Title 23: Division of Medicaid

Part 200: General Provider Information

Chapter 1: General Administrative Rule for Providers

Rule 1.13: Rounding of Timed Codes

A. The Division of Medicaid requires providers to adhere to Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) billing and coding guidelines when reporting timed-based services.

   1. Providers are required to bill for services according to Medicaid National Correct Coding Initiative (NCCI) coding policies, the Fee Schedules on the Division of Medicaid's website and Administrative Code.

   2. Should a conflict arise between this rule and specific CPT/HCPCS coding guidelines, the CPT/HCPCS guidelines take precedence.

B. Documentation must support the level of service billed and the medical appropriateness of the service by providing a detailed description of services provided.

C. Providers may bill for CPT/HCPCS codes with 15-minute allotment as follows:

   1. Providers may bill the first initial unit if direct patient contact time is at least eight (8) minutes.

   2. Providers may bill for additional 15-minute increment units after completing the initial full fifteen (15) minutes of service, if at least eight (8) minutes of the next time block are used to perform direct patient services.

   3. Providers may not round up to the next timed code if less than eight (8) minutes of direct patient services are performed of a 15-minute increment.

D. Providers may bill for units of service that are measured in minutes based on the following:

   1. The provider must have provided services for more than half of the time allotment in the code description for the service to bill the unit of service.

   2. Additional units may be billed in increments, provided that at least more than half of the time of each billable increment has been provided.

   3. Providers are not permitted to bill for a unit of service if half or less than half the time requirement is met.

E. For time-based, evaluation and management services, providers must document the activities related to the beneficiary visit including the total time with start and end times of all procedures or services performed for time-based codes. Total time includes all activities related to the visit

performed by the physician, physician assistant or nurse practitioner on the date of the visit and may comprise activities including, but not limited to the following:

1. Preparing to see the beneficiary, including review of previous documentation and test results,

2. Obtaining and/or reviewing separately obtained history,

3. Ordering medications, tests, or procedures,

4. Documentation of clinical information in the health record or other records; and,

5. Communicating with the patient, family, or caregiver.

F. Providers may round CPT/HCPCS procedure codes with a one-hour allotment as follows:

1. Providers may bill one unit for one hour of service if at least forty-five (45) minutes but less than 60 minutes is spent with the beneficiary.

2. Providers may not round up to the next level of service if total time spent with the beneficiary is equal to or less than forty-five (45) minutes.

3. If a more appropriate time code is available according to Medicaid National Correct Coding Initiative (NCCI) coding policies, the provider must bill the available code.

G. The Division does not allow the billing of mixed remainder minutes across multiple codes.

H. The Division of Medicaid may conduct audits of provider billing to ensure compliance with rounding rules and recoup payments as necessary.

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

History: New Rule eff. 03/01/2025.