Administrative Code

Title 23: Medicaid
Part 202
Hospital Services

Table of Contents

Title 23: Division of Medicaid 1

Part 202: Hospital Services 1

Part 202 Chapter 1: Inpatient Services 1

Rule 1.1: Definitions 1

Rule 1.2: Provider Enrollment 1

Rule 1.3: Prior Authorization of Inpatient Hospital Services 2

Rule 1.4: Covered Services 3

Rule 1.5: Non-Covered Services 6

Rule 1.6: Hyperbaric Oxygen Therapy 6

Rule 1.7: Chelation Therapy 8

Rule 1.8: Sterilization/ Hysterectomy 9

Rule 1.9: Abortions 10

Rule 1.10: Trauma Team Activation/Response 10

Rule 1.11: Documentation Requirements 11

Rule 1.12: Disproportionate Share Hospital 12

Rule 1.13: Out-of-State Facilities 13

Rule 1.14: Inpatient Per Diem Rates 13

Rule 1.15: Cost Reports 14

Rule 1.16: Split Billing 15

Rule 1.17: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) 15

Part 202 Chapter 2: Outpatient Services 16

Rule 2.1: General 16

Rule 2.2: Outpatient Hospital Services 16

Rule 2.3: Emergency Room Outpatient Visit Limitations 17

Rule 2.4: Outpatient (23-Hour) Observation Services 17
Rule 2.5: Outpatient Dialysis 20
Rule 2.6: Mental Health Services 20
Rule 2.7: Out-of-State Facilities 20
Rule 2.8: Outpatient Rates 20
Rule 2.9: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) 21
Part 202 Chapter 3: Swing Beds 21
Rule 3.1: Definition 21
Rule 3.2: Certification of Providers/ Provider Enrollment 22
Rule 3.3: Coverage Criteria 22
Rule 3.4: Reimbursement 24
Rule 3.5: Documentation Requirements 25
Part 202 Chapter 4: Organ Transplants 26
Rule 4.1: Transplant Procedures 26
Rule 4.2: Organ Acquisition 27
Rule 4.3: Fundraising 27
Rule 4.4: Prior Approval 28
Rule 4.5: Facility Criteria 29
Rule 4.6: Documentation Requirements 30
Rule 4.7: Reimbursement 30
Rule 4.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) 31
Rule 4.9: Cornea Transplant 31
Rule 4.10: Heart Transplant 31
Rule 4.11: Heart/Lung Transplant 33
Rule 4.12: Kidney Transplant 35
Rule 4.13: Liver Transplant 35
Rule 4.14: Single Lung Transplant 37

Rule 4.15: Bilateral Lung Transplant 40
Rule 4.16: Bone Marrow Transplant 42
Rule 4.17: Peripheral Stem Cell Transplant 45
Rule 4.18: Small Bowel Transplant 48

Title 23: Division of Medicaid

Part 202: Hospital Services

Part 202 Chapter 1: Inpatient Services

Rule 1.1: Definitions

A. Medicaid considers a patient an inpatient if formally admitted as an inpatient with the expectation that he/she will remain at least overnight and occupy a bed even though it later develops that he/she can be discharged or is transferred to another hospital and does not actually use a hospital bed overnight.

B. Inpatient services are services that are ordinarily furnished by the hospital for the care and treatments of the beneficiary, solely during his/her stay in the hospital.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 440.2; 440.10

Rule 1.2: Provider Enrollment

Hospital providers, including psychiatric hospitals and swing bed providers applying for enrollment into the Medicaid program must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

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

B. Written confirmation from the IRS confirming your tax identification number and legal business name.

C. CLIA certificate and completed certification form.

D. Licensed freestanding psychiatric hospitals must submit Joint Commission on Accreditation of Health Care Organization (JCAHO).

E. Copy of current Medicare certification or Tie-In Notice. EOMB is not acceptable.

F. Out of state facility: Copy of outstanding claims, if applicable.

G. Copy of hospital license

1. Out-of-state facility: Copy of license/certification in effect during the claims period for which they are billing.

2. In-state facility: A copy of letter from the Mississippi State Department of Health is acceptable.

3. Hospital undergoing a Change of Ownership (CHOW): License in effect for the new owner.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 482.11

Rule 1.3: Prior Authorization of Inpatient Hospital Services

A. Requirement:

1. Prior authorization is required for all inpatient hospital admissions except obstetrical deliveries. Emergent admissions and urgent admissions must be authorized on the next working day after admission. Failure to obtain the prior authorization will result in denial of payment to all providers billing for services, including the hospital and the attending physician.

2. Prior authorization must be obtained from the Utilization Management and Quality Improvement Organization when a beneficiary has third party insurance and Medicaid.

3. Prior authorizations are not required for Medicaid beneficiaries who are also covered by both Medicare Parts A & B, unless inpatient Medicare benefits are exhausted. Prior authorizations are required for Medicaid beneficiaries who are also covered by Medicare Part A only or Medicare Part B only.

B. Non-Approved Services

1. Medicaid beneficiaries in hospitals shall be billed for inpatient care occurring after they have received written notification of Medicaid non-approval of hospital services. Notification prior to the beneficiary's admission shall be cause to bill the beneficiary for full payment if he/she enters the hospital. Notification at or after admission shall be cause to bill the beneficiary for all services provided after receipt of the notice.

2. The hospital must not bill the Medicaid beneficiary for an inpatient stay when it is determined upon retrospective review by the Utilization Management and Quality Improvement Organization (UM/QIO) that the admission did not meet inpatient care criteria.

C. Maternity-Related Services

1. Hospitals must report all admissions for deliveries, both vaginal and Cesarean section, to the Division of Medicaid's UM/QIO. The hospitals must report the admissions in accordance with the requirements provided by the UM/QIO. A Treatment Authorization Number (TAN) will be issued to cover up to three (3) days for a vaginal delivery or up to five (5) days for a Cesarean section delivery.

2. For admissions exceeding three (3) days for a vaginal delivery or five (5) days for a

Cesarean section delivery, providers must submit a request for a continued stay in accordance with the policies and procedures provided by the UM/QIO.

D. Newborns

1. Normal well-baby services provided in the hospital are non-covered when billed separately from the mother's hospital claim for labor, delivery, and immediate postpartum services.

2. The hospital must obtain a Treatment Authorization Number (TAN) for sick newborns requiring hospitalization beyond the mother's hospital stay. The mother's discharge date shall become the sick newborn's beginning date for certification.

3. The hospital must obtain authorization for newborns delivered outside the hospital and newborns admitted to accommodations other than well baby.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1814(e)

Rule 1.4: Covered Services

A. Covered inpatient services include:

1. Ancillary services.

2. Blood and blood components- the first six (6) pints of whole blood and/or equivalent quantities of packed red blood cells for each eligible beneficiary, when they are not available from other sources.

3. Drugs, excluding take home drugs.

4. Supplies.

5. Oxygen.

6. Durable Medical Equipment.

7. Implantable Programmable Baclofen Pump.

   a) The cost of implantable programmable baclofen drug pumps used to treat spasticity which are implanted in an inpatient hospital setting will be reimbursed outside the hospital Medicaid per diem rate.

   b) Hospitals must remove the cost of these pumps from the cost report filed with Medicaid. Reimbursement is limited to $10,000 per state fiscal year, July 1- June 30, per Medicaid beneficiary. Claims submitted for beneficiaries who have exhausted their inpatient benefit limit or for non-certified days will be denied.

8. Newborn Hearing Screens - refer to Part 218.

9. Therapy Services

   a) Therapeutic services ordinarily furnished to inpatients by the hospital, or by others under arrangements made by the hospital, are covered.

   b) Inpatient services rendered by a psychologist or a therapist who is employed by the hospital, and whose services are normally included in the billing of the hospital, are covered on a reasonable basis in the same manner as the services of other non-physician hospital employees.

10. Inpatient Psychiatric Services are covered in the following settings as outlined:

    a) Acute Freestanding Psychiatric Facility

       1) Services available for children up to age twenty-one (21).

       2) Certification by the UM/QIO is required.

    b) Psychiatric Unit at a Medical Surgical Facility

       1) Services available to children or adults.

       2) Certification by the UM/QIO is required.

       3) Services are applied to the thirty (30) inpatient hospital days per state fiscal year.

11. Inpatient or outpatient hospital services rendered to a beneficiary who leaves the hospital against medical advice.

12. Canceled or incomplete procedures related to the beneficiary's medical condition. Services performed before the surgical or other procedure is canceled or terminated before completion due to a change in the beneficiary's condition.

