MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 223
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

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Title 23: Division of Medicaid

Part 223: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Chapter 1: General

Rule 1.1: Program Description

A. The Division of Medicaid has established a program of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) which provides screenings, preventive and comprehensive health services for certain beneficiaries who are eligible for full Medicaid benefits. EPSDT services are provided to beneficiaries under age twenty-one (21).

B. EPSDT stands for:

1. Early is assessing health care in early life so that potential disease and disabilities can be prevented or detected in their preliminary states, when they are most effectively treated.

2. Periodic is assessing a child's health at regular, recommended intervals in the child's life to assure continued healthy development.

3. Screening is the use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention.

4. Diagnosis is the determination of the nature or cause of conditions identified by the screening.

5. Treatment is the provision of services needed to control, correct or lessen health problems.

C. Providers of EPSDT screenings must be currently enrolled Mississippi Medicaid providers, have signed an EPSDT specific provider agreement, and must adhere to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule. EPSDT screening providers include, but are not limited to:

1. The Mississippi State Department of Health,

2. Public schools and/or public school districts certified by the Mississippi Department of Education,

3. Federally Qualified Health Centers (FQHC),

4. Rural Health Clinics (RHC),

5. Comprehensive health clinics, and

6. Similar agencies which provide various components of EPSDT screenings.

D. EPSDT diagnostic and treatment services are primarily provided by referral to other enrolled Mississippi Medicaid providers.

Source: 42 U.S.C. § 1396d; 42 C.F.R. Part 441, Subpart B; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 18-0014 (eff. 10/01/2018) effective 12/01/2018. Revised to correspond with SPA 15-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.2: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Provider Enrollment

A. Physicians, physician assistants or nurse practitioners who wish to provide EPSDT screenings must meet the Mississippi Medicaid enrollment requirements, complete and sign an EPSDT specific provider agreement and pass an onsite clinic inspection performed by the Division of Medicaid.

B. Registered nurses employed through the Mississippi Department of Education (MDE), who meet the certification requirement and the established protocols mandated by the Mississippi State Department of Health (MSDH), MDE, Mississippi School Nurse Association, and Mississippi Board of Nursing, may perform EPSDT health assessments following the protocols established by the MSDH. MDE employed registered nurses must have the educational basis and clinical basis needed to perform health assessments. In addition to the certification requirement, claims submitted for these services must be submitted under the school's provider number and the billing provider must have a current letter of referral affiliation on file with the Division of Medicaid.

Source: 42 U.S.C § 1396d; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.3: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Provider Participation Requirements

A. Enrolled Mississippi Medicaid providers who have signed an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) specific provider agreement must conduct periodic screenings and medically necessary interperiodic visits for all EPSDT-eligible beneficiaries in accordance with the EPSDT Periodicity Schedule as recommended by the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule and must provide or refer EPSDT-eligible beneficiaries with an identified need for additional assessment, diagnosis, and/or treatment services to an appropriate provider.

B. Dental providers must provide services to all EPSDT-eligible beneficiaries in accordance with the dental schedule of the American Academy of Pediatric Dentistry (AAPD) and in

accordance with AAP guidelines. Dental providers must provide or refer EPSDT-eligible beneficiaries with an identified need for additional assessment, diagnosis, and/or treatment services to an appropriate provider.

C. EPSDT screening providers must refer EPSDT-eligible beneficiaries to other enrolled Mississippi Medicaid licensed practitioners of the beneficiary's choice for assessment, diagnosis and/or treatment services necessary to correct or ameliorate any physical, mental, psychosocial and/or behavioral health conditions discovered by the screenings, whether or not such services are covered under the State Plan.

Source: 42 U.S.C § 1396d; Miss. Code Ann. § 43-13-117.

History: Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.4: Periodicity Schedule

A. EPSDT providers must adhere to the current American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule.

B. EPSDT providers must schedule all health assessment screening appointments for the EPSDT-eligible beneficiary according to the AAP Bright Futures Periodicity Schedule.

