NOTICE OF RULE ADOPTION—FINAL RULE

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

Miss. Division of Medicaid
c/o Bob M. Dent, Staff Officer
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http://www.dom.state.ms.us

Specific Legal Authority Authorizing the promulgation of Rule: Miss Code Ann. §43-13-121(1972), as amended

Reference to Rules repealed, amended or suspended by the Proposed Rule :
Provider Policy Manual Sec 43 NEW - chapter 6 FQHC Clinic Manual

Date Rule Proposed:

Explanation of the Purpose of the Proposed Rule and the reason(s) for proposing the rule:
AP 2006-55. Provider Policy Manual Update to create section 43 regarding Federally Qualified Health Centers (FQHC), which includes the Introduction, Provider Enrollment/Agreement, Reimbursement Methodology, Service Limits, EPSDT, Co-Payments on Medicaid Services, Pregnancy-Related Eligibles, Documentation Requirements, Prior Authorization, Encounter/Core Services, Vision, Dental, Solid Organ/Tissue Transplant, Reserved, and Hospital Services in subsections 43.01 - 43.15 respectively. The only changes from the Proposed Rule is the cross-reference section # in section 43.15 from 43.14 to 43.10 and remove the DOM address in section 43.05.

The Agency Rule Making Record for this rule including any written comments received during the comment period and the record of any oral proceeding is available for public inspection by contacting the Agency at the above address.

☐ An oral proceeding was held on this rule:

Date:
Time:
Place:

☒ An oral proceeding was not held on this rule.

The Agency has considered the written comments and the presentations made in any oral proceedings, and

☐ This rule as adopted is without variance from the proposed rule.

☐ This rule as adopted differs from the proposed rule as there are minor editorial changes which affect the form rather than the substance of the rule.

☒ The rule as adopted differs from the proposed rule. The differences however are:
Within the scope of the matters in the Notice of Proposed Rule Adoption, the logical outgrowth of the contents of the Notice of Proposed Rule Adoption and the comments submitted in response thereto, and
The Notice of Proposed Rule Adoption provided fair warning that the outcome of the proposed rule adoption could be the rule in question.

The entire text of the Proposed Rule including the text of any rule being amended or changed is attached.

Effective Date of Rule: December 1, 2006

Executive Director
Signature and Title of Person Submitting Rule for Filing

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified citizens. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid (DOM), Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

In order to participate in the Mississippi Medicaid program, an organization must be approved as a Federally Qualified Health Center (FQHC) or a Federally Qualified Health Center look-alike by the Department of Health and Human Services. Medicaid payments may not be made to any organization prior to the date of approval and execution of a valid provider agreement.

A FQHC provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed personal health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. The Division of Medicaid is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

The Provider Agreement - New Providers and Participating Providers

When DOM receives a copy of the letter and Provider Tie-in Notice from the Department of Health and Human Services, Centers for Medicare and Medicaid (CMS), which states approval of the center, the following steps will be taken by the Medicaid program:

1. A Mississippi Medicaid Provider Enrollment Request Form, two (2) unsigned provider agreements, and a direct deposit authorization/agreement form will be sent to the center for completion.

2. The Medicaid Provider Enrollment form and a cover letter directs that the forms and both agreements will be signed and returned to DOM along with:

   - a certified copy of the minutes or other legally sufficient documents authorizing the person who signs the agreements to do so on behalf of the corporation.

   - a copy of the interim rate notice from the Medicare intermediary.

3. When the above material is received, it will be reviewed for completeness and, if complete, submitted to the Executive Director of DOM for approval or disapproval.

4. If approved, the Executive Director will sign both agreements; one (1) will be returned to the facility and one (1) will be filed in the facility's Medicaid provider file. The center will be notified in writing of the effective date and the interim encounter rate. **The effective date is the date the Executive Director signs the agreement.** The Medicaid provider enrollment forms will be sent to the fiscal agent with a copy of the approval letter for assignment of a Medicaid provider group number. Multiple Medicaid provider group numbers may be required.