B. Covered inpatient procedures include:

1. Sterilization as outlined in Rule 1.8 of this chapter.

2. Hysterectomy as outline in Rule 1.8 of this chapter.

3. Abortions as outlined in Rule 1.9 of this chapter.

4. Hyperbaric Oxygen Therapy as outlined in Rule 1.6 of this chapter.

5. Chelation Therapy as outlined in Rule 1.7 of this chapter.

6. Trauma Team Activation Response as outlined in Rule 1.10 of this chapter.

C. Hospitals with Multiple Accommodations:

1. Private Room: When private room accommodations are furnished, the following rules will govern:

a) Private Room/Critical Care Units – Medically Necessary – The reasonable cost of a private room or other accommodations more expensive than semi-private are covered services when such accommodations are medically necessary. Private rooms will be considered medically necessary when the physician documents that the patient's condition requires him/her to be isolated for his/her own health or for the health of others. This includes the use of critical care units.

b) Private Room – Not Medically Necessary – Based on Availability – When accommodations more expensive than semi-private are furnished, the assigned accommodations are considered medically necessary and are covered by Medicaid if at the time of admission less expensive accommodations are not available (this includes hospitals with private rooms only.) The subsequent availability of semi-private or ward accommodations would offer to the hospital the right to transfer that patient to such accommodations or, at the express request of the patient, to allow him/her to continue occupancy of the private room as a private-room patient enjoying a personal comfort item and subject to be billed the room differential charge.

c) Private Room – Requested by Beneficiary – When a private room is not medically necessary but is furnished at the beneficiary's request, the hospital may change the patient no more than the difference between the customary charge for the accommodations furnished and the customary charge for the semi-private accommodations at the rate in effect at the time services are rendered. No such charge may be made to the patient unless he/she requested the more expensive accommodations with the knowledge that he/she would be charged the differential. The patient's account file, over the signature of an authorized hospital employee, should reflect the patient's knowledge that the differential charge will be expected.

d) Deluxe Accommodations – The Medicaid program does not cover deluxe accommodations and/or deluxe services. These would include a suite/birthing suite, or a room substantially more spacious than is required for treatment, or specifically equipped or decorated, or serviced for the comfort and convenience of persons willing to pay a differential for such amenities. A room differential cannot be charged to the beneficiary when the differential is based on such factors as differences between older and newer wings, proximity to lounge, elevators or nursing stations, or a desirable view. Such rooms are standard on-bed units and not deluxe rooms for purposes of this instruction.

2. Semi-private Room – Two (2) beds per room – Medicaid will cover the reasonable cost of semi-private accommodations.

3. Ward Accommodations – Three (3) or more beds per room – If less than semi-private accommodations are furnished, Medicaid will cover the cost or the accommodation furnished only if the patient requests such or when semi-private accommodations are not available. If less than semi-private accommodations are furnished because all semi-private rooms are filled, the patient should be transferred to semi-private accommodations as soon as one becomes available.

Source: Miss. Code Ann. § 43-13-121

Rule 1.5: Non-Covered Services

A. Services provided in a geriatric psychiatric unit of a hospital.

B. Services rendered to a Medicaid beneficiary and billed by a physician employed by or contracted with the hospital.

C. Elective cancellation of procedures not related to the beneficiary's medical condition.

1. Surgical or other procedures canceled due to scheduling conflicts of the operating suite or physicians, beneficiary request, or other reasons not related to medical necessity.

2. Additional room and board days required due to rescheduling.

Source: Miss. Code Ann. § 43-13-121

Rule 1.6: Hyperbaric Oxygen Therapy

A. Hyperbaric Oxygen Therapy (HBOT) is covered when the following criteria are met:

1. The patient's entire body must be placed into the hyperbaric chamber. Note that topical application of oxygen with portable chambers is not covered.

2. HBOT must be performed in the hospital setting, either inpatient or outpatient.

3. A physician must order HBOT treatments, document medical necessity, and establish the plan of care specifying the goals for hyperbaric oxygen therapy to accomplish and an estimated number of treatments, with revisions made as appropriate and justification for extending treatments.

4. A cardiopulmonary resuscitation team and a fully equipped emergency cart must be immediately available where the hyperbaric chamber is located when a patient is receiving HBOT in the event of a complication.

B. Hyperbaric oxygen therapy is covered for the following medical diagnoses only:

1. Acute carbon monoxide intoxication,

2. Decompression illness (Caisson disease),

3. Air (gas) embolism,

4. Gas gangrene,

5. Acute traumatic peripheral ischemia, as adjunctive treatment to accepted standard therapeutic measures when function, life, or limb is threatened,

6. Crush injuries and suturing of severed limbs, as adjunctive treatment to accepted standard therapeutic measures when function, life, or limb is threatened,

7. Progressive necrotizing infections - necrotizing fasciitis or meleney ulcer also known as pyoderma gangrenosum,

8. Acute peripheral arterial insufficiency,

9. Preparation and preservation of compromised skin grafts,

10. Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management,

11. Osteoradionecrosis, as an adjunct to conventional treatment,

12. Soft tissue radionecrosis, as an adjunct to conventional treatment,

13. Cyanide poisoning, and

14. Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment.

C. Physician must be in constant personal attendance where the hyperbaric oxygen chamber is located while the patient is receiving HBOT and must not delegate administration of HBOT to hospital staff. Physician's absence during the entire HBOT treatment shall result in reimbursement to the facility only.

D. Documentation of Medical Necessity

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

2. Documentation must include the following:

a) Specific written record that HBOT was performed in a hospital setting, inpatient or outpatient, utilizing a full body hyperbaric chamber;

b) A written physician order, comprehensive history, and physical report detailing the condition/diagnosis(es) requiring HBOT, including prior treatments and their results and additional treatments being rendered concurrently with HBOT;

c) Physician progress notes and consultation reports that describe the patient's response to treatment;

d) Established goals for hyperbaric oxygen therapy to accomplish and an estimated number of treatments, with revisions made as appropriate and justification for extending treatments;

e) Wound description, if applicable, including wound size and appearance, for each day of service billed;

f) Radiology and laboratory reports, including culture and sensitivity studies, to support the diagnosis when applicable;

g) Specific written record of the physician's constant personal attendance where the hyperbaric chamber is located while the patient is undergoing HBOT;

h) Specific written record of the availability of a cardiopulmonary resuscitation team and a fully equipped emergency cart where the hyperbaric chamber is located while the patient is undergoing HBOT.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1862(a)(1)(A), 1833(e); 42 CFR 410.27(f); 410.26(a)(2); 410.32(b)(3)(ii)

Rule 1.7: Chelation Therapy

A. Medicaid will reimburse only for FDA-approved chelation in an inpatient or outpatient hospital setting in accordance with current standards of medical practice.

B. Conditions which may be treated with chelation include:

1. Lead poisoning,

2. Iron overload,

3. Metallic mercury poisoning,

4. Copper poisoning,

5. Arsenic poisoning,

6. Gold poisoning,

7. Cystinuria,

8. Wilson's disease, and

9. Severe, active rheumatoid arthritis that has failed to respond to an adequate trial of conventional therapy.

C. Documentation in the medical records of symptoms and/or laboratory tests must support one (1) of the listed diagnoses. Chelation therapy for the treatment of any other conditions is not a covered service.

Source: Miss. Code Ann. § 43-13-121; 21 CFR § 312

Rule 1.8: Sterilization/ Hysterectomy

A. Sterilization procedures for males and females are covered as "once per lifetime" when the following criteria is met with no exceptions:

1. The beneficiary must be mentally competent. Medicaid benefits are not available for sterilization of a mentally incompetent or institutionalized individual.

2. The beneficiary must be twenty-one (21) years old when the consent form is signed.

3. The beneficiary, and only the beneficiary, must sign the consent form voluntarily.

4. The consent form is valid for one hundred eighty (180) days from the date it is signed by the patient.

5. The consent form must be fully and accurately completed.

6. There must be at least a thirty (30) day waiting period between the date that the beneficiary signs the form and the date of the surgery.

B. An individual may be sterilized at the time of a premature delivery or emergency abdominal surgery if at least seventy-two (72) hours have passed since he or she gave informed consent for the sterilization.

C. Informed consent must have been given at least thirty (30) days before the expected date of delivery for premature deliveries.

D. Caesarean deliveries are not routinely considered as emergency abdominal surgery.

E. Appropriate medical documentation is required to justify any emergency abdominal procedures

or premature deliveries. The physician must document the expected date of delivery for premature deliveries.

F. Failed Sterilization: Coverage shall be provided for a second covered sterilization due to failure of the first. Documentation in the beneficiary's medical record must reflect the date of the first sterilization and the reason for the procedure failure.