C. EPSDT providers must maintain a screening periodicity tracking system for EPSDT-eligible beneficiaries seen for initial screening to ensure that subsequent screenings are performed timely and in accordance to the AAP Bright Futures Periodicity Schedule. EPSDT-eligible beneficiaries, guardians and/or legal representatives must be informed of the AAP Bright Futures Periodicity Schedule.

1. EPSDT providers must follow up on missed appointments. If the beneficiary fails to keep the scheduled appointment, or the beneficiary, guardian and/or legal representative fails to contact the provider to reschedule, an appointment letter or telephone contact must be made providing the beneficiary another opportunity to be screened within thirty (30) days of the initial appointment.

2. Two (2) good faith efforts, defined as an attempt to contact the beneficiary, guardian and/or legal representative, are required to reschedule a screening appointment. EPSDT providers must document in the medical record any missed appointments and two (2) good faith efforts to reschedule the appointment.

3. Failure of a beneficiary, guardian and/or legal representative to keep the second appointment and respond to the provider's attempted contact is considered a declination of that screening only. The provider must continue to maintain periodicity and schedule the beneficiary for the next screening due following the same process.

Source: 42 C.F.R § 441.58; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.5: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screenings

A. An initial or established age appropriate medical screening which must include at a minimum:

   1. A comprehensive health and developmental history including assessment of both physical and mental health development and family history,

   2. A comprehensive unclothed physical examination,

   3. Appropriate immunizations according to the Advisory Committee on Immunization Practices (ACIP), and specific to age and health history,

   4. Laboratory tests adhering to the AAP Bright Futures Periodicity Schedule,

   5. Sexual development and sexuality screening adhering to the AAP Bright Futures Periodicity Schedule, and

   6. Health education, including anticipatory guidance.

B. Developmental screening or surveillance to include diagnosis with referral to an enrolled Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

C. Psychosocial/behavioral assessment to include diagnosis with referral to an enrolled Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

D. Vision screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid optometry or ophthalmology provider for diagnosis and treatment for defects discovered.

E. Hearing screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid audiologist, otologist, otolaryngologist or other physician hearing specialists for diagnosis and treatment for defects discovered.

F. Dental screening, at a minimum, to include diagnosis with referral to an enrolled Mississippi Medicaid dental provider for beneficiaries at eruption of the first tooth or twelve (12) months of age for diagnosis and referral to a dentist for treatment and relief of pain and infections, restoration of teeth and maintenance of dental health.

G. Maternal depression screening, to include a referral:

   1. To an enrolled Medicaid provider if the mother is eligible for Medicaid, or

   2. To other healthcare providers as medically indicated including, but not limited to:

a) Federally Qualified Health Center (FQHC),

b) Rural Health Clinic (RHC), or

c) Community Mental Health Center (CMHC).

Source: 42 U.S.C. §1396d; 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 18-0014 (eff. 10/01/2018) effective 12/1/2018. Revised to correspond with SPA 15-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.6: Documentation Requirements for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Screenings

A. The medical record must include, at a minimum, documentation of the specific age appropriate screening requirements according to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule including the date the test or procedure was performed, the specific tests or procedures performed, the results of the tests or procedures or an explanation of the clinical decision to not perform a test or procedure in accordance with the AAP Bright Futures Periodicity Schedule, and documentation of the following:

1. Consent for screening with the beneficiary's and/or legal guardian/representative's signature,

2. Beneficiary and family history with appropriate updates at each screening visit, including, but not limited to, the following:

   a) Psychosocial/behavioral history,

   b) Developmental history, and

   c) Immunization history,

3. Measurements, including, but not limited to:

   a) Length/height and weight,

   b) Head circumference,

   c) Weight for length percentiles,

   d) Body mass index (BMI), and

   e) Blood pressure,

4. Sensory screenings, subjective and/or objective:
    a) Vision, and
    b) Hearing,
5. Developmental/behavioral assessment, as appropriate, including:
    a) Developmental screening to include, but not limited to:
        1) A note indicating the date the test was performed,
        2) The standardized tool used which must have:
            (a) Motor, language, cognitive, and social-emotional developmental domains,
            (b) Established reliability scores of approximately 0.70 or above,
            (c) Established validity scores of approximately 0.70 or above for the tool conducted on a significant amount of children and using an appropriate standardized developmental or social-emotional assessment instrument, and
            (d) Established sensitivity/specificity scores of approximately 0.70 or above, and
        3) Evidence of a screening result or screening score,
    b) Autism screening,
    c) Developmental surveillance,
    d) Psychosocial/behavioral assessment,
    e) Tobacco, alcohol and drug use assessment,
    f) Depression screening, and
    g) Maternal depression screening.
6. Unclothed physical examination,
7. Procedures, as appropriate, including, but not limited to:
    a) Newborn blood screening,
    b) Vaccine administration, if indicated,

c) Anemia testing,

d) Lead screening and testing,

e) Tuberculin test, if indicated,

f) Dyslipidemia screening,

g) Sexually transmitted infection screening,

h) Human immunodeficiency virus (HIV) testing,

i) Cervical dysplasia screening, and

j) Other pertinent lab and/or medical tests, as indicated,

8. Oral health, including:

a) Dental assessment,

b) Dental counseling, and

c) Referral to a dental home at the eruption of the first tooth or twelve (12) months of age,

9. Anticipatory guidance, including, but not limited to:

a) Safety,

b) Risk reduction,

c) Nutritional assessment, and

d) Supplemental Nutrition Assistant Program (SNAP) and Women, Infants and Children (WIC) status,

10. Appropriate referral(s) to other enrolled Mississippi Medicaid providers for diagnosis and treatment,

11. Follow-up on referral(s) made to other enrolled Mississippi Medicaid providers for diagnosis and treatment,

12. Next scheduled EPSDT screening appointments, and

13. Missed appointments and any contacts or attempted contacts for rescheduling of EPSDT

screening appointments.

B. Medical records must be available to the Division of Medicaid and/or designated entity upon request. [Refer to Maintenance of Records Miss. Admin. Code Part 200, Rule 1.3]

Source: Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121, 43-13-129.

History: Revised to correspond with SPA 18-0014 (eff. 10/01/2018) effective 12/01/2018. Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.7: Diagnostic and Treatment Program Services

The Division of Medicaid covers any medically necessary Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) diagnostic and treatment services required to correct or ameliorate physical, mental, psychosocial, and/or behavioral health conditions discovered by a screening, whether or not such services are covered under any Medicaid Administrative Rule or the State Plan for EPSDT-eligible beneficiaries and, if required, prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity. [Refer to Miss. Admin. Code Part 200, Rule 5.1].

Source: 42 U.S.C § 1396d; Miss. Code Ann. § 43-13-121.

History: Revised to correspond with SPA 2015-017 (eff. 11/01/2015), eff. 10/01/2016.

Rule 1.8: Reimbursement

A. The Division of Medicaid reimburses a separate fee in addition to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodic screenings and medically necessary interperiodic visits for each of the following when documented in accordance with Miss. Admin. Code Title 23, Part 223, Rule 1.6.A.

1. Developmental screenings according to the American Academy of Pediatrics (AAP) guidelines,

2. Vision screenings,

3. Hearing screenings,

4. Autism screenings,

5. Depression screenings,

6. Maternal depression screening, and

7. Other medically necessary services prior authorized by the Division of Medicaid or designee, if required:

a) Lab tests, excluding hemoglobin or hematocrit,

b) Diagnostic tests, and

c) Other procedures.

B. The Division of Medicaid reimburses EPSDT screening fees using Current Procedural Terminology (CPT) Codes based on the American Medical Association (AMA) methodology for determining medical services at ninety (90) percent of the Medicare fee schedule per state law.