5. If disapproved, the facility will be notified in writing. The reasons for the disapproval will be clearly stated and information will be given on how to appeal the decision.

The provider agreement will be in effect until such time that the center ceases to qualify as a Medicaid FQHC provider.

Change of Ownership or Change of Organizational Structure

Refer to Provider Information, Sections 4.03 and 4.08 for information regarding change of ownership and change of tax ID.

The Division of Medicaid (DOM) uses the Prospective Payment System method of reimbursement for FQHCs and FQHC Look-Alikes. All ambulatory services provided in the FQHC will be reimbursed an encounter rate on a per visit basis. Refer to section 43.10 of this manual section for the definition of a visit and policy related to the encounter rate per visit reimbursement methodology.

All services provided in an inpatient hospital setting (place of service 21), outpatient hospital setting (place of service 22), and an emergency room hospital (place of service 23) will be paid on a fee-for-service basis. If a physician employed by an FQHC provides physician services at the hospital, inpatient or outpatient, the CMS-1500 claim form must be billed under the individual physician's Medicaid provider number. Payment will be made directly to the physician, and a 1099 form will be provided to the physician for tax purposes. The financial arrangement between the physician and the FQHC should be handled through the agreement.

For services provided on and after January 1, 2001, during calendar year 2001, payment for services shall be calculated (on a per visit basis) in an amount equal to 100% of the average of the FQHC's reasonable costs of providing Medicaid covered services during fiscal years 1999 and 2000. The average rate will be computed from the FQHC Medicaid cost reports by applying a forty percent (40%) weight to fiscal year 1999 and a sixty percent (60%) weight to fiscal year 2000 and adding those rates together. If a FQHC first qualifies during fiscal year 2000, the rate will only be computed from the fiscal year 2000 Medicaid cost report. The PPS baseline calculation shall include the cost of all Medicaid covered services including other ambulatory services that were previously paid under a fee-for-service basis. This rate will be adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC during fiscal year 2001.

When a new provider first qualifies as a FQHC after fiscal year 2000, payment for services shall be calculated (on a per visit basis) in an amount equal to 100% of the FQHC's reasonable costs of providing Medicaid covered services during such calendar year based on the rates established for other FQHC's in the same or adjacent area with a similar case load. In the absence of such a FQHC, the rate for the new provider will be based on projected costs (estimated expenditures). After the FQHC's initial year, a Medicaid cost report must be filed. The cost report will be desk reviewed and a rate shall be calculated (on a per visit basis) in an amount equal to 100% of the FQHC's reasonable costs of providing Medicaid covered services. The FQHC may be subject to a retroactive adjustment based on the difference between projected and actual allowable costs. After the initial year, payment for services shall be calculated in accordance with paragraph 2 above.

Payment rates may be adjusted by the Division of Medicaid pursuant to changes in Federal and/or State laws or regulations.

Beginning in calendar year 2002, and for each calendar year thereafter, the FQHC is entitled to the payment amount (on a per visit basis) to which the FQHC was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services for that calendar year, and adjusted to take into account any increase or decrease in the scope of services furnished by the FQHC during that calendar year. The rate will be retroactively adjusted to reflect the MEI.

A change in the scope of service is defined as a change in the type, intensity, duration and/or amount of service as follows:

- The addition of a new service (i.e., dental, EPSDT, optometry) not previously provided by the FQHC and/or

- The elimination of an existing service provided by the FQHC.

However, a change in the scope of service does not mean the addition or reduction of staff members to or from an existing service. Also, a change in the cost of a service is not considered in and of itself a change in the scope of service.

It is the responsibility of the FQHC to notify the Division of Medicaid of any change in the scope of service and provide proper documentation of said change.

Cost Reports

All centers must submit to the Division of Medicaid a copy of their Medicare cost report for information purposes using the appropriate Medicare forms postmarked on or before the last day of the fifth month following the close of its Medicare cost reporting year. All filing requirements shall be the same as for Title XVIII. When the due date of the cost report falls on a weekend or State of Mississippi or federal holiday, the cost report is due on the following business day. Extensions of time for filing cost reports will not be granted by the Division of Medicaid except for those supported by written notification of the extension granted by Title XVIII. Cost reports must be prepared in accordance with the State Plan for reimbursement of Federally Qualified Health Centers. The center's cost report should include information on all satellite clinics. A copy of the Plan is available upon written request.