Source: Miss. Code Ann. § 43-13-121; § 441.251, 252, 253, 254; 42 CFR § 441.255,256, 257, 258; 42 CFR § 441, Subpart F; 42 CFR § 50.207; 43 FR 52171

Rule 1.9: Abortions

A. Notwithstanding any other provision of law to the contrary, no public funds that are made available to any institution, board, commission, department, agency, official, or employee of the State of Mississippi, or of any local political subdivision of the state, whether those funds are made available by the government of the United States, the State of Mississippi, or a local governmental subdivision, or from any other public source, shall be used in any way for, to assist in, or to provide facilities for abortion, except:

   1. When the abortion is medically necessary to prevent the death of the mother, r

   2. When the abortion is being sought to terminate a pregnancy resulting from an alleged act of rape or incest, or

   3. When there is a fetal malformation that is incompatible with the baby being born alive.

B. Medicaid coverage for abortion services is governed by federal law under the Hyde Amendment, which provides that abortion services are reimbursable under Medicaid as follows:

   1. When the abortion is medically necessary to prevent the death of the mother, or

   2. When the abortion is being sought to terminate a pregnancy resulting from an alleged act of rape or incest.

C. The physician is required to maintain sufficient documentation in the medical record that supports the medical necessity for the abortion for one of the reasons outlined in Rule 1.7.B (a)(b).

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 441, Subpart E; Consolidated Appropriations Act, 2008 (H.R. 2764), signed into law Dec. 26, 2007, (Public Law 110-161) Sections 507-508

Rule 1.10: Trauma Team Activation/Response

Trauma team activation/response fees are covered under the Mississippi Medicaid Program according to the following criteria:

A. The billing hospital must have a complete designation as a Level I, II, III, or IV trauma center through the Mississippi State Board of Health, Office of Emergency Planning and Response; or if out of state, through the responsible governing body of the state in which the beneficiary received services.

B. Payment will be made in accordance with the reimbursement methodology of Medicaid's inpatient or outpatient hospital services.

C. Trauma activation fees for beneficiaries who are "drive by," or arrive by private vehicle without notification from pre-hospital caregivers, are not covered. The patient must arrive by ambulance and the hospital must be pre-notified by pre-hospital caregivers.

D. Documentation must be maintained in the patient's medical record that supports provision of an organized trauma team response that meets the criteria for the Level I, II, III, or IV service. A facility must not bill and cannot be paid for a level of care above the one (1) which they have been designated by the Mississippi State Department of Health.

E. All patients must have a primary diagnosis that falls within the appropriate International Classification Of Disease (ICD) diagnosis code range plus documentation in the medical record of one (1) of the following situations:

1. Transfer between acute care facilities, in or out,

2. Admission to critical care unit, no minimum,

3. Hospitalization for three (3) or more calendar days,

4. Death after receiving any evaluation or treatment,

5. Admission directly from Emergency Department to Operating Room for major procedure, excluding plastics or orthopedics procedures on patients that do not meet the three day hospitalization criteria,

6. Triaged, in accordance with regional trauma protocols, to a trauma hospital by pre-hospital care regardless of severity, or

7. Treated in the Emergency Department by the trauma team regardless of severity of injury.

Source: Miss. Code Ann. § 43-13-121

Rule 1.11: Documentation Requirements

The hospital must maintain legible and auditable records that will substantiate the claim submitted to Medicaid. At a minimum, the records must contain the following on each patient:

A. Date of service.

B. A comprehensive history and physical assessment/report, including the patient's presenting complaint.

C. Diagnosis(es) to substantiate the hospitalization and all treatments/procedures rendered during the hospitalization.

D. The specific name/type of all diagnostic studies, including lab, x-ray, and the like, and the medical indication and results/finding of the studies.

E. Documentation and consult reports to substantiate treatment/procedures rendered, the patient's response to the treatment/procedure; and the signature or initials of the appropriate health care worker providing the treatment/procedure, including but not limited to the physician, nurse, therapist, dietitian.

F. The name, strength, dosage, route, either IM, IV, PO, topical, enteral, intracatheter, date and time, indication for, and the administration of all medications administered to the patient.

G. Discharge planning and instructions, including the signature or initials of the health care worker performing the instruction; the name of the person being instructed; date and time of instruction; whether the instructions are given in writing, verbally, by telephone or other means; and how much instruction was comprehended by the beneficiary, including level of proficiency on return demonstration when a procedure is being taught.

H. Discharge orders for medications, treatments and procedures that indicate whether the orders/prescriptions are issued in writing, verbally, or by telephone, and to whom the orders are issued.

I. Signed physician orders for all medications, treatments, and procedures rendered to the patient.

J. All x-ray images, including films and digital images, films, and digital images must be of such quality that they can be clearly interpreted.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 424.13

Rule 1.12: Disproportionate Share Hospital

The Disproportionate Share Hospital (DSH) program and the qualifications for participation in the DSH program are defined in Attachment 4.19-A of the Medicaid State Plan.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 447.298

Rule 1.13: Out-of-State Facilities

A. Out-of-state hospitals in contiguous states are reimbursed at the lower of either:

   1. The average rate paid to a like-sized hospital in Mississippi, or

   2. The inpatient rate established by the Medicaid agency of the domicile state.

B. Verification of the rate with the Medicaid agency in the domicile state must be done annually.

C. Out-of-state hospitals in states, other than contiguous states are reimbursed at the average rate paid a like-sized hospital in Mississippi.

D. Out-of-state hospitals providing services not otherwise available within the state of Mississippi to Mississippi children under the age of twenty-one (21) be paid an amount not to exceed the cost of their services.

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

Rule 1.14: Inpatient Per Diem Rates

A. Medicaid uses a prospective method of reimbursement and will not make retroactive adjustments except as specified in the Title XIX Inpatient Hospital Reimbursement Plan. Per diem rates are determined annually with an effective date of October 1.

B. For rate years prior to October 1, 2005 and rate years beginning on or after October 1, 2010, inpatient rates are determined from cost reports and appropriate audits or by other means approved by the grantor agency. The methodology is explained in detail in Appendices A, B, and C of the Title XIX Inpatient Hospital Reimbursement Plan.

   1. For rate periods prior to October 1, 2005, rates will be retroactively adjusted using the results of final and amended final cost reports provided by the Medicare intermediary. Rates may also be adjusted based on the results of audits performed by or on behalf of DOM.

   2. For rate periods beginning on or after October 1, 2010, only the original final settlement provided by the Medicare intermediary will be reviewed and adjustments made therefrom. Rates may also be adjusted based on the results of audits performed by or on behalf of the Division of Medicaid.

C. In no case may the reimbursement rate for services exceed an individual facility's customary charge to the general public for such services in the aggregate except for those public facilities rendering such services free of charge or at a nominal charge.

D. Medicaid may adjust prospective rates pursuant to changes in federal and/or state laws or

regulations. All plan changes must be approved by the federal grantor agency. Based on allowable and reasonable costs or by other means approved by the grantor agency, Medicaid establishes a per diem reimbursement rate for each facility.

E. In cases of a change of ownership, the first cost report filed by the new owner will be used to set the per diem reimbursement rate retroactive to the date of the change of ownership. A base rate will be established for hospitals that open or change ownership on or after October 1, 2005. A new owner will be reimbursed at the previous owner's rate until the rate is recalculated based on the new owner's initial cost report using rate-setting procedures in place prior to October 1, 2005.

F. A new hospital will be reimbursed the average rate paid a like-sized Mississippi hospital as of the effective date of the Medicaid provider agreement until the rate is recalculated based on the new hospital's initial cost report using rate-setting procedures in place prior to October 1, 2005. Each rate year the inpatient per diem for each Mississippi hospital is grouped by bed class and an average rate is determined for each class. New Mississippi hospitals will be reimbursed the average for their bed class based on the number of beds. The fiscal year 2005 class ceilings will be trended using the percentage increase of the most recent Medicare Inpatient Hospital PPS Market Basket Update as published in the Federal Register to establish class ceilings for rates through September 30, 2010.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117; Social Security Act § 1814 142 USC 1395f; 42 U.S.C. § 139 SWW. Also known as Social Security Act § 1886; 42 CFR § 447.325

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 DOM in writing. In cases where there is a change in the fiscal year end, the most recent cost report will be used to determine the prospective rate. 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 (5th) 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 (1st) business day following such weekend or holiday. Medicaid will not grant extensions for cost reports, except extensions granted by Medicare, beyond the five (5) months given to complete the cost report.

C. Cost reports that are either postmarked or hand delivered 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, upon initial review for completeness, that a cost report has been submitted without all the required information, providers will be allowed a specific period of time to submit the requested information without incurring a penalty for a delinquent cost report. For cost reports submitted by the due date, ten (10) 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.

