Title 23: Division of Medicaid Administrative Code Change Log

Effective Date	Part/Chapter/Rule	Summary
02/01/2020	Part 223: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Chapter 3: Prescribed Pediatric Extended Care (PPEC) Services, Rule 3.1 – 3.6.	This Administrative Code includes coverage and reimbursement language for PPEC services in the Mississippi Administrative Code, Title 23 under part 223: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), effective February 1, 2020.
01/01/2020	Part 200: General Provider Information, Chapter 4: Provider Enrollment, Rule 4.2: Conditions of Participation, 4.4: Effective Date of Provider Agreement and Provider Agreement Termination	This Administrative Code clarifies out-of-state provider enrollment requirements and specifies effective dates for provider agreements.
01/01/2020	Part 213: Therapy Services, Chapter 1: Physical Therapy, Rule 1.11: Documentation, Chapter 2: Occupational Therapy, Rule 2.9: Documentation, Chapter 3: Outpatient Speech-Language Pathology	This Administrative Code clarifies that progress notes for therapy services must be documented at least weekly.
01/01/2020	Part 300: Appeals, Chapter 1: Appeals, Rule 1.4: Provider Peer Review Protocol	This Administrative Code filing (1) replaces "healthcare provider" with "provider" in the Rule name and throughout the document, (2) replaces the requirement for a peer review panel with a peer review consultant, (3) increases the peer review levels to IV by adding a Request for Reconsideration Review, and (4) other minor edits to the language.
12/1/2019	Part 203: Physician Services, Chapter 2: Physician Administered Drugs and Implantable Drug System Devices, Rule 2.1: Covered Services	This Administrative Code adds a prior authorization requirement for certain physician administered drugs (PAD) as determined by the Division of Medicaid.
12/1/2019	Part 202: Hospital Services, Chapter 2: Outpatient Services, Rule 2.2: Outpatient Hospital Services	This Administrative Code adds a prior authorization requirement for certain physician administered drugs (PAD) as determined by the Division of Medicaid.

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12/1/2019	Part 200: General Provider Information, Chapter 4: Provider Enrollment, Rule 4.1: Definitions, 4.2: Conditions of Participation, 4.4: Effective Date of Provider Agreement and Provider Agreement Termination.	This Administrative Code final filing specifies effective dates for provider agreements. This filing removes the proposed revisions for out-of-state provider enrollment requirements.
12/1/2019	Part 203: Physician Services, Chapter 7: Nurse Practitioner, Rules 7.1: Provider Enrollment and 7.2: Nurse Practitioner Services and Reimbursement, Chapter 8: Physician Assistant, 8.1: Physician Assistant Enrollment Requirements, and 8.2: Physician Assistant Services and Reimbursement.	This Administrative Code adds language regarding the requirement that advanced practice registered nurses (APRNs), also referred to as nurse practitioners (NPs), and physician assistants (PAs) provide a copy of protocols and practice settings approved by the appropriate licensure board upon enrollment as a Mississippi Medicaid Provider.
11/1/2019	Part 207: Institutional Long-Term Care, Chapter 2: Nursing Facilities, Rule 2.5: Reimbursement and Rule 2.8: Temporary Leave	This Administrative Code clarifies the nursing facility home/therapeutic and inpatient hospital temporary leave days.
10/1/2019	Part 207: Institutional Long-Term Care, Chapter 3: Long-Term Care Pre-Admission Screening, Rule 3.9: Utilization Review	This Administrative Code corresponds with State Plan Amendment (SPA) 19-0014 Utilization Review (UR) in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs). This administrative code will allow the Division of Medicaid to change control of the utilization of ICF/IIDs from the Mississippi Department of Health (MDOH) to the Division of Medicaid's contracted Utilization Management/Quality Improvement Organization (UM/QIO).
10/1/2019	Part 200: General Provider Information, Chapter 6: Indian Health Services, New Rule 6.6: Cost-Sharing.	This Administrative Code reflects that there is no cost-sharing imposed on American Indians/Alaskan Natives (AI/ANs).