C. The Division of Medicaid only reimburses Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Mississippi Department of Health (MSDH) Clinics an encounter rate that is all inclusive of all items listed in Miss. Admin. Code Title 23, Part 223, Rule 1.8.A.

Source: 42 U.S.C. § 1396d; 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond with SPA 18-0014 (eff. 10/01/2018) effective 12/01/2018. New Rule to correspond with SPA 15-017 (eff. 11/01/2016) eff. 10/01/2016.

Chapter 2: Early Intervention / Targeted Case Management

Rule 2.1: Provider Participation

A. Providers

1. Qualified providers shall be state agencies, private and public providers and their subcontractors.

2. Providers must meet the following Medicaid criteria to ensure that case managers for the children with developmental disabilities are capable of providing needed services to the targeted group:

a) Demonstrated successfully a minimum of three (3) years of experience in all core elements of case management including:

1) Assessment,

2) Care/services plan development,

3) Linking/coordination of services, and

4) Reassessment/follow-up.

b) Demonstrated case management experience in coordinating and linking such community resources as required by the target population,

c) Demonstrated experience with the target population, and

d) Demonstrated the ability to provide or has a financial management system that documents services delivered and costs associated.

B. Case Managers

1. Each case manager must be a Mississippi Early Intervention Program certified service provider and have both of the following:

a) A bachelor's degree in child development, early childhood education, special education, social work, or be a registered nurse, and

b) Two (2) years' experience in service coordination for children with disabilities up to age eighteen (18) or two (2) years' experience in service provision to children under six (6) years of age.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b); 34 CFR 303

Rule 2.2: TCM Activities

A. Early Intervention/Targeted Case Management (EI/TCM) is an active ongoing process that involves activities carried out by a case manager to assist and enable a child enrolled and participating in the Mississippi Early Intervention Program to gain access to needed medical, social, educational and other services. Service Coordination to assist the child and child's family, as it relates to the child's needs, from the notice of referral through the initial development of the child's needs identified on the Individualized Family Services Plan (IFSP). Additionally, Service Coordination assists the child and child's family, as it relates to the child's needs, with ongoing service coordination, for the child, provided by the individual service coordinator selected at the time the IFSP is finalized.

B. These activities include:

1. Arranging for evaluation and assessment activities to determine the identification of services as it relates to the child's medical, social, educational and other needs,

2. Arranging for and coordinating the development of the child's IFSP,

3. Arranging for the delivery of the needed services as identified in the IFSP,

4. Assisting the child and his/her family, as it relates to the child's needs, in accessing needed services for the child and coordinating services with other programs,

5. Monitoring the child's progress by making referrals, tracking the child's appointments, performing follow-up on services rendered, and performing periodic reassessments of the child's changing service needs,

6. Make a minimum of one (1) face-to-face contact quarterly and documented successful contacts monthly,

7. Obtaining, preparing and maintaining case records, reports, documenting contacts, services needed, and the child's progress,

8. Providing case consultation, with the service providers/collaterals in determining child's status and progress,

9. Coordinating crisis assistance, intervention on behalf of the child, making arrangements for emergency referrals and coordinating other needed emergency services, and

10. Coordinating the transition of an enrolled child to ongoing services prior to the child's third (3rd) birthday.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b); 34 CFR 303

Rule 2.3: Quality Assurance and Monitoring

A. The Division will establish and maintain an assurance process that ensures a quality case management program and the delivery of necessary covered services that appropriately address the individual needs. The provider agrees to share data as part of the quality assurance program timely upon request by the Division.