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.

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

Rule 1.16: Split Billing

A. Mississippi Medicaid requires split billing for Medicaid and crossover claims in the following situations:

   1. Dates of service spanning Medicaid's fiscal year, July 1 through June 30.

   2. Dates of service spanning the hospital's fiscal year.

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

Source: Miss. Code Ann. § 43-13-121

Rule 1.17: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 202 Chapter 2: Outpatient Services

Rule 2.1: General

Medicaid provides financial assistance for outpatient hospital services. An outpatient is a person who is being provided services by a hospital other than on an inpatient basis or for whom laboratory or radiology services are performed for a referring physician. All rules set forth in Part 202, Chapter 1, are applicable to outpatient services in addition to those specifically outlined in this chapter.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 440.20(a)

Rule 2.2: Outpatient Hospital Services

A. Medicaid defines outpatient hospital services as preventative, diagnostic, therapeutic, rehabilitative, or palliative services provided by a licensed hospital to an outpatient by or under the direction of a physician or dentist.

   1. Medically necessary outpatient hospital services are covered when all of the following criteria apply:

      a) Outpatient services are provided in a clinic or other facility that is not located inside the hospital.

      b) The clinic or other facility has been designated as an outpatient facility by the hospital.

      c) The clinic or other facility was in operation or under construction on July 1, 2009. and

      d) The costs and charges associated with the operation of the hospital clinic are included in the hospital's cost report.

   2. For hospital clinics not located inside the hospital and constructed after July 1, 2009 the Medicare thirty five (35) mile rule will apply.

   3. Outpatient services must be provided by hospital salaried or contracted employees. For purposes of this rule, contracted services are defined as hospital services provided according to a written agreement between a hospital and the health care professional providing the hospital services.

4. Hospitals may bill only for services provided in the hospital's outpatient department as defined above.

B. Off Site Services are services provided off site and outside of the outpatient hospital departments by contracted or employed hospital employees are not covered as outpatient hospital services.

C. Partial hospitalization programs or day treatment programs are not covered in an outpatient hospital setting. The Division of Medicaid defines partial hospitalization or day treatment programs as:

1. Those clearly billed as partial hospitalization/day treatment,

2. Those represented to the community as partial hospitalization programs or day treatment programs, or

3. Those billed to the Division of Medicaid using revenue and procedure codes reflecting multiple units or daily services.

D. Professional Fees are physician services performed in hospital owned physician clinics. Hospitals are covered and must be submitted under a physician group provider number.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 440.20(a)

Rule 2.3: Emergency Room Outpatient Visit Limitations

Medicaid covers six (6) emergency room outpatient visits per state fiscal year. All emergency room charges must be submitted as an outpatient bill. Emergency room charges must be included on an inpatient bill for patients admitted to the hospital directly from the emergency room. Hospital outpatient charges related to services outside of the emergency room are not counted toward the emergency room outpatient visit limit.

Source: Miss. Code Ann. § 43-13-121

Rule 2.4: Outpatient (23-Hour) Observation Services

A. Medicaid defines outpatient twenty-three (23) 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. The terms "outpatient observation", "twenty-three (23) hour observation", and/or "day patient" are interchangeable. The availability of outpatient observation 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. Covered Services - Outpatient observation status must be ordered in writing 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 to admit into observation or as an inpatient is solely the responsibility of the physician. Factors that must be taken into consideration by the physician or authorized individual when ordering outpatient observation:

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

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 twenty-four (24) hours or more) to assist in assessing whether the beneficiary should be admitted, and

4. The 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) 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 observation status for physician-ordered inpatient services.

b) Services not reasonable, cost effective, and necessary for 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 observation status.

f) Inpatients discharged 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 written order and documentation of the time, date, and medical reason for admission.

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

l) Complex cases requiring inpatient care.

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) Observation 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 observation status and the reason for observation must be written on the physician's order sheet, not the emergency room record, and must specify, "admit to observation." Rubber stamped orders are not acceptable.

b) Changes from "observation status" to "inpatient" must be made by a physician or authorized individual.

c) Outpatient observation to inpatient status change must be supported by documentation of medical necessity.

d) A physician's order is required for admission and discharge from an observation unit.

e) There must be documentation that a physician had personal contact with the beneficiary at least once during the observation stay.

f) Medical records must contain appropriate documentation of the actual time a patient is

in the observation unit, as well as, services provided.

E. Billing

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

2. Services provided during an observation stay that result in an inpatient hospital admission must be included on the inpatient bill. The admission date will be the date and time that observation services began.

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

Rule 2.5: Outpatient Dialysis

Services provided in hospital-based renal dialysis units (RDU) are covered and are not subject to any visit limitations.

Source: Miss. Code Ann. § 43-13-121, 43-13-117(2)

Rule 2.6: Mental Health Services

A. Mental Health services are covered when:

1. Provided in an outpatient department of a general hospital, and outpatient mental health services are not covered in acute freestanding psychiatric facilities.

2. Prior authorized through the Utilization Management and Quality Improvement Organization (UM/QIO). Failure to obtain prior authorization will result in denial of payment.

B. Outpatient hospital mental health services will be reimbursed using the same methodology as other outpatient hospital services.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 410.155

Rule 2.7: Out-of-State Facilities

Out-of-state hospitals shall be reimbursed at the lower of seventy-five percent (75%) of charges or the average cost-to-charge ratio of a like-sized hospital in Mississippi for outpatient services.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 431.52

Rule 2.8: Outpatient Rates

A. Outpatient hospital services shall be reimbursed at a percentage of billed charges, unless

specified differently. The percentage paid is the lower of seventy-five percent (75%) of charges or the cost-to-charge ratio, as computed by Medicaid using the hospital's cost report or by other means approved by the grantor agency. The cost-to-charge ratio shall be computed each year for use in the following year's payments. Adjustments to outpatient services claims may be made if the cost-to-charge ratio is adjusted as a result of an amended cost report, audit, or Medicare Final Settlement. The cost-to-charge ratio for outpatient services will be computed under Title XVIII (Medicare) methodology, excluding bad debts and other services paid by Medicaid under a different methodology, like Rural Health Clinic services and Federally Qualified Health Center services.

B. All outpatient laboratory and radiology services shall be reimbursed on a fee-for-service basis.

C. Hospital-based clinics may not bill facility fees unless they are a teaching hospital with a resident-to-bed ratio of 0.25 or greater.

D. In cases of a change of ownership, the first cost report filed by the new owner will be used to set the outpatient percentage retroactive to the date of the change of ownership.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 447.321

Rule 2.9: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 202 Chapter 3: Swing Beds

Rule 3.1: Definition

Swing bed services are extended care services provided in a hospital bed that has been designated as such. Services consist of one or more of the following:

A. Skilled nursing care and related services for patients requiring medical or nursing care,

B. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and

C. On a regular basis, health related care and services to individuals who, because of their medical status, require care and services above the level of room and board which can be made available to them only through institutional facilities.

Source: Miss. Code Ann. § 43-13-121

Rule 3.2: Certification of Providers/ Provider Enrollment

A. The Division of Medicaid requires any hospital certified for participation in the Medicare swing bed program who wants to participate in the Medicaid program to become a provider. A separate provider number from the hospital is required for the swing bed.

B. Hospital providers, including swing bed providers applying for enrollment into the Medicaid program must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to submitting 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 IRS confirming the provider's tax identification number and legal business name.

3. CLIA certificate and submit the completed certification form.

4. Joint Commission on Accreditation of Health Care Organization (JCAHO) for licensed hospitals.

5. Copy of current Medicare certification or Tie-In Notice. Explanation of Medicare Benefits (EOMB) is not acceptable.

6. Copy of outstanding claims, if applicable, for out-of state facility.

7. Copy of Hospital license:

a) Copy of license/certification, in effect during the claims period for which they are billing for out-of state facility.

b) In-state facility: A copy of letter from the Mississippi State Department of Health is acceptable for in-state facility.

c) License in effect for the new owner for Hospital undergoing a Change of Ownership (CHOW).

Source: Miss. Code Ann. § 43-13-121

Rule 3.3: Coverage Criteria

A. Swing bed services are covered when all these criteria are met:

1. Services to be furnished are ordered by a physician, are consistent with the nature and severity of the beneficiary's illness or injury, medical needs, and accepted standards of medical practice, and are reasonable in duration and quantity,

2. The beneficiary requires daily and continuous (not intermittent) skilled nursing and/or rehabilitation services to prevent or minimize deterioration or to sustain health status,

3. The beneficiary does not require daily supervision of a physician but does require a physician visit and evaluation at least every thirty (30) days while the beneficiary is in the swing bed setting,

4. A nursing facility bed is not available and the required services cannot be safely and effectively provided in the beneficiary's residence,

5. In addition to the need for skilled nursing and/or rehabilitation services, the beneficiary must require, at a minimum, assistance with at least three (3) activities of daily living (eating, toileting, personal hygiene, bathing, ambulation, dressing) which cannot be safely and cost-effectively provided in the beneficiary's residence and which must be performed by, or under the supervision of, registered nurses, licensed practical nurses, physical therapists, or occupational therapists.