Effective Date	Part/Chapter/Rule	Summary
10/1/2019	Part 202: Hospital Services, Chapter 5: Hospital Procedures, New Rule 5.7: Dental Services Provided in a Hospital Setting	This Administrative Code adds language describing the current reimbursement methodology for dental procedures and requires that the appropriate code set be used when billing for dental services based on the servicing provider type.
10/1/2019	Part 200 General Provider Information, Chapter 1: General Administrative Rules for Providers, Rule 1.7: Timely Processing of Claims	This Administrative Code allows up to ninety (90) days for a provider to resubmit a claim if the Division of Medicaid adjusts a claim after the processing period has ended.
10/1/2019	Part 210: Ambulatory Surgical Centers, Chapter 1: General, Rules 1.4: Covered Services and 1.6: Reimbursement	This Administrative Code add languages describing the current reimbursement methodology for dental procedures and require that the appropriate code set be used when billing for dental services based on the servicing provider type.
10/1/2019	Part 209: Durable Medical Equipment, Medical Appliances and Medical Supplies, Chapter 2: Medical Supplies, Rule: 2.2	This Administrative Code clarifies the number of incontinent garments covered per day by removing the following language from Miss. Admin. Code Part 209, Rule 2.2.AA.2.c): In extenuating circumstances, where there is documentation that justifies the medical necessity for more than six (6) units per day, a prior authorization request signed by a physician must be submitted to the Division of Medicaid or designee.
10/1/2019	Part 214: Pharmacy Services, Chapter 1: General Pharmacy, Rule 1.6: Prescription Requirements.	This Administrative Code filing increases the prescription drug limit from five (5) prescription drugs to six (6) prescription drugs per month and add language regarding coverage of prescription drugs for institutionalized long-term care (LTC) beneficiaries and Early and Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries, effective July 1, 2019. This Administration Code filing is to correspond with State Plan Amendment (SPA) 19-0004 Prescription Drug Limit Increase

Effective Date	Part/Chapter/Rule	Summary
9/1/2019	Part 211: Federally Qualified Health Centers, Chapter 1: General, Rule 1.2: Service Limits	This Administrative Code filing clarifies which "other health professional for mental health services" can perform an FQHC encounter. The language "other health professional for mental health services" is being replaced with "Licensed Professional Counselors (LPCs) and/or Board Certified Behavior Analysts (BCBAs)"
9/1/2019	Part 208: Home and Community Based Services (HCBS) Long-term Care, Chapter 2: Home and Community Based Services (HCBS) Independent Living Waiver, Rule(s) 2.1-2.14	This Administrative Code corresponds with the Independent (IL) Waiver renewal, effective July 1, 2018.
9/1/2019	Part 207 Institutional Long-Term Care, Chapter 2: Nursing Facility, Rules 2.6: Per Diem, 2.20: Facility and Initiated Discharges (New), Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Rules 3.5: Per Diem, 3.13: Facility Initiated Discharges (New)	This Administrative Code filing includes requirements for beneficiary notification and facility documentation when the facility initiates the transfer or discharge of a resident and includes all incontinence garments in the per diem rate for nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).
9/1/2019	Part: 202 Hospital Services, Chapter 5: Hospital Procedures, Rule 5.1: Hyperbaric Oxygen Therapy	This Administrative Code is being filed to mirror Medicare's coverage and reimbursement of HBOT which: (1) allows for direct supervision of HBOT by a non-physician practitioner (NPP), (2) allows for coverage and reimbursement per beneficiary session of physician or NPP attendance or supervision of HBOT, (3) defines the cardio-pulmonary response (CPR) team, and (4) revises the coverage of medical conditions to those Food and Drug Administration (FDA) approved or that follow medically accepted indications supported by one (1) or more of the official compendia as designated by the Centers for

