to remain at the hospital for more than seventy-two (72) hours to assist in assessing whether the beneficiary should be admitted, and

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

C. Non-Covered Services

1. Medicaid does not cover more than seventy-two (72) consecutive hours in an observation period and only covers service that are appropriate to the specific medical needs of the beneficiary.

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

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

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

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

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

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

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

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

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

   i) Services provided in an intensive care unit.

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

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

   l) Complex cases requiring inpatient hospital services.

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

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

   o) Outpatient observation services billed concurrently with therapeutic services such as

chemotherapy or physical therapy.

D. Medical Records Documentation

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

2. Documentation in the medical record must include:

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

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

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

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

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

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

E. Billing

1. Medicaid considers the seventy-two (72) hour outpatient observation stay as an outpatient service when the stay does not result in an inpatient hospital admission.

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

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

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

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

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

Source: 42 CFR §§ 440.2(a), 482.24(c); SPA 2012-008; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2021; Revised E.2. to correspond with SPA 2012-008 (eff. 10/01/2012) and added language for clarification to E.2. eff. 11/01/13.

Rule 2.8: Outpatient Hospital Rates

The Division of Medicaid reimburses all outpatient hospital services except for Indian Health Service Facilities, using the outpatient prospective payment system (OPPS) methodology. Effective as of July 1, 2021 all rates and/or fees for services will remain the same as those in effect July 1, 2021.

Source: 42 C.F.R. § 447.321; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2021; Revised eff. 01/01/2019; 09/01/2012.

Part 202 Chapter 3: Swing Beds

Rule 3.4: Reimbursement

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

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

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

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

b) Medicare benefits are exhausted.

B. The methods and standards used to determine payment rates to hospital providers of nursing facility (NF) services furnished by a swing bed hospital provides for payment for the routine NF services at the average rate per patient day paid to NFs for routine services furnished during the previous calendar year. Effective July 1, 2021, rates will remain the same as in effect as of July 1, 2021.

C. Beneficiaries who have Part A Medicare are the responsibility of the Medicare program when

in a swing bed. Medicaid will cover the Medicare coinsurance after the 20th consecutive day in a swing bed for Medicare/Medicaid beneficiaries through day one hundred (100) or the last day covered by Medicare, whichever comes first.

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

1. Nursing services,

2. Specialized rehabilitative services,

3. Dietary services,

4. Activity programs,

5. Room/bed maintenance services,

6. Routine personal hygiene items and services,

7. Personal laundry, or

8. Drugs not covered by the Medicaid Pharmacy program.

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

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

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

a) Lab services,

b) X-rays,

c) Drugs covered as specified in Part 214,

d) Therapy services as specified in Part 213, or

e) Durable Medical Equipment as specified in Part 209.

Source: Omnibus Budget Reconciliation Act of 1987 (OBRA 87) Pub. L. 97-35, Section 2153; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: Revised eff. 07/01/2021.

Part 202 Chapter 4: Organ Transplants

Rule 4.4: Reimbursement

A. All fee-for-service (FFS) transplants performed in the state of Mississippi are paid under the Mississippi All Patient Refined-Diagnosis Related Group (APR-DRG) payment methodology, including a policy adjustor.

B. All FFS transplants available in Mississippi but performed outside the state of Mississippi are paid under the Mississippi APR-DRG payment methodology, including a policy adjustor.

C. Payment for transplant services not available in Mississippi is made under the Mississippi APR-DRG payment methodology including a policy adjustor. If the Mississippi APR-DRG payment limits access to care, a case rate may be set.

    1. A case rate is set at forty percent (40%) of the sum of billed charges for transplant services as published in the State Plan according to *Milliman's U.S. Organ and Tissue Transplant Cost Estimates and Discussion* in effect as of July 1, 2019.

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

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

    4. Reimbursement for transplant services cannot exceed one-hundred percent (100%) of the sum of *Milliman's* billed charges for the categories listed in Miss. Admin. Code Part 202, Rule 4.4.C.2.