6. Swing bed services may be covered as long as the beneficiary meets the coverage criteria and there is no available bed in a nursing facility. It is expected that the beneficiary will be discharged or transferred to a nursing facility when the beneficiary's condition allows or a nursing home bed becomes available.

B. Swing bed services are not covered when the beneficiary does not meet the coverage criteria in this Part. Examples include, but are not limited to, the following:

1. The primary service is oral medications.

2. The beneficiary is capable of independent ambulation, dressing, feeding, toileting, and hygiene.

3. Insulin injections are the only service a beneficiary is receiving, and prior to hospitalization, the beneficiary was on self-injections at the beneficiary's residence.

4. The beneficiary and/or primary caregiver are capable of being taught to safely perform the necessary treatment at the beneficiary's residence.

5. When services can be safely and more cost-effectively provided in the beneficiary's residence.

6. If the beneficiary needs intermittent rather than daily and continuous care.

7. If a beneficiary's condition requires an acute inpatient hospital level of care.

Source: Miss. Code Ann. § 43-13-121

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.

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

Rule 3.5: Documentation Requirements

A. The Division of Medicaid requires providers of swing bed services to maintain auditable records that substantiate the services provided. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3. At a minimum, the records must contain the following on each beneficiary:

   1. Date of service,

   2. History and physical exam, with update if necessary,

   3. Physician's progress notes,

   4. Medical indication,

   5. Results and finding of all diagnostic and lab procedures,

   6. Treatment rendered,

   7. Provider's signature or initials,

   8. Documentation of services consisting of skilled nursing care and related services for patients requiring medical or nursing care,

   9. Documentation of rehabilitation services for the rehabilitation of injured, disabled or sick persons, and

   10. Frequent documentation of health related care and services to individuals who, because of their medical status, require care and services above the level of room and board which

can be made available only through institutional facilities.

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

Part 202 Chapter 4: Organ Transplants

Rule 4.1: Transplant Procedures

A. Medicaid covers benefits for transplants listed in Rules 4.9 – 4.18 in this Chapter if the transplant facility obtains prior approval (PA), when required, and satisfies all criteria listed in the Rule.

B. Requests for prior approval must be sent to Medicaid's Utilization Management/Quality Improvement Organization (UM/QIO). Providers should submit requests as soon as it is determined that the beneficiary may be a potential candidate for transplant.

C. Transplant benefits are dependent on all of the following:

1. The beneficiary must be eligible for Mississippi Medicaid.

2. The beneficiary's prior authorization request for the transplant must be approved by the UM/QIO.

3. All inpatient days must be certified the UM/QIO.

4. The days included in the transplant hospital stay does not count against the thirty (30) days limit for inpatient hospital care.

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

6. All providers must complete requirements for participation in the Mississippi Medicaid program.

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

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

9. The transplant facility must provide appropriate medical records, progress or outcome reports as requested by Medicaid, the UM/QIO or the fiscal agent.

10. The transplant procedure must be performed at the facility requesting transplant approval.

E. Transplant procedures/services subject to denial include, but are not limited to, the following:

1. Transplant procedures/services when medical necessity has not been proven.

2. Transplant procedures/services still in clinical trials and/or investigative or experimental in nature.

3. Transplant procedures/services performed in a facility not approved by Medicaid.

4. Inpatient or outpatient admissions for transplant procedures/services have not been certified/re-certified by the UM/QIO.

F. Pancreas transplants are not covered by Medicaid. Pancreas transplants done in conjunction with another covered transplant procedure will only be covered for those charges related to the covered transplant procedure.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.35; 42 CFR 482.90 - 482.104

Rule 4.2: Organ Acquisition

A. Medicaid covers all charges, facility and physician, relating to acquisition, whether cadaveric or living donor, to the transplant facility using the appropriate revenue codes.

B. Donor related charges may include the following:

1. A search for matching tissue, bone marrow, or organ.

2. Donor's transportation.

3. Charges for removal, withdrawal, and preservation/storage

4. Donor's hospitalization.

C. Medically necessary follow-up care outside of the transplant admission for the living donor will be covered only if the donor is a Mississippi Medicaid beneficiary and will be reimbursed as routine benefits.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.35; 42 CFR 482.90 – 482.104

Rule 4.3: Fundraising

A. Fundraisers may be used to obtain funds needed for transplant costs not normally covered by Medicaid program.

B. Fundraising Criteria

1. Prior to accepting donations, arrangements must be made to place donations in a trust fund/ special account.

2. The trust fund/special account must be established/administered in compliance with all applicable federal and state rules/regulations.

3. The trust fund/special account must be managed/administered by someone other than the beneficiary or the beneficiary's family member/legal guardian. The beneficiary or the beneficiary's family member/legal guardian may not have direct access to the fund/account.

4. The trust fund/special account must be maintained separate from personal monies belonging to the beneficiary or the beneficiary's family member/legal guardian. Mixed funds could be counted as income or an asset which could result in a loss or reduction of Medicaid benefits.

5. Legible documentation of income and expenditures must be maintained and must be made available to the Division of Medicaid, the fiscal agent, and/or the UM/QIO upon request.

6. The beneficiary must report all sources of income to the source of eligibility. Donated funds for the purpose of payment of medical services are considered a third party source.

7. Transplant facilities/providers cannot participate in fundraising for beneficiaries to raise additional funds to pay for the transplant procedure and/or related services.

Source: Miss. Code Ann. § 43-13-121

Rule 4.4: Prior Approval

A. Transplants must be prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO), regardless of the age of the beneficiary, with certain exceptions:

   1. Kidney transplants,

   2. Cornea transplants, or

   3. Bone marrow/peripheral stem cell transplants.

B. Transplants on beneficiaries with Medicare coverage do not require prior approval.

C. Prior authorization from the UM/QIO is required on transplants when the beneficiary has third party coverage and the hospital intends to bill Medicaid for any transplant related hospital charges.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.35; 42 CFR 482.90 - 482.104

Rule 4.5: Facility Criteria

A. Medicaid requires organ transplant procedures to be performed in a Medicare approved transplant facility, unless otherwise authorized by Medicaid.

B. Bone marrow/peripheral stem cell transplant facilities must meet the following medical, experience and administrative criteria:

1. Medical Criteria

a) The facility must have written criteria for transplant candidate selection and a written implementation plan.

b) The facility must have a written transplant candidate management plan/protocol that includes both evaluative and therapeutic procedures for the waiting period, in-hospital period, and post-transplant phases of treatment.

c) The facility must make a sufficient commitment of resources and planning to the transplant program to demonstrate the importance of the program at all levels. Indications of this commitment must be broadly evident throughout the facility. The facility must use a multidisciplinary team that includes representatives with expertise in the appropriate organ specialty (ex: hepatology, cardiology, or pulmonology) and the following general areas: transplant surgery, vascular surgery, anesthesiology, immunology, infectious diseases, pathology, radiology, nursing, blood banking, and social services.

2. Experience Criteria

a) The facility's volume of transplants and survival rates must demonstrate both experience and success with bone marrow and/or peripheral stem cell transplantation. The facility staff must have performed a reasonable number of successful transplants for each transplant type for which Medicaid approval is sought.

b) The facility must provide documentation to support the current competence of its transplant physicians and transplant surgeons, and, if requested, its transplant-specific and general clinical staff. The qualifications and transplant experience of transplant physicians and surgeons specified by UNOS (UNOS bylaws Appendix B – III (2): Liver; (4): Heart; and (5): Lung and Heart-Lung) will be considered appropriate for each specified transplant program.

3. Administrative Criteria

a) The facility must be an active member of the OPTN and abide by its approved rules. The facility must also have an agreement with an OPO.

b) The facility must make available, either directly or by specified arrangements, all

laboratory services needed to meet the needs of transplant candidates/recipients.

c) The facility must agree to maintain and, when requested, periodically submit clinical data, including pre-certification, concurrent review, and other requested information to Medicaid or to the UM/QIO.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 121; 42 CFR § 482.90 – 482.104; 42 CFR 482.12

Rule 4.6: Documentation Requirements

Providers of transplant services must document and maintain records in accordance with requirements set forth in Part 200, Chapter 1, Rule 1.3. Medicaid requires at a minimum, transplant medical record documentation must contain the following on each beneficiary:

A. Comprehensive history and physical.

B. Treatments rendered that were unable to prevent progressive disability and/or death.

C. Use of tobacco, alcohol, and/or illegal drugs currently or within the last six (6) months.

D. Absence of severe and irreversible organ dysfunction in organ(s) other than the organ(s) being transplanted.

E. Relevant diagnostic studies (ex: x-rays, lab reports, EKG reports, pulmonary function studies, psychosocial reports, nutritional evaluation, performance status) and the results of the studies.