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8/1/2019	Part 208: Home and Community Based Services (HCBS) Long-Term Care, Chapter1: Home and Community Based Services (HCBS) Elderly and Disabled Waiver, Rule 1.6: Covered Services	This Administrative Code filing is being revised to reflect the increase of the State Plan home health visit limit from twenty-five (25) to thirty-six (36) corresponding with SPA 19-0005 Home Health Visit Increase, effective August 1, 2019.
8/1/2019	Part 200: General Provider Information, Chapter 5: General, New Rule 5.7: Electronic Health Record (EHR) and Electronic Signature	This Administrative Code filing adds a new rule which requires EHRs and electronic signatures meet certified electronic health record technology (CEHRT) criteria and comply with Health Insurance Portability and Accountability Act (HIPAA) in regards to the access, transfer, storage and signing of EHR, effective
7/1/2019	Part 209: Durable Medical Equipment, Medical Appliances and Medical Supplies, Chapter 2: Medical Supplies, Rules 2.2: Covered Medical Supplies, 2.5: Reserved	This Administrative Code is being filed to move the language in Rule 2.5: Diapers and Underpads to Rule 2.2.AA: Incontinence Garments and revise the language to include the coverage of pull-ons, effective July 1, 2019.
7/1/2019	Part 209: Durable Medical Equipment, Medical Appliances and Medical Supplies, Chapter 1: Durable Medical Equipment and Medical Appliances, Rule 1.28: Hospital Beds and Rule 1.29: Hydraulic Lift with Seat or Sling	This Administrative Code is being filed to revise the credentialing requirements for the evaluators conducting on-site evaluations of the location where hospital beds or electrical lifts have been ordered. This revision will allow physical therapists and occupational therapist to conduct these on-site evaluations.
7/1/2019	Part 200, Chapter 1, New Rules 1.6: Timely Filing, 1.7: Timely Processing of Claims and 1.8: Administrative Reviews for Claims	This Administrative Code filing is being submitted to add new rules which address the timely filing requirements for providers and the Division of Medicaid's claims processing policies. This filing includes changes to clarify language based on comments received by the Division of Medicaid
7/1/2019	Part 215: Home Health Services, Chapter 1: Home Health Services, Rule 1.3: Covered Services	This Administrative Code is being filed to correspond with SPA 19-0005 Home Health Visit Increase, which allows the Division of Medicaid (DOM) to increase the number of home health visits from twenty five (25) visits per state fiscal year to thirty-six (36) visits per state fiscal year, effective July 1, 2019

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6/1/2019	Part 214: Pharmacy Services, Chapter 1: General Pharmacy, Rule 1.16: Clinician Administered Drugs and, Implantable Drug System Devices (CADDs)	This Administrative Code is being filed to allow the Division of Medicaid to reimburse for certain Physician Administered Drugs (PADs) under the pharmacy benefit to improve beneficiary access. These certain PADs are referred to as CADDs and include, but are not limited to, long-acting reversible contraceptives (LARCs), pregnancy maintaining agents, injectable atypical antipsychotic agents, and chemical dependency treatment agents. CADDs may be billed as either
6/1/2019	Part 303: Pre-Admission Screening and Resident Review, Chapter 1: Pre-Admission Screening and Resident Review, Rules 1.1 – 1.10	This Administrative Code filing is being submitted to move all PASRR Level I and Level II information from Part 303 to Part 206 and Part 207 and to update language.
6/1/2019	Part 207: Institutional Long-Term Care Pre-Admission Screening and Resident Review (PASRR) Rules 1.1 -1.6 and 2.7	This Administrative Code filing is being submitted to (1) remove the physician certification of clinical eligibility requirement (2) Remove the Assisted Living Waiver, Elderly and Disabled Waiver, Independent Living Waiver, and Traumatic Brain Injury/Spinal Cord Injury Waiver's requirements to complete the PASRR, (3) To define the PASRR Level 1, and (4) Refer providers to Part 206 for the requirements of PASRR Level II
6/1/2019	Part 212: Rural Health Clinics, Chapter 1: General, Rule 1.1: Provider Enrollment Requirements, Rule 1.2: Service Limits, Rule 1.3: Covered and Non-Covered Services, Rule 1.4: Reimbursement Methodology, Rule 1.5: Documentation Requirements, Rule 1.6: Co-Mingling, Rule 1.7: Pregnancy Related Eligibles and Rule 1.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	This Administrative Code filing is being submitted to allow the Division of Medicaid to reimburse an RHC the encounter rate for the administration of certain categories of physician administered drugs (PADS) referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs), reimbursed under the pharmacy benefit, effective to correspond with SPA 18-0013 eff. 07/01/18 and to allow Licensed Professional Counselors (LPCs) and Board Certified Behavior Analysts (BCBAs) to provide mental health services in an RHC. This final filing contains non-substantive changes to Rules 1.2 and 1.3 by specifying LPCs and BCBAs as the mental professionals that can