If the Medicare cost report is not received within thirty (30) days of the due date, payment of claims will be suspended until receipt of the required report. This penalty may only be waived by the Executive Director of the Division of Medicaid.

A FQHC that does not file a Medicare cost report within six (6) calendar months after the close of its Medicare cost reporting year may be subject to cancellation of its provider agreement at the Division of Medicaid's discretion.

Centers beginning operations during a reporting year will prepare the cost report from the effective date of participation to June 30th, the end of the regular reporting period.

Visits by beneficiaries are limited to a total of twelve (12) per fiscal year in any office, nursing facility, or clinic setting. When a beneficiary has exhausted these visits, payment will no longer be made for services provided in the office or clinic setting. The encounter codes subject to the limitation are:

99201 – 99205

99212 - 99215

The procedure code 99211 (Established Patient - Minimal Office Medical Service) may be used to allow a visit to the center when a patient is seen for follow-up care, such as blood pressure check, injections, etc. This procedure does not accumulate toward the 12-visit limit. However, once the limit has been reached, the procedure is no longer reimbursable.

All service limits of the Mississippi Medicaid Program are applicable.

Expanded EPSDT services include any necessary Medicaid reimbursable health care to correct or ameliorate illnesses and conditions found on screening. Services not covered, or exceeding the limits set forth in the Mississippi State Plan, must be prior authorized by DOM to ensure medical necessity. Expanded services are available to children from birth to 21 years of age. Eligibility extends through the last day of the child's birth month only.

Prior authorization is required for Expanded EPSDT services. The primary physician must submit a copy of the Plan of Care Authorization Request Form (MA-1148) to:

Division of Medicaid
Bureau of Maternal and Child Health

The physician who submits the Plan of Care will be notified of approval or denial.

Refer to Section 73.0, EPSDT of the Provider Policy Manual for further information on services available to children.

Refer to Beneficiary Information, Section 3.08 of this manual for co-payment information.

Women who are eligible for Medicaid only because of pregnancy, as specified in the Mississippi State Plan, are covered only for those services which are related to:

- Pregnancy (including prenatal, delivery, postpartum, and family planning services); and
- Other conditions which may complicate pregnancy.

Therefore, dental and eyeglass services are **NOT** covered for women in these eligibility categories.

All professional and institutional providers participating in the Medicaid program are required to maintain records that will disclose services rendered and billed under the program and, upon request, make such records available to representatives of DOM or the Office of the Attorney General in substantiation of any or all claims. These records should be retained a minimum of five (5) years in order to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligations to verify services to Medicaid beneficiaries and those paid for by Medicaid, FQHC facilities must maintain auditable records that will substantiate the claim submitted to Medicaid. At a minimum, the records must contain the following on each patient:

- date of service
- patient's presenting complaint
- provider's findings
- treatment rendered
- provider's signature or initials

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.

Certain services require additional documentation. Laboratory procedures paid for by Medicaid must be substantiated by records that reflect the type of lab procedure performed and the findings. X-ray procedures paid for by Medicaid must be recorded as to the type of x-ray (i.e., full chest, etc.) and the findings. Injections paid for by Medicaid must be recorded as to the drug name, strength, and dosage.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) includes a provision which provides continuous Medicaid eligibility to any infant born to a Medicaid eligible mother for the first full year of the infant's life, provided he/she remains in the household of the mother. This is without regard to the mother's Medicaid status during the infant's first year of life. To establish eligibility for children living in the mother's household, the following three items of information must be maintained on file in your facility or office with the patient's chart:

- the infant's name;
- the infant's birth date; and
- a statement that the infant resides in the mother's household.

DOM and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the FQHC facility.