F. Reports, consults or other documentation to substantiate the transplant including documentation of transplant approval by the center's transplant review team.

G. Copy of signed informed consent form.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 42 CFR § 482.90 -104

Rule 4.7: Reimbursement

A. For services not available in Mississippi**,** Medicaid will cover a reasonable reimbursement for the transplant services to ensure access to care for adults and children. The transplant reimbursement rate may be inclusive of all charges for covered hospital and physician services provided during the transplant admission, inpatient or outpatient.

B. The days included in the transplant hospital stay will not count against the thirty (30) day limit for inpatient hospital care.

Source: Miss. Code Ann. § 43-13-121

Rule 4.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Rule 4.9: Cornea Transplant

Medicaid covers cornea transplants for all beneficiaries and does not require prior authorization.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 482.90 - 104

Rule 4.10: Heart Transplant

A. Prior authorization is required.

B. Heart transplants are covered when all the following criteria are met:

1. Candidate is less than sixty-six (66) years of age.

2. New York Heart Association (NYHA) Class III or IV on maximal medical therapy.

3. Meets transplanting facility's blood and tissue-type compatibility standards.

4. Infections are controlled for at least forty-eight (48) hours prior to transplant.

5. Pulmonary Functions studies of FEV1 of >1.5 liter, PVR of <3 Wood units (if >3, prior to vasodilators, <3 after), Pulmonary artery systolic pressure <65-70 mm Hg.

6. Absence of irreversible and severe end organ dysfunction, such as hepatic, renal, peripheral vascular, or cerebrovascular, as well as, refractory hypertension, or uncontrolled malignancy.

7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

9. The candidate has been approved by the transplant review team.

10. Required serology studies have been completed for HIV, Hepatitis A, B, and C,

Cytomegalovirus (CMV), and Varicella.

11. Immunizations have been administered as follows:

    a) All immunizations for children age two (2) to six (6) are up-to-date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP),

    b) Hepatitis A, if serology does not indicate immunity,

    c) Hepatitis B, if serology does not indicate immunity,

    d) Pneumococcal, and

    e) Influenza, annually.

12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated,

    b) Candidate's social support system has been evaluated and found to be adequate, and

    c) Candidate has no previous history of significant non-compliance to medical treatment.

13. Specific diagnostic inclusion criteria include the following conditions if expected to limit the candidate's survival rate to less than twelve (12) months:

    a) Congestive, restrictive, or ischemic cardiomyopathy,

    b) Valvular, congenital and other organic heart disease,

    c) Recurrent and refractory life-threatening ventricular dysrhythmias, or

    d) Refractory severe angina pectoris.

14. The facility is approved for heart transplants.

C. Transplants are not covered when the candidate has one (1) of the following:

1. Active chemical dependency, drugs or alcohol, within the preceding six (6) months.

2. Gastrointestinal hemorrhage.

3. Severe and irreversible pulmonary, for instance FEV1 < 1 liter, or other non-cardiac organ dysfunction.

4. Recent or unresolved pulmonary infarction, not embolism.

5. Uncorrectable absence of an essential psychosocial support system.

6. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.

7. HIV.

8. Hepatitis B or Hepatitis C.

9. Systemic malignancy.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 482.90 -104; 52 FR 10935

Rule 4.11: Heart/Lung Transplant

A. Prior authorization is required.

B. Heart/lung transplants are covered when the following criteria are met:

1. Candidate is less than fifty-six (56) years of age.

2. NYHA Class III or IV with rehabilitation potential.

3. Preserved nutritional state.

4. Meets facility's blood and tissue-type compatibility standards.

5. Infections controlled for at least forty-eight (48) hours prior to transplant, unless the infection is limited to the lung to be removed.

6. Absence of irreversible and severe end organ dysfunction, including hepatic, gastrointestinal, renal, peripheral vascular, or cerebrovascular, or uncontrolled malignancy.

7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

9. The candidate has been approved by the center's transplant review team.

10. Required serology studies have been completed for HIV, Hepatitis (A, B, and C), Cytomegalovirus (CMV), and Varicella.

11. Immunizations have been administered as follows:

    a) All immunizations for children age two (2) to six (6) are up-to-date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

    b) Hepatitis A, if serology does not indicate immunity.

    c) Hepatitis B, if serology does not indicate immunity.

    d) Pneumococcal.

    e) Influenza, annually.

12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated.

    b) Candidate's social support system has been evaluated and found to be adequate.

    c) Candidate has no previous history of significant non-compliance to medical treatment.

13. Specific Diagnostic Inclusion Criteria

    a) End-stage fibrotic lung disease unresponsive to alternative therapy with FVC <65% of predicted.

    b) End-stage obstructive lung disease with FVC <25% of predicted.

    c) End-stage pulmonary hypertension, either primary or secondary – without significant right heart dysfunction, unless heart-lung transplant planned.

    d) Cystic fibrosis with FVC <40% and FEV1 <30% of predicted.

    e) Bronchiectasis.

f) Bronchopulmonary dysplasia.

g) Obliterative bronchiolitis.

14. Facility must be approved for heart and lung transplants by Medicaid.

C. Heart/Lung transplants are not covered when the candidate has one (1) of the following:

1. Active chemical dependence, drugs or alcohol within the preceding six (6) months,
2. Steroid therapy >20mg/day, and must be off steroids or weanable from them,
3. Bone marrow failure of any stem line: RBC, WBC, platelets,
4. Severe osteoporosis,
5. Severe chest wall deformity
6. Cachexia, a body weight <70% of ideal for height, or obesity, body weight >120% of ideal for height, in candidates with Cystic Fibrosis,
7. Recent pulmonary embolism or current deep venous thrombosis,
8. Viral hepatitis, in candidates with Cystic Fibrosis,
9. HIV,
10. Uncorrectable absence of an essential psychosocial support system, or
11. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 482.90 – 104

Rule 4.12: Kidney Transplant

Medicaid covers kidney transplants for all beneficiaries and does not require prior authorization.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 482.90 - 104

Rule 4.13: Liver Transplant

A. Prior authorization is required.

B. Liver transplants are covered when the following criteria are met:

1. Candidate is less than sixty-five (65) years of age.

2. Model for End Stage Liver Disease (MELD) score.

3. Pediatric End Stage Liver Disease (PELD) score.

4. Meets transplant facility's blood and tissue-type compatibility standards.

5. Infection controlled for at least forty-eight (48) hours prior to transplant.

6. Absence of severe and irreversible end organ dysfunction, either cardiac, pulmonary, renal, peripheral vascular, or cerebrovascular, or uncontrolled extrahepatic malignancy.

7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

9. The candidate has been approved by the transplant review team.

10. Required serology studies have been completed for HIV, Hepatitis A, B, and C, Cytomegalovirus (CMV), and Varicella.

11. Immunizations have been administered as follows:

    a) All immunizations for children age two (2) to six (6) are up-to-date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP),

    b) Hepatitis A, if serology does not indicate immunity,

    c) Hepatitis B, if serology does not indicate immunity,

    d) Pneumococcal, and

    e) Influenza, annually.

12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated.

b) Candidate's social support system has been evaluated and found to be adequate.

c) Candidate has no previous history of significant non-compliance to medical treatment.

13. Specific Diagnostic Inclusion Criteria

a) Chronic progressive liver disease, not otherwise correctable, including cirrhosis due to: alcoholism, if abstinent at least the prior six (6) months, chronic hepatitis C, primary or secondary biliary disease, sclerosing cholangitis, inborn error of metabolism, or other causes.

b) Non-cirrhotic liver failure due to: biliary atresia, fulminant liver failure, submassive hepatic necrosis, hepatoblastoma, Budd-Chiari syndrome, an obstruction of the hepatic veins – if associated with a treatable disorder.

c) Hepatocellular carcinoma, in conjunction with chemotherapy, if there is no evidence of extrahepatic metastases.