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6/1/2019	Part 211: Federally Qualified Health Centers, Chapter 1: General, Rule 1.1: Provider Enrollment Requirements, Rule 1.2: Service Limits, Rule 1.3: Covered and Non-Covered Services, Rule 1.4: Pregnancy-Related Eligibles, Rule 1.5: Reimbursement Methodology, Rule 1.6: Documentation Requirements and Rule 1.7: Early and Periodic Screening, Diagnosis and Treatment	This Administrative Code filing is being submitted to allow the Division of Medicaid to reimburse an FQHC the encounter rate for the administration of certain categories of physician administered drugs (PADS) referred to as Clinician Administered Drug and Implantable Drug System Devices (CADDs), reimbursed under the pharmacy benefit, effective to correspond with SPA 18-0012 eff. 07/01/18 and to allow Licensed Professional Counselors (LPCs) and Board Certified Behavior Analysts (BCBAs) to provide mental health services in an FQHC .
6/1/2019	Part 203: Physicians Services, Chapter 1: General, Rule 1.4: Physician Office Visits, Chapter 9: Psychiatric Services, Rule 9.5: Service Limits	This Administrative Code filing is being submitted to increase the combined physician office and outpatient hospital visit limit from twelve (12) to sixteen (16) per state fiscal year for both psychiatric and non-psychiatric services. These are two (2) separate service limits and both will be increased effective July 1, 2019, to correspond with SPA 18-0020 (eff. 01/01/2019)
4/1/2019	Part 200: General Provider Information; Chapter 4: Provider Enrollment; Rule 4.10: 340B Providers	This Administrative Code filing is to include language which was omitted with the final filing of system number 23710.
4/1/2019	Part 207: Institutional Long-Term Care, Chapter 4: Psychiatric Residential Treatment Facility, Rules: 4.11	This Administrative Code filing is to comply with the Cures Act, effective January 1, 2019, which requires psychiatric residential treatment facilities (PRTFs) to ensure EPSDT-eligible beneficiaries receive early and periodic screening, diagnostic, and treatment (EPSDT) services regardless of whether such services are identified in the individual's plan of care, effective
3/1/2019	Part 203: Physician Services, Chapter 4: Surgery, Rule: 4.18 Reduction Mammoplasty	This Administrative Code is being filed to add primary care physician documentation requirements for reduction mammoplasty and remove that the final determination of medical necessity is made by the surgeon, effective March 1, 2019.