    5. Provisions listed in Miss. Admin. Code Part 202, Rule 4.4 apply to transplant services on or after October 1, 2012.

    6. Transplant services not available in Mississippi and not listed in the *Milliman's U.S. Organ and Tissue Transplant Cost Estimates and Discussion* will be reimbursed using the Mississippi APR-DRG payment methodology. If the Mississippi APR-DRG payment limits access to care, the Division of Medicaid will reimburse what the domicile state pays for the service.

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

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

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

G. The Division of Medicaid reimburses all facility and physician charges relating to the procurement of an organ, whether from a cadaver or a living donor, to the transplant facility using the appropriate revenue codes.

Source: 42 C.F.R. §§ 441.35, 482.90 - 104; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 20-0021 (eff. 07/01/2020) eff. 07/01/2021; Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017; Revised eff. 10/01/2012.

Title 23: Division of Medicaid

Part 202: Hospital Services

Part 202 Chapter 1: Inpatient Services

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A. Out-of-state hospitals are reimbursed under the APR-DRG payment methodology. The inpatient cost-to-charge ratios (CCRs) used to pay cost outlier payments for each out-of-state hospital are set ~~annually~~ using the Federal Register in effect as of July 1, 2021, that applies to the federal fiscal year beginning October 1, 2020 ~~of each year~~, issued prior to the reimbursement period. The inpatient CCR is calculated using the sum of the statewide average operating urban CCR plus the statewide average capital CCR for each state.

B. For transplants not available in Mississippi, payment for transplant services performed outside of Mississippi is made under the MS APR-DRG payment methodology including a policy adjustor. If access to quality services is unavailable under the MS APR-DRG payment methodology, a case rate may be set as described in Part 202, Chapter 4, Rule 4.7.

C. For specialized services not available in Mississippi, the Division of Medicaid will make payment using the MS APR-DRG payment methodology. If MS APR-DRG payment limits access to care, the Division will reimburse what the domicile state pays for the service or a comparable payment other states reimburse under APR-DRG.

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

History: Revised eff. 07/01/2021; Revised - 01/01/2013, 10/01/2012

Rule 1.14: Inpatient Hospital Payments

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

B. The Division of Medicaid may adjust APR-DRG rates pursuant to changes in federal and/or state laws or regulations or to obtain budget goals. Effective July 1, 2021, ~~A~~all Plan changes must be ~~approved~~ authorized by the state Legislature and federal grantor agency, and rates shall not be increased, decreased or otherwise changed from the levels in effect on July 1, 2021, unless such changes are authorized by the state Legislature.

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

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

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

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

1. The Cost-to-Charge Ratios (CCRs) used to calculate cost outlier payments are calculated ~~annually,~~ for each provider by performing a desk review program developed by the Division of Medicaid, using the most recent filed cost report. The Division accepts amended original cost reports if the cost report is submitted prior to the end of the reimbursement period in which the cost report is used for payment purposes. If the provider's inpatient cost-to-charge ratio used to pay cost outlier payments is changed as a result of the amended cost report, no retroactive adjustments are made to cost outlier payments using the amended cost-to-charge ratio. After the amended desk review is completed and the thirty (30) day appeal option has been exhausted the new inpatient cost-to-charge ratio is entered into the Mississippi Medicaid Management Information System and is in effect from the date of entry through the end of the current reimbursement period. Effective July 1, 2021, the CCRs in effect as of July 1, 2021 will be used to calculate cost outlier payments.

2. Out-of-state hospitals are reimbursed under the APR-DRG payment methodology. The inpatient cost-to-charge ratios (CCRs) used to pay cost outlier payments for each out-of-state hospital are set ~~annually~~ using the Federal Register in effect as of July 1, 2021, that applies to the federal fiscal year beginning October 1, 2020 ~~of each year~~, issued prior to the reimbursement period. The inpatient CCR is calculated using the sum of the statewide average operating urban CCR plus the statewide average capital CCR for each state.

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

new owner must submit provider enrollment information required under the Division of Medicaid policy.

4. The inpatient cost-to-charge ratio <u>in effect as of July 1, 2021,</u> of the old owner is used to pay cost outlier payments for the new owner. ~~The new owner's inpatient cost-to-charge ratio used to pay cost outlier payments is calculated for the first rate year beginning October 1, for which the new owner's cost report is available.~~ There are no retroactive adjustments to a new owner's inpatient cost-to-charge ratio used to pay cost outlier payments.