14. Facility is approved for liver transplants by the Division of Medicaid.

B. Liver transplants are not covered when the candidate has one (1) of the following.

1. Active chemical dependency, drugs or alcohol within the preceding six (6) months.

2. Acute alcoholic hepatitis.

3. Uncorrectable hemodynamic instability.

4. Extensive and uncorrectable portal vein thrombosis precluding portal inflow to graft.

5. Extrahepatic malignancy or hepatic malignancy with extrahepatic metastases.

6. Severe terminal diabetic and organ disease.

7. HIV.

8. Uncorrectable absence of an essential psychosocial support system.

9. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 482.90 – 104; 56 FR 15006

Rule 4.14: Single Lung Transplant

A. Prior authorization is required.

B. Single lung transplants are covered when the following criteria are met:

1. Candidate is less than sixty-six (66) years of age.

2. NYHA Class III or IV with rehabilitation potential.

3. Preserved nutritional state.

4. Meets facility's blood and tissue-type compatibility standards.

5. Infections controlled for at least forty-eight (48) hours prior to transplant, unless the infection is limited to the lung to be removed.

6. Absence of irreversible and severe end organ dysfunction, either hepatic, gastrointestinal, renal, peripheral vascular, or cerebrovascular, or uncontrolled malignancy

7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

9. The candidate has been approved by the center's transplant review team.

10. Required serology studies have been completed for HIV, Hepatitis A, B, and C, Cytomegalovirus (CMV), and Varicella.

11. Immunizations have been administered as follows:

a) All immunizations for children age two (2) to six (6) are up-to-date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP)

b) Hepatitis A, if serology does not indicate immunity.

c) Hepatitis B, if serology does not indicate immunity.

d) Pneumococcal.

e) Influenza, annually

12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated.

    b) Candidate's social support system has been evaluated and found to be adequate.

    c) Candidate has no previous history of significant non-compliance to medical treatment.

13. Specific Diagnostic Inclusion Criteria

    a) End-stage fibrotic lung disease unresponsive to alternative therapy with FVC <65% of predicted.

    b) End-stage obstructive lung disease with FVC <25% of predicted.

    c) End-stage pulmonary hypertension, either primary or secondary – without significant right heart dysfunction, unless heart-lung transplant planned.

    d) Cystic fibrosis with FVC <40% and FEV1 <30% of predicted.

    e) Bronchiectasis.

    f) Bronchopulmonary dysplasia.

    g) Obliterative bronchiolitis.

14. Facility must be approved for lung transplants by the Division of Medicaid.

C. Single lung transplants are not covered when the candidate has one (1) of the following:

1. Active chemical dependence, drugs or alcohol, within the preceding six (6) months.

2. Steroid therapy >20mg/day, must be off steroids or weanable from them.

3. Bone marrow failure of any stem line: RBC, WBC, platelets.

4. Severe osteoporosis.

5. Severe chest wall deformity.

6. Cachexia, body weight <70% of ideal for height, or obesity, body weight >120% of ideal for height, in candidates with Cystic Fibrosis

7. Recent pulmonary embolism or current deep venous thrombosis.

8. Viral hepatitis in candidates with Cystic Fibrosis.

9. HIV.

10. Uncorrectable absence of an essential psychosocial support system.

11. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 482.90 - 104

Rule 4.15: Bilateral Lung Transplant

A. Prior Authorization is required.

B. Bilateral lung transplants are covered when the following criteria are met:

1. Candidate is less than sixty-one (61) years of age.

2. NYHA Class III or IV with rehabilitation potential.

3. Preserved nutritional state.

4. Meets facility's blood and tissue-type compatibility standards.

5. Infections controlled for at least forty-eight (48) hours prior to transplant, unless the infection is limited to the lung to be removed.

6. Absence of irreversible and severe end organ dysfunction, either hepatic, gastrointestinal, renal, peripheral vascular, or cerebrovascular), or uncontrolled malignancy.

7. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

8. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

9. The candidate has been approved by the center's transplant review team.

10. Required serology studies have been completed for HIV, Hepatitis (A, B, and C), Cytomegalovirus (CMV), and Varicella.

11. Immunizations have been administered as follows:

a) All immunizations for children age two (2) to six (6) are up-to-date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

b) Hepatitis A, if serology does not indicate immunity.

c) Hepatitis B, if serology does not indicate immunity.

d) Pneumococcal.

e) Influenza, annually.

12. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

a) Candidate's psychiatric disorders, if present, are being treated.

b) Candidate's social support system has been evaluated and found to be adequate.

c) Candidate has no previous history of significant non-compliance to medical treatment.

13. Specific Diagnostic Inclusion Criteria:

a) End-stage fibrotic lung disease unresponsive to alternative therapy with FVC <65% of predicted.

b) End-stage obstructive lung disease with FVC <25% of predicted.

c) End-stage pulmonary hypertension, either primary or secondary – without significant right heart dysfunction, unless heart-lung transplant planned

d) Cystic fibrosis with FVC <40% and FEV1 <30% of predicted.

e) Bronchiectasis.

f) Bronchopulmonary dysplasia.

g) Obliterative bronchiolitis.

14. Facility is approved for lung transplants by Medicaid.

C. Bilateral lung transplants are not covered when the candidate has one of the following:

1. Active chemical dependence, drugs or alcohol within the preceding six (6) months.

2. Steroid therapy >20mg/day, must be off steroids or weanable from them.

3. Bone marrow failure of any stem line: RBC, WBC, platelets.

4. Severe osteoporosis.

5. Severe chest wall deformity

6. Cachexia, body weight <70% of ideal for height, or obesity, body weight >120% of ideal for height, in candidates with Cystic Fibrosis.

7. Recent pulmonary embolism or current deep venous thrombosis.

8. Viral hepatitis in candidates with Cystic Fibrosis.

9. HIV.

10. Uncorrectable absence of an essential psychosocial support system.

11. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.

Source**:** Miss. Code Ann. § 43-13-121; 42 CFR 482.90 -104

Rule 4.16: Bone Marrow Transplant

A. No prior authorization is required.

B. Bone marrow transplants (BMT), Autologous, Syngeneic, or Allogeneic, are covered for inpatient and outpatient when the following criteria are met:

1. Candidate is less than fifty-six (56) years of age for allogeneic, < sixty-six (66) if fully matched sibling donor.

2. Candidate is less than seventy (70) years of age for autologous.

3. Karnofsky >70 or ECOG <3.

4. Allogeneic HLA-MLC match, 1 antigen mismatch accepted.

5. Infections controlled for forty-eight (48) hours prior to transplant.

6. Left ventricular ejection fraction >40%.

7. FEV1 of >50% of predicted.

8. Dlco >60% of predicted.

9. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

10. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

11. The candidate has been approved by the transplant review team.

12. The candidate's immunization history and HIV status has been obtained.

13. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated.

    b) Candidate's social support system has been evaluated and found to be adequate.

    c) Candidate has no previous history of significant non-compliance to medical treatment.

14. Specific Diagnostic Inclusion Criteria (Allogeneic BMT or PSCT)

    a) Severe aplastic anemia.

    b) Pure erythrocyte aplasia.

    c) Myelodysplasia.

    d) Severe hemoglobinopathy, including sickle cell, thalassemia.

    e) Selected immunodeficiency syndrome including SCID, Wiskott-Aldrich, Chediak-Higashi

    f) Genetic storage disease, including Hurler's, Morquio's.

    g) Primary amyloidosis.

    h) Paroxysmal nocturnal hemoglobinuria.

    i) Severe platelet dysplasia.

j) Acute lymphocytic leukemia, in first remission if high risk, at early relapse, or in second remission.

k) Acute myelogenous leukemia, in same clinical states as listed for acute lymphocytic leukemia.

l) Chronic lymphocytic leukemia.

m) Chronic myelogenous leukemia.

n) Hodgkin's lymphoma, failed first line therapy or failed at least one standard chemotherapy regimen.

o) Non-Hodgkin's lymphoma failed or responsive to first line therapy or high risk during first remission.

p) Familial hemophagocytic lymphohistiocytosis (FHL) also known as familial erythrophagocytic.

q) Lymphohistiocytosis (FEL).

15. Specific Diagnostic Inclusion Criteria (Autologous BMT or PSCT)

a) Acute lymphocytic leukemia in first remission if high risk, at early relapse, or in second remission.

b) Acute myelogenous leukemia in same clinical states as listed for acute lymphocytic leukemia.

c) Chronic lymphocytic leukemia.

d) Chronic myelogenous leukemia.

e) Hodgkin's lymphoma, for failed first line therapy or if failed at least one standard chemotherapy regimen.

f) Multiple Myeloma-a single autologous BMT/SCT transplant will be considered for beneficiaries with Durie-Salmon stage II or stage III disease if the following criteria is met. Newly diagnosed disease or responsive multiple myeloma. This includes beneficiaries with previously untreated disease, those with at least a partial response to prior chemotherapy, which is defined as 50% decrease in either measurable serum and/or urine paraprotein or in bone marrow infiltration, sustained for at least one (1) month, and those in responsive relapse with adequate renal, pulmonary, and hepatic function.