Effective Date	Part/Chapter/Rule	Summary
3/1/2019	Part 202: Hospital Services, Chapter 1: Inpatient Services, Rule 1.1: Definitions, 1.14: Inpatient Hospital Payments, 1.16: Split Billing	This Administrative Code is being filed to add clarifying language to the three (3) day payment window rule to instruct providers to split bill for the outpatient services provided outside of the three (3) day window on a claim separate from the inpatient claim, if outpatient services are provided more than three (3) days prior to admission to a beneficiary by the admitting hospital, or an entity wholly owned or operated by the admitting hospital, and the outpatient service dates span to days outside of the three (3) day window the hospital must, effective
3/1/2019	Part 222: Maternity Services, Chapter 1: General, Rule: 1.12 Tobacco Cessation Counseling Services (New)	This Administrative Code is being filed to include language to correspond with SPA 2013-002 Tobacco Cessation for Pregnant Women and to comply with section 4107 of the Affordable Care Act requiring coverage of face-to-face counseling services for cessation of tobacco use by pregnant women, effective March 1, 2019.
2/1/2019	Part 201: Transportation, Chapter 2: Non-Emergency Transportation (NET) Broker Program, Rule 2.1: Non-Emergency Transportation (NET) Broker Program; Chapter 3: Non-Emergency Transportation (NET) Services Not Covered Under the Broker Program, Rule 3.1: Non-Emergency Transportation (NET) Services Not Covered Under the Broker Program	This final filing removes prescribed pediatric extended care (PPEC) transportation from the Non-Emergency Transportation (NET) Broker program and includes non-emergency air services in the NET Broker Program effective February 1, 2019 to correspond with the operational effective of the new NET Broker contract.
2/1/2019	Part 302: Beneficiary Health Management, Chapter 1: Beneficiary Health Management, Rules 1.1 – 1.7	This administrative code is being filed to ensure the appropriate utilization of pharmacy services within the Medicaid program and to improve the identification of inappropriate and/or overutilization of prescribed controlled substances and DEA Schedule I-IV drugs. This filing also revises and moves Part 302 Beneficiary Health Management to Part 305 Program Integrity,

Effective Date	Part/Chapter/Rule	Summary
1/1/2019	Part 202: Hospital Services, Chapter 2: Outpatient Services, Rules 2.2: Outpatient Hospital Services, 2.8: Outpatient Hospital Rates, and New Rule 2.12: Hospital-Based Physician Clinics	This administrative code final filing includes additional clarification language regarding the location of a hospital-based physician clinic.
12/1/2018	Part 204, Chapter 1: General, Rule 1.11: Dental Services Provided at a Hospital or Ambulatory Surgical Center (ASC) Setting	This administrative code is being filed to clarify when dental services are covered in the outpatient hospital and ASC setting.
12/1/2018	Part 208: Home and Community Based Services (HCBS) Long Term Care, Chapter 1: HCBS Elderly and Disabled Waiver, Rules: 1.1 – 1.14	This Administrative Code revision is being filed to revise the language to correspond with the E&D Waiver renewal, effective July 1, 2017.
12/1/2018	Part 209: Durable Medical Equipment, Medical Appliances and Medical Supplies, Chapter 1: Durable Medical Equipment and Medical Supplies, Rule 1.35: Oxygen and Oxygen Related Equipment	This final filing includes revisions made as a result of public input as follows: (1) adds clarifying language throughout the rule, (2) adds coverage language for portable home compressor systems, and (3) removes language that aligned with Medicare's home oxygen reimbursement.
12/1/2018	Part 223: Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Chapter 1: General, Rule 1.1: Program Description; Rule 1.5: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screenings; Rule 1.6: Documentation Requirements for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Screenings; Rule 1.8: Reimbursement; Diagnosis and Treatment (EPSDT) Screenings	This administrative code is being filed to correspond with State Plan Amendment (SPA) 18-0014 EPSDT which revises language to reflect the recommendations in the fourth (4th) edition of the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule published in February of 2017. This final filing removes New Rules 1.9 AND 1.10, effective December 1, 2018.