5. New Mississippi hospitals beginning operations during a reporting year must file an initial cost report from the date of certification to the end of the cost report year end. Each rate year the inpatient cost-to-charge ratio used to pay outlier payments for each Mississippi hospital is grouped by bed class of facilities and an average inpatient cost-to-charge ratio is determined for each class. The initial inpatient cost-to-charge ratio used to pay cost outlier payments to a new hospital will be the average inpatient cost-to-charge ratio used for the bed class of Mississippi hospitals as of the effective date of the Medicaid provider agreement until the inpatient cost-to-charge ratio is recalculated based on the new hospital's initial cost report. There are no retroactive adjustments to a new hospital's inpatient cost-to-charge ratio used to pay cost outlier payments.

E. The Division of Medicaid reimburses for Graduate Medical Education (GME). Payment schedules and calculations are defined in Attachment 4.19-A of the Medicaid State Plan. The Division of Medicaid does not reimburse for indirect GME costs. To qualify for GME payments, Mississippi hospitals must meet the following criteria:

1. Be located in the state of Mississippi.

2. Have accreditation from the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) at the beginning of the state fiscal year in order to qualify for the quarterly payments during the payment year.

3. Have a Medicare approved teaching program for direct GME costs.

4. Be eligible for Medicare GME reimbursement.

5. Render services on the campus of the teaching hospital or at a participating hospital site.

    a) The participating site must be listed on the ACGME website.

    b) If the participating site uses the teaching hospital's ACGME accreditation, there must be a current affiliation agreement in place with the teaching hospital as of July 1st of the payment year.

    c) Only the teaching hospital or the participating hospital site is eligible for GME reimbursement.

6. Have full-time equivalents (FTEs) reported on Worksheet E-4, line 6, line 15 or line 16 columns 1 and 2 of the most recent Medicare cost report filed with DOM for the calendar year immediately prior to the beginning of the fiscal year for sponsoring/participating hospitals.

7. Any hospital which is a newly accredited sponsoring/participating hospital or is within the five (5) year resident cap building period for the newly accredited sponsoring/participating hospital must be in operation as of July 1 of the payment year and must submit:

    a) Documentation of accreditation,

    b) Medicare's most recent interim rate letter, and

        (1) The number of residents used to calculate medical education payments during cap building years will be the number of FTEs as reported on the Medicare interim rate letter.

        (2) If the number of FTEs reported on the Medicare interim rate letter does not cover the entire cost reporting period, the reported FTEs will be annualized and used to calculate medical education payments,

    c) Start date of the GME accredited sponsoring/participating hospital prior to the July 1 calculation of the payments.

8. Has GME eligibility determined each year with the submission of the following annually:

    a) Documentation of accreditation,

    b) Medicare's most recent interim rate letter,

    c) Number of filled resident positions,

    d) Start date of the GME program prior to the July 1 calculation of the payments, and

    e) Documentation that the program was in operation as of July 1 of the payment year.

F. Outpatient services provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital, within the three (3) days prior to an inpatient hospital admission that are related to the reason for the inpatient hospital stay must be included in the APR-DRG payment for the inpatient hospital stay. This is referred to as the three (3) day payment window rule.

1. The inpatient hospital claim must include the following:

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

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

2. If outpatient services are provided more than three (3) days prior to admission to a beneficiary by the admitting hospital, or an entity wholly owned or operated by the admitting hospital, and the outpatient service dates span to days outside of the three (3) day window the hospital must:

   a) Split bill for the outpatient services provided outside of the three (3) day window on a claim separate from the inpatient claim, and

   b) Include the outpatient services provided that are related to the reason for the inpatient hospital stay within the three (3) day window on the inpatient hospital claim.

3. Maintenance renal dialysis services are excluded from the three (3) day window payment rule.

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

Source: 42 U.S.C. § 1395f; 42 C.F.R. § 447.325; Miss. Code Ann. §§ 43-13-121, 43-13-117; SPA 20-0018; SPA 19-0019.