B. The providers will make available to the Division the documentation/records maintained for case management services with the following information:

1. The name of eligible client,

2. Dates of case management services,

3. The nature, content, and units of the case management services received and whether goals specified in the care plan have been achieved,

4. Whether the client has declined services in the care plan, the need for and occurrences of coordination with other case managers,

5. The time line for obtaining needed services,

6. The time line for reevaluation of the plan,

7. Case Management Needs Assessment to determine the services needed and requested by

the individual,

8. Service Coordination and Linkage to identify, assess, and link eligible individuals with the appropriate medical, social, and educational services to ensure that appropriate services are being provided while reducing duplication of services, and

9. Individual Service Monitoring to assure that all services are being appropriately delivered according to the Individualized Family Service Plan (IFSP) and in accordance with the established time lines.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b)

Rule 2.4: Freedom of Choice

A. Enrolled and participating recipients will have free choice of the available providers of case management services; and

B. Enrolled and participating recipients will have free choice of the available providers of other medical care under the plan.

Source: Miss. Code Ann. § 43-13-121; Section 1920(a) (23) of the Social Security Act.

Rule 2.5: Reimbursement

A. The Division of Medicaid uses rate setting as a prospective method of reimbursement on both the state and federal level. This method does not allow for retrospective settlements. The rates are determined from cost reports and appropriate audits.

B. Standard rates will be re-determined annually. The Division of Medicaid uses a fee-for-service reimbursement rate for private providers. In no case may the reimbursement rate for services provided exceed an individual facility's customary charge to the public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.

C. Payments under the plan do not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

D. Case management providers are paid on a unit of service basis that does not exceed fifteen (15) minutes.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(19)(b); 34 CFR 303

Chapter 3: Prescribed Pediatric Extended Care (PPEC) Services

Rule 3.1: Definitions

The Division of Medicaid defines:

A. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries as beneficiaries who qualify for the federally mandated EPSDT program according to 42 U.S.C. § 1396d and 42 C.F.R. Part 441.

B. Prescribed pediatric extended care (PPEC) services as medically necessary skilled nursing services and therapeutic interventions for EPSDT eligible, medically complex beneficiaries who:

    1. Are medically or technologically dependent, and

    2. Require continual care.

C. PPEC center as any building or buildings, or other place, whether operated for profit or non-profit, which undertakes through its ownership or management to provide basic nonresidential services to three (3) or more medically dependent or technologically dependent children who are not related to the owner or operator by blood, marriage or adoption and who require such services.

D. Medically or technologically dependent as requiring on-going, physician prescribed, technologically-based skilled nursing supervision and/or requiring routine use of a medical device to compensate for the deficit of life-sustaining body function due to a medical condition/disability whether acute, chronic or intermittent in nature.

E. Medically complex as a medical condition that requires continual care as prescribed by the child's attending physician.

Source: 42 U.S.C. § 1396d; Miss. Code Ann. §§ 41-125-3, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 01/01/2020), eff. 02/01/2020.

Rule 3.2: Provider Requirements

A. Prescribed pediatric extended care (PPEC) providers, including out-of-state providers, must satisfy all requirements set forth in Miss. Admin Code Title 23, Part 200, Rule 4.8 in addition to the following provider type specific requirements:

    1. National Provider Identifier (NPI) verification from National Plan and Provider Enumeration System (NPPES).

    2. Written confirmation from the Internal Revenue Service (IRS) confirming the provider's tax identification number and legal business name.

3. A copy of the provider's current Medicare certification or Tie-In Notice from the Medicare Administrative Contractor. An Explanation of Medicare Benefits (EOMB) is not acceptable.

4. A copy of License from the Mississippi State Department of Health, Health Facilities Licensure and Certification. If parent entity is an out-of-state facility with a servicing location in Mississippi, a copy of the respective State's license is required.

B. PPEC providers must adhere to the Mississippi State Department of Health Minimum Standards of Operation of PPEC Centers, as required for Licensure.

C. PPEC providers must development, implement and monitor the comprehensive plan of care, developed in conjunction with the parent or guardian, which specifies the medical, nursing, psychosocial and developmental therapies required.

Source: 42 U.S.C § 1396d; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 01/01/2020), eff. 02/01/2020.