Effective Date	Part/Chapter/Rule	Summary
11/1/2018	Part 221: Family Planning and Family Planning Related Services, Chapter 2: 1115(a) Family Planning and Family Planning, Rule 2.2: Eligibility, Rule 2.3: Freedom of Choice, Rule 2.4: Covered Services, Rule 2.5: Non-covered Services and Items, Rule 2.6 Quality Assurance, Rule 2.7: Participant Cost Sharing, Rule 2.8: Primary Care Referrals, Rule 2.9: Documentation/Record Maintenance	This Administrative Code filing is being submitted to update the language in the Administrative Code to correspond with the Family Planning Waiver Renewal Standard Terms and Conditions (STCs), effective January 1, 2018. The updates include clarifications on billing, services included in preventative medicine codes, documentation regarding education and counseling, and other minor edits.
11/1/2018	Part 200: General Provider Information, Chapter 4: Provider Enrollment Rule(s) 4.10 340B Providers	This Administrative Code is being filed to define 340B drugs, define a 340B beneficiary, describe the opt-in and opt-out procedure for providers of the 340B program and include the billing requirements for 340B purchased drugs to correspond with SPA 17-002 Pharmacy Reimbursement, effective November 1, 2018
11/1/2018	Part 214: Pharmacy Services, Chapter 1: General Pharmacy, Rule 1.5: Reimbursement	This Administrative Code is being filed to revise language regarding payment methodology for prescription drugs at point-of-sale (POS) pharmacies and describe reimbursement for 340B covered entities to correspond with SPA 17-0002 Pharmacy Reimbursement effective April 1, 2017, proposed effective
11/1/2018	Part 202: Hospital Services, Chapter 1: Inpatient Services, Rule 1.14: Inpatient Hospital Payments.	This Administrative Code is being filed to correspond with State Plan Amendment 18-0004 All Patient Refined Diagnosis Related Group (APR-DRG) effective July 1, 2018. This filing implements a Diagnosis Related Group (DRG) charge cap policy
9/9/2018	Part 201: Transportation, Chapter 1: Emergency Transportation, Rule 1.7: Ambulance Transport of Nursing Facility Residents by Ambulance and Chapter 2: Non-Emergency Transportation (NET) Broker Program, Rule 2.4: Non-Emergency Transport of Nursing Facility Residents	This Administrative Code filing is being submitted to remove long-term care residents from the NET Broker Program and refer to Miss. Admin. Code Part 207 for the coverage of non-emergency (NET) transportation of long-term care (LTC) residents to correspond with SPA 18-0010 Transportation (effective 08/01/2018), effective September 9, 2018.

Effective Date	Part/Chapter/Rule	Summary
9/1/2018	Part 215: Home Health Services, Chapter 1: Home Health Services, Rule 1.1: Definitions, Rule 1.2: Provider Enrollment Requirements, Rule 1.3: Covered Services, Rule 1.4 Non-Covered Services, Rule 1.5: Reimbursement, Rule 1.6: Documentation, Rule 1.7: Early, Periodic Screening, Diagnosis and Treatment (EPSDT)	This Administrative Code filing is being submitted to require (1) a face-to-face visit with a physician or authorized non-physician practitioner prior to the initiation of home health visits or provision of durable medical equipment (DME) and appliances, (2) to require the provision of home health services in any setting in which normal life activities take place, and (3) to revise the definition of DME to comply with the Medicaid Home Health Final Rule, published February 2, 2016.
9/1/2018	Part 209: Durable Medical Equipment (DME), Medical Appliances and Medical Supplies, Chapter 1: Durable Medical Equipment and Medical Supplies and Chapter 2: Medical Supplies	This Administrative Code filing is being submitted to require (1) a face-to-face visit with a physician or authorized non-physician practitioner prior to the initiation of home health visits or provision of durable medical equipment (DME) and appliances, (2) to require the provision of home health services in any setting in which normal life activities take place, (3) to revise the definition of DME to comply with the Medicaid Home Health Final Rule, published February 2, 2016, and (4) to remove language allowing physician assistants and nurse practitioners to
9/1/2018	Part 207: Institutional Long-Term Care (LTC), Chapter 2: Nursing Facility, Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Chapter 4: Psychiatric Residential Treatment Facility (PRTF), Rules 2.6: Per Diem, 2.11: Resident Funds, 3.5: Per Diem, 3.8: Resident Personal Funds, and 4.6: Reimbursement	This Administrative Code is being filed to require long-term care (LTC) facilities to arrange all non-emergency transportation and report the cost on the LTC facility's cost report and not utilize the Non-emergency Transportation (NET) Broker to correspond with SPA 18-0010 Transportation (effective 08/01/2018), effective September 1, 2018.
9/1/2018	Part 202: Hospital Services, Chapter 2: Outpatient Services, Rule 2.3: Emergency Department Visits	This administrative code is being filed to clarify how the evaluation and management code must be billed for services rendered in an outpatient hospital emergency department that spans through midnight