If a FQHC provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to the Mississippi Medicaid program any money received from the program for such non-substantiated services. If a refund is not received within 60 days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the FQHC provider.

A FQHC provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the FQHC provider as a provider of Medicaid Services.

Refer to General Policy, Section 7.03 Maintenance of Records, for additional documentation information.

Dental

Refer to Dental, Section 11.0 for information regarding dental services requiring prior authorization.

EPSDT

Refer to EPSDT, Section 73.0 for information regarding those EPSDT or Expanded EPSDT services requiring prior authorization.

Pharmacy

Refer to Pharmacy, Section 31.0 for information regarding prior authorization and reimbursement for drugs provided in an FQHC.

Vision

Refer to Vision, Section 29.0 for those vision services requiring prior authorization.

Core Services

Core services are those which are normally provided by a core service provider including physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and certified social workers. A center's encounter rate covers the beneficiary's visit to the center, including all services and supplies (drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional service and which are included in the PPS. When services, supplies, drugs and biologicals are included in the PPS, the clinic cannot send the beneficiary to another provider that will bill Medicaid for the same service, supply, drug or biological. All services and drugs are included in the encounter rate and cannot be billed separately.

A visit is defined as a face-to-face encounter between a FQHC patient and a health professional during which a FQHC service is furnished. **Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.**

For Example:

- A beneficiary under age 21 receives an EPSDT screening at the FQHC, later becomes ill, returns to the FQHC and is examined by a physician. In this scenario the clinic would be paid for two (2) encounters.
- A beneficiary under age 21 has an EPSDT screening and dental exam scheduled on the same day. In this scenario the clinic would receive payment for one (1) encounter.
- A beneficiary under age 21 is examined by the physician and receives an EPSDT screening. In this scenario the clinic would be paid for one (1) encounter.

Encounters requiring additional diagnosis or treatment must be submitted to the fiscal agent as a paper claim. Claims submitted to the fiscal agent for a beneficiary will pay one encounter rate for each date of service and each location code (i.e., clinic, nursing facility). All medical services for a beneficiary provided on the same date of service must be billed on the same claim form. In addition, claims for dental and eyeglass visits on the same date of service should be billed on separate claims. Refer to the DOM website at **www.dom.state.ms.us** for a list of procedure codes which generate an encounter rate.

Approved Places of Service

All ambulatory services performed by a center employee or contractual worker for a center patient must be billed as an FQHC claim. This includes services provided in the clinic, skilled nursing facility, nursing facility or other institution used as a patient's home. The program will pay for visits at multiple places of service for a patient. Services performed for clinic patients by an outside lab should be billed to Medicaid by the outside lab. However, claims for in-house lab services must be billed with the same place of service code as the visit. In-house lab services are covered in the visit payment.

Federally Qualified Health Center services are not covered when performed in a hospital (inpatient or outpatient). Physicians employed by an FQHC and rendering services to Medicaid beneficiaries in a hospital will be reimbursed fee-for-service. The physician must obtain a provider number from the Division of Medicaid and bill using the CMS 1500 claim form.

Fee-for-Service

No services (same or separate dates) will be reimbursed to the clinic at a fee-for-service rate. All ambulatory services provided in an FQHC will be reimbursed an encounter rate on a per visit basis.

Non-Core Services

Non-core services include those which do not fall into the core service category. Refer to page one of this section for a definition of services classified as core services.

Drugs Purchased Under a Veterans Health Care Act Discount Agreement

The Veterans Health Care Act applies to FQHCs and allows centers to sign an agreement with drug companies to purchase drugs at a discount price. DOM is not allowed to file for a rebate on drugs purchased through a discount agreement. Therefore, all drugs purchased at a discounted price through a discount agreement must not be billed through the Medicaid pharmacy program. The reimbursement for the drugs is included in the encounter rate.

Obstetrical

Providers must utilize CPT evaluation and management codes 99201 through 99215, 59425, and 59426 to bill antepartum visits as listed below.

(A) Providers must bill CPT codes in the 99201 through 99215 range for antepartum visits 1 or 2 or 3. Bill one code per visit.