Rule 3.3: Covered Services

A. The Division of Medicaid covers up to twelve (12) hours per day of medically necessary prescribed pediatric extended care (PPEC) services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries when:

1. Ordered by the beneficiary's attending physician,

2. Provided by a Mississippi licensed and Medicaid enrolled PPEC center, and

3. Prior authorized by the Division of Medicaid or designee:

a) Prior authorizations must be submitted every six (6) months, and

b) The ordering physician must perform an in-person evaluation of the beneficiary a minimum of every six (6) months to review and update the plan of care (POC) as necessary.

B. PPEC services include, but are not limited to:

1. Nursing services,

2. Respiratory therapy,

3. Developmental services,

4. Nutrition services,

5. Social services,

6. Physical therapy, occupational therapy and/or speech-language pathology,

7. Durable medical equipment and medical supplies as required by the Mississippi Department of Health (MSDH), and

8. Transportation to and from the PPEC facility unless the beneficiary's parent and/or legal guardian chooses for the beneficiary to be transported by a family member or friend.

C. All PPEC services must meet the MSDH's minimum standards in order to be covered.

Source: 42 U.S.C § 1396d; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 01/01/2020), eff. 02/01/2020.

Rule 3.4: Non-covered Services

The Division of Medicaid does not cover the following as prescribed pediatric extended care (PPEC) services:

A. Services that are not part of a written plan of care,

B. Services that have not been ordered by a physician,

C. Educational services,

D. Services provided to beneficiaries that are related to the owner or operator by blood, marriage or adoption, and

E. Services that do not meet the Mississippi Department of Health's (MSDH's) minimum standards.

Source: 42 U.S.C § 1396d; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 01/01/2020), eff. 02/01/2020.

Rule 3.5: Reimbursement

A. The Division of Medicaid reimburses up to twelve (12) hours per day of medically necessary prescribed pediatric extended care (PPEC) services for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries when:

1. Ordered by the beneficiary's attending physician,

2. Provided by a Mississippi licensed and Medicaid enrolled PPEC center, and

3. Prior authorized by the Division of Medicaid or designee every six (6) months.

B. The Division of Medicaid reimburses the lesser of the provider's usual and customary charge or:

1. An hourly rate for each complete hour of PPEC services for the first six (6) complete hours of PPEC services,

2. A daily rate for over six (6) hours of PPEC services, and

3. A daily rate for transportation to and from the PPEC center when provided by the PPEC.

C. The following items and services are not included in the hourly or daily rates for PPEC services and must be billed separately by the rendering provider:

1. Occupational therapy,

2. Physical therapy, and

3. Speech-language pathology.

4. Baby food or formula,

5. Total parenteral and enteral nutrition,

6. Mental health and/or psychiatric services, and

7. Durable medical equipment (DME) and medical supplies.

Source: 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 01/01/2020), eff. 02/01/2020.

Rule 3.6: Documentation

A. Providers must maintain required documentation in accordance with Miss. Admin. Code Part 200, Rule 1.3, and must maintain auditable records to substantiate claims submitted to the Division of Medicaid or designated entity.

B. Documentation must include, but is not limited to:

1. The physician's orders and any changes in physician orders,

2. Progress notes,

3. Prior authorization,
4. The plan of care and quarterly updates,
5. Immunization records,
6. Dates and times of all services provided including, but not limited to:
    a) Medication administration record,
    b) Treatment administration record, and
    c) Respiratory treatment record
7. Dates and times of educational services,
8. Dietary orders,
9. Pick-up and drop-off times,
10. Accident reports,
11. Incident Reports, and
12. Emergency contact information.

C. Medical records must be available to the Division of Medicaid and/or designated entity upon request. [Refer to Maintenance of Records Part 200, Rule 1.3]

Source: 42 C.F.R Part 441, Subpart B; Miss. Code Ann. §§ 41-125-19, 43-13-117, 43-13-121.

History: Revised to correspond with SPA 19-0002 (eff. 01/01/2020), eff. 02/01/2020.