16. Tandem BMT/SCT for multiple myeloma is specifically excluded from coverage.

a) Non-Hodgkin's lymphoma, either failed or responsive to first line therapy or, if high risk, during first remission

b) Neuroblastoma.

c) Nephroblastoma.

17. Transplant facilities must meet Medicaid facility criteria.

C. Bone marrow transplants are not covered if the candidate has one (1) of the following:

1. Active chemical dependency, drugs or alcohol, within the preceding six (6) months

2. HIV.

3. Breast cancer.

4. Uncorrectable absence of an essential psychosocial support system.

5. Unmanageable psychiatric disorder felt to significantly compromise the candidate's compliance with the post-transplant regimen.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 482.90 - 104

Rule 4.17: Peripheral Stem Cell Transplant

A. No prior authorization is required.

B. Peripheral Hematopoietic Stem Cell Transplants (PSCT), Autologous, Syngeneic, or Allogeneic, are covered for inpatient and outpatient when the following criteria are met:

1. Candidate is less than fifty-six (56) years of age for allogeneic, < sixty-six (66) if fully matched sibling donor.

2. Candidate is less than seventy (70) years of age for autologous.

3. Karnofsky >70 or ECOG <3.

4. Allogeneic HLA-MLC match, 1 antigen mismatch accepted.

5. Infections controlled for forty-eight (48) hours prior to transplant.

6. Left ventricular ejection fraction >40%.

7. FEV1 of >50% of predicted.

8. Dlco >60% of predicted.

9. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

10. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

11. The candidate has been approved by the transplant review team.

12. The candidate's immunization history and HIV status has been obtained.

13. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated.

    b) Candidate's social support system has been evaluated and found to be adequate.

    c) Candidate has no previous history of significant non-compliance to medical treatment.

14. Specific Diagnostic Inclusion Criteria (Allogeneic PSCT)

    a) Severe aplastic anemia.

    b) Pure erythrocyte aplasia.

    c) Myelodysplasia.

    d) Severe hemoglobinopathy, including sickle cell, thalassemia.

    e) Selected immunodeficiency syndrome, including SCID, Wiskott-Aldrich, Chediak-Higashi.

    f) Genetic storage disease, including Hurler's, Morquio's.

    g) Primary amyloidosis.

    h) Paroxysmal nocturnal hemoglobinuria.

    i) Severe platelet dysplasia.

    j) Acute lymphocytic leukemia, in first remission if high risk, at early relapse, or in

second remission.

k) Acute myelogenous leukemia, in same clinical states as listed for acute lymphocytic leukemia.

l) Chronic lymphocytic leukemia.

m) Chronic myelogenous leukemia.

n) Hodgkin's lymphoma, failed first line therapy or failed at least one standard chemotherapy regimen.

o) Non-Hodgkin's lymphoma, failed or responsive to first line therapy or high risk during first remission.

p) Familial hemophagocytic lymphohistiocytosis (FHL) also known as familial erythrophagocytic.

q) Lymphohistiocytosis (FEL).

15. Specific Diagnostic Inclusion Criteria (Autologous PSCT).

a) Acute lymphocytic leukemia, in first remission if high risk, at early relapse, or in second remission.

b) Acute myelogenous leukemia, in same clinical states as listed for acute lymphocytic leukemia.

c) Chronic lymphocytic leukemia.

d) Chronic myelogenous leukemia.

e) Hodgkin's lymphoma, for failed first line therapy or if failed at least one standard chemotherapy regimen.

f) Multiple Myeloma single autologous BMT/SCT transplant will be considered for beneficiaries with Durie-Salmon stage II or stage III disease if this is a newly diagnosed disease or responsive multiple myeloma. This includes beneficiaries with previously untreated disease, those with at least a partial response to prior chemotherapy which is defined as 50% decrease in either measurable serum and/or urine paraprotein or in bone marrow infiltration, sustained for at least one (1) month, and those in responsive relapse with adequate renal, pulmonary, and hepatic function.

16. Tandem BMT/SCT for multiple myeloma is specifically excluded from coverage.

a) Non-Hodgkin's lymphoma, either failed or responsive to first line therapy or, if high

risk, during first remission.

b) Neuroblastoma.

c) Nephroblastoma.

17. Transplant facilities must meet Medicaid facility criteria.

C. Peripheral stem cell transplants are not covered when the candidate has one of the following:

1. Active chemical dependency, drugs or alcohol, within the preceding six (6) months.

2. HIV.

3. Breast cancer.

4. Uncorrectable absence of an essential psychosocial support system.

5. Unmanageable psychiatric disorder felt to significantly compromise the candidate's compliance with the post-transplant regimen.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 482.90 - 104

Rule 4.18: Small Bowel Transplant

A. Prior authorization is required.

B. Medicaid covers small bowel transplants meeting the following criteria for small bowel (or intestinal) transplantation, whether performed as a solitary procedure (SBT); or performed in conjunction with liver (SB/LT); or with stomach, duodenum, and pancreas, with or without liver (SB/MVT) transplantation:

1. The loss or absence of sufficient absorptive capacity of the intestinal tract to support life; and

2. The demonstrated failure of total parenteral nutrition (TPN).

C. Concomitant liver or multivisceral transplantation can only be medically justified by documentation of severe and irreversible damage to the individual organ(s) to be replaced. Concomitant live or multivisceral transplants must meet the following criteria:

1. Candidate is less than sixty-five (65) years of age.

2. Meets transplanting facility blood and tissue-type compatibility standards.

3. Infections controlled for at least forty-eight (48) hours prior to transplant

4. Absence of severe and irreversible end organ dysfunction, to include cardiac, central nervous system, pulmonary, renal, peripheral vascular or cerebrovascular.

5. All other treatments have been attempted or considered and none will prevent progressive disability and/or death.

6. The candidate and/or legal representative understands the transplant risks and benefits, gives informed consent, and has the capacity and is willing to comply with needed care, including immunosuppressive therapy.

7. The candidate has been approved by the transplant review team.

8. Required serology studies have been completed for HIV, Hepatitis A, B, and C, Cytomegalovirus (CMV), and Varicella.

9. Immunizations have been administered as follows:

   a) All immunizations for children age two (2) to six (6) are up-to-date in accordance with the most current recommended childhood immunization schedule developed and endorsed by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

   b) Hepatitis A, if serology does not indicate immunity.

   c) Hepatitis B, if serology does not indicate immunity.

   d) Pneumococcal.

   e) Influenza, annually.

10. A psychosocial evaluation has been performed for the adult candidate or, if the candidate is a child, for the family, with the following results:

    a) Candidate's psychiatric disorders, if present, are being treated.

    b) Candidate's social support system has been evaluated and found to be adequate.

    c) Candidate has no previous history of significant non-compliance to medical treatment.

11. Specific Diagnostic Inclusion Criteria

    a) Severe and irreversible intestinal insufficiency, congenital or acquired, including, but not limited to the following causes:

1) Intestinal atresia.

2) Splanchnic vascular occlusive disease.

3) Gastroschisis.

4) Inflammatory bowel disease.

5) Microvillus involution disease, intractable diarrhea of infancy.

6) Post-traumatic, including surgical short bowel syndrome.

7) Volvulus.

8) Necrotizing enterocolitis.

9) Chronic intestinal pseudo-obstruction.

10) Radiation enteritis.

b) Failure of Total Parenteral Nutrition (TPN) as documented by:

1) Overt or impending liver failure due to TPN-induced hepatic injury,

2) Thrombosis of two or more central venous channels: jugular, subclavian, femoral,

3) Two or more episodes of TPN catheter-induced sepsis in a year or a single episode of line-related fungemia, or

4) Frequent episodes of dehydration due to uncontrollable and high volume loss of fluids through the gastrointestinal tract.

12. Facility is approved for small bowel transplants by Medicaid.

D. Small bowel transplants are not covered when the candidate has one (1) of the following:

1. Active chemical dependency, drugs or alcohol within the preceding six (6) months.

2. Profound and progressive neurological dysfunction, like Tay-Sachs.

3. Non-correctable non-gastrointestinal disease with a lethal prognosis.

4. Congenital immunodeficiency syndrome.

5. Active tuberculosis or active sepsis.

6. Uncorrectable absence of an essential psychosocial support system.

7. Unmanageable psychiatric disorder felt to significantly compromise compliance with the post-transplant regimen.

8. HIV.

9. Systemic malignancy.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 482.90 - 104