(B) Providers must bill CPT code 59425 for antepartum visits 4, 5, or 6. Bill one code per visit.

(C) Providers must bill CPT code 59426 for antepartum visits 7 or over. Bill one code per visit.

The number of the antepartum visit is defined as to the number of the visit(s) that the beneficiary has been to one physician. For example, if a beneficiary goes to Dr. A for antepartum visit 1, 2, 3, and 4 and then moves and goes to Dr. B, Dr. A will bill the appropriate evaluation and management code for each antepartum visit 1 or 2 or 3 and CPT code 59425 for antepartum visit 4. Dr. B will then bill for his antepartum visits starting with antepartum visit number 1, etc.

CPT codes 59410, 59515, 59614, and 59622 will be used to reimburse deliveries and postpartum care as of October 1, 2003. The postpartum care is inclusive of both hospital and office visits following vaginal or cesarean section deliveries. These codes must be billed under the individual physician's Medicaid provider number.

CPT code 59430 can only be billed for postpartum visits when the clinic physician was not the delivering physician.

Modifier TH identifies "obstetrical treatment/services, prenatal and postpartum" and must be reported with each code for antepartum visits and deliveries and postpartum care. The Division of Medicaid will utilize this modifier to track data and to bypass the physician visit limitation of twelve (12). Antepartum office visits will not be applied to this limitation.
Refer to the Maternity, Section 38.0 of the Provider Policy Manual.

Subdermal Implant

The cost of a subdermal implant is included in the encounter rate and will not be reimbursed separately.

All Medicaid policy related to vision services is applicable. Vision services performed in an FQHC are reimbursed at an encounter rate. All vision services for the same date of service must be billed on one claim form.

Refer to Section 29.0, Vision Services, of this manual for policy related to vision services.

Multiple Encounters/ Same Date of Service

Refer to Section 43.10, Encounter/Core Services, in this manual.

All Medicaid policy related to dental services is applicable. Dental services performed in an FQHC are reimbursed at an encounter rate. All dental services for the same date of service must be billed on one claim form.

Refer to Section 11.0, Dental, of this manual for policy related to dental services.

Multiple Encounters/ Same Date of Service

Refer to Section 43.10, Encounter/Core Services, in this manual.

Refer to the Transplant, Section 28.0 of this Provider Policy Manual.

Section 43.14 is RESERVED FOR FUTURE USE.

Federally Qualified Health Center services are covered when provided in outpatient settings only, including a patient's place of residence, which may be a skilled nursing facility or a nursing facility or other institution used as a patient's home.

"Physician services" are professional services that are performed by a physician at the clinic or away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services.

If a physician employed by a FQHC provides physician services at the hospital, inpatient or outpatient, the CMS 1500 claim form must be billed under the individual physician's Medicaid provider number and will be reimbursed fee-for-service. Payment will be made directly to the physician, and a 1099 form will be provided to the physician for tax purposes. The financial arrangement between the physician and the FQHC should be handled through the agreement.

Refer to Section 43.10 Encounter/ Core Services of this manual section.

Effective for dates of service on and after November 1, 2006, Mississippi Medicaid will require that modifiers -54 and -55 be reported with the CPT surgery codes when appropriate. The modifiers will be acceptable on the CPT surgery code range 10000 – 69999.

Modifier	Description	Mississippi Medicaid Allowable
-54	Surgical Care Only	85% of Medicaid Allowable
-55	Postoperative Management Only	15% of Medicaid Allowable
-56	Preoperative Management Only	No separate benefits are allowed as preoperative management is inclusive in the allowance for surgical care. Surgical codes billed with modifier -56 will be denied.

Documentation

When one physician performs a patient's surgical service and another provides the postoperative management, an agreement for the transfer of care must be retained in the beneficiary's medical record. This agreement can be in the form of a letter, discharge summary, chart notation, or other written documentation, but in any case, both the surgeon and the physician who intends to provide the postoperative management must have a copy of the agreement.

Refer to Surgery, Section 52.13, Surgery in this manual.