History: Revised eff. 07/01/2021; Revised to correspond with SPA 19-0019 (eff. 10/01/2019) and SPA 20-0018 (eff. 07/01/2020) eff. 12/01/2020; Revised eff. 03/01/2019; Revised - 10/01/2012.

Rule 1.15: Cost Reports

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

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

K. Cost reports and related information must be uploaded electronically to the cost report data base as designated by the Division of Medicaid. ~~that are either postmarked or hand delivered~~ Cost reports uploaded after the due date will be assessed a penalty in the amount of fifty dollars ($50.00) per day the cost report is delinquent.

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

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

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

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

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

Source: Social Security Act § 1886(f)(1)(A), § 1886(b), § 1815(a), § 1833(e); 42 CFR §§ 412.52; 413.20, 413.24, 413.40; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised - 10/01/2012

Rule 1.16: Split Billing

A. Under Diagnosis Related Groups (DRG)-based payment, hospitals cannot split bill inpatient hospital Medicaid claims when a stay crosses a state fiscal year end, cost report year end, or under any other circumstance unless otherwise specified by the Division of Medicaid.

B. For Mississippi Medicaid, the ~~twenty-three (23)~~ seventy two (72) hour observation stay is not considered a split bill.

C. Refer to Miss. Admin. Code Part 202, Rule 1.14.E. for split billing of claims for services subject to the three (3) day window rule.

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

History: Revised eff. 07/01/2021; Revised eff. 03/01/2019; Revised - 10/01/2012.

Part 202 Chapter 2: Outpatient Services

Rule 2.3: Emergency Department Outpatient Visits

A. Emergency department services, also referred to as emergency room services, are allowed for all beneficiaries without limitations. Emergency department services provided by hospitals, except for Indian Health Services (IHS), are reimbursed using the outpatient prospective payment methodology. Effective as of July 1, 2021 all rates and/or fees for services will remain the same as those in effect July 1, 2021.

B. The date of service for evaluation and management procedure code line items for outpatient hospital emergency department claims must be the date the beneficiary enters the emergency department even if the beneficiary's encounter spans multiple dates of service.

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

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

2. The Treatment Authorization Number (TAN) on the inpatient hospital claim is received from the Utilization Management and Quality Improvement Organization (UM/QIO), the Division of Medicaid, or a designated entity which corresponds with the date the physician documents the inpatient hospital admission in the physician's orders.

a) A TAN is not required for an emergency department visit.

b) A TAN issued by the UM/QIO, the Division of Medicaid, or a designated entity is only required for an inpatient admission or continued stay.

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

History: Revised eff. 07/01/2021; Revised eff. 09/01/2018. Removed Rule 2.3.B language to correspond with SPA 2012-009 (eff. 09/01/2012) and added language for clarification with SPA 2012-008 (eff. 10/01/2012) eff. 11/01/2013, Revised eff. 01/01/2013, Revised eff. 11/01/2012, Revised eff. 09/01/2012.

Rule 2.4: Outpatient (~~23~~72-Hour) Observation Services

A. Medicaid defines outpatient ~~twenty-three (23)~~seventy-two (72) hour observation services as those services furnished on a hospital's premises, whether in an emergency department or a designated non-critical care area, including use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate a beneficiary's condition or determine the need for possible admission as an inpatient.

1. The terms "outpatient observation", "~~twenty-three (23)~~seventy two (72) hour observation", and/or "day patient" are interchangeable.

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

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

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

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

3. Need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the beneficiary to remain at the hospital for more than ~~twenty-three~~seventy two (~~23~~72) hours to assist in assessing whether the beneficiary should be admitted, and

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

C. Non-Covered Services

1. Medicaid does not cover more than ~~twenty-three (23)~~ seventy two (72) consecutive hours in an observation period and only covers service that are appropriate to the specific medical needs of the beneficiary.

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

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

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

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

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

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

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

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

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

   i) Services provided in an intensive care unit.

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

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

   l) Complex cases requiring inpatient hospital services.

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

   n) Routine preparation services furnished prior to diagnostic testing in the hospital

outpatient department and the recovery afterwards.

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

D. Medical Records Documentation

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

2. Documentation in the medical record must include:

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

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

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

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

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

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

E. Billing

1. Medicaid considers the ~~twenty-three (23)~~seventy two (72) hour outpatient observation stay as an outpatient service when the stay does not result in an inpatient hospital admission.

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

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

b) The "Treatment Authorization Code" on the inpatient hospital claim is the Treatment Authorization Number (TAN) received from the Utilization Management and Quality

Improvement Organization (UM/QIO) which corresponds with the date the physician documents the inpatient hospital admission in the physician's orders.

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

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

Source: 42 CFR §§ 440.2(a), 482.24(c); SPA 2012-008; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2021; Revised E.2. to correspond with SPA 2012-008 (eff. 10/01/2012) and added language for clarification to E.2. eff. 11/01/13.

Rule 2.8: Outpatient Hospital Rates

The Division of Medicaid reimburses all outpatient hospital services except for Indian Health Service Facilities, using the outpatient prospective payment system (OPPS) methodology. Effective as of July 1, 2021 all rates and/or fees for services will remain the same as those in effect July 1, 2021.

Source: 42 C.F.R. § 447.321; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 07/01/2021; Revised eff. 01/01/2019; 09/01/2012.

Part 202 Chapter 3: Swing Beds

Rule 3.4: Reimbursement

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

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

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

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

b) Medicare benefits are exhausted.

B. The methods and standards used to determine payment rates to hospital providers of nursing facility (NF) services furnished by a swing bed hospital provides for payment for the routine NF services at the average rate per patient day paid to NFs for routine services furnished during the previous calendar year. Effective July 1, 2021, rates will remain the same as in effect as

of July 1, 2021.

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

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

1. Nursing services,

2. Specialized rehabilitative services,

3. Dietary services,

4. Activity programs,

5. Room/bed maintenance services,

6. Routine personal hygiene items and services,

7. Personal laundry, or

8. Drugs not covered by the Medicaid Pharmacy program.

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

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

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

a) Lab services,

b) X-rays,

c) Drugs covered as specified in Part 214,

d) Therapy services as specified in Part 213, or

e) Durable Medical Equipment as specified in Part 209.

Source: Omnibus Budget Reconciliation Act of 1987 (OBRA 87) Pub. L. 97-35, Section 2153; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: Revised eff. 07/01/2021.

Part 202 Chapter 4: Organ Transplants

Rule 4.4: Reimbursement

A. All fee-for-service (FFS) transplants performed in the state of Mississippi are paid under the Mississippi All Patient Refined-Diagnosis Related Group (APR-DRG) payment methodology, including a policy adjustor.

B. All FFS transplants available in Mississippi but performed outside the state of Mississippi are paid under the Mississippi APR-DRG payment methodology, including a policy adjustor.

C. Payment for transplant services not available in Mississippi is made under the Mississippi APR-DRG payment methodology including a policy adjustor. If the Mississippi APR-DRG payment limits access to care, a case rate may be set.

1. A case rate is set at forty percent (40%) of the sum of billed charges for transplant services as published in the State Plan according to *Milliman's U.S. Organ and Tissue Transplant Cost Estimates and Discussion* in effect as of July 1, 2019.

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

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

4. Reimbursement for transplant services cannot exceed one-hundred percent (100%) of the sum of *Milliman's* billed charges for the categories listed in Miss. Admin. Code Part 202, Rule 4.4.C.2.

5. Provisions listed in Miss. Admin. Code Part 202, Rule 4.4 apply to transplant services on or after October 1, 2012.

6. Transplant services not available in Mississippi and not listed in the *Milliman's U.S. Organ and Tissue Transplant Cost Estimates and Discussion* will be reimbursed using the Mississippi APR-DRG payment methodology. If the Mississippi APR-DRG payment limits access to care, the Division of Medicaid will reimburse what the domicile state pays for the service.

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

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

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

G. The Division of Medicaid reimburses all facility and physician charges relating to the procurement of an organ, whether from a cadaver or a living donor, to the transplant facility using the appropriate revenue codes.

Source: 42 C.F.R. §§ 441.35, 482.90 - 104; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 20-0021 (eff. 07/01/2020) eff. 07/01/2021; Revised to correspond with SPA 15-018 (eff. 12/01/2015) eff. 01/01/2017; Revised eff. 10/01/2012.