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8/1/2018	Part 201: Transportation Services, Chapter 1: Ambulance, Subchapter 1: General, Rule 1.1.1: Ambulance Provider Enrollment Requirements, Rule 1.1.2: Definitions, Rule 1.1.3: Reimbursement, Rule 1.1.4: Documentation Requirements, Rule 1.1.5: Mileage, Rule 1.1.6: Injectable Drugs, Rule 1.1.7: Ambulance Transport of Nursing Facility Residents by Ambulance, Rule 1.1.8: Transport of Dual Eligibles, Rule 1.1.9: Non-Covered Services, 1.1.10: Subscription Programs, Rule 1.1.11: Early and Periodic Screening, Diagnosis and Treatment (EPSDT), Subchapter 2: Emergency (Ground/Air), Rule 1.2.1: Emergency Ground Ambulance, Rule 1.2.2: Multiple Patients/Arrivals, Rule 1.2.3: Air Ambulance, Subchapter 3: Non-Emergency, Rule 1.3.1: Non-Emergency Ground Ambulance, Chapter 2: Non-Emergency Transportation (NET) (Non-Ambulance), Rule 2.1: NET Broker Program, Rule 2.2: Eligibility, Rule 2.3: NET Services, Rule 2.6: NET Driver Requirements, Rule 2.7: Vehicle Requirements	This Administrative Code proposed filing (1) updates the definitions of advanced life support (ALS) and basic life support (BLS) (2) moves language for coverage of non-emergency ambulance services to Chapter 2 in order to reflect the current NET Broker program, and (3) includes a new Chapter 3 and Rule 3.1 to address coverage and reimbursement of NET via air ambulance and hospital-to-hospital NET ambulance outside of the Broker program.
8/1/2018	Part 200: General Provider Information, Chapter 1: General Administrative Rules for Providers, Rule 1.3: Maintenance of Records	This Administrative Code adds language which prohibits providers from billing the Division of Medicaid for providing or accessing records substantiating services provided and claims submitted as is required by the Provider Agreement. It also revises the retention of records providers who are required to submit cost reports from five (5) years to three (3) years in compliance with Senate Bill 2826 effective July 1, 2018

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8/1/2018	Part 209: Durable Medical Equipment and Medical Supplies, Chapter 1: Durable Medical Equipment, Rule 1.11: Augmentative Communication Device (ACD)	This administrative code filing is being filed to revise the requirement of the evaluation and recommendation for an Augmentative Communication Device (ACD) must be completed by a speech-language pathologist (SLP) in conjunction with other health care professionals as appropriate
8/1/2018	Part 207: Institutional Long Term Care, Chapter 2: Nursing Facility, Rule 2.5: Reimbursement and Rule 2.8: Temporary Leave Payment; Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Rule 3.7: Temporary Leave Payment	This administrative code is being filed to 1) revise the definition of home/therapeutic temporary leave, 2) add clarification language of home/therapeutic and inpatient hospital temporary leave to improve the bed hold record keeping accuracy by the providers and the bed hold reconciliation process that is conducted by Division of Medicaid case mix nurses, and 3) revise the number of home/therapeutic bed hold days allowed for nursing facilities and ICF/IID as required by Miss. Code Ann. §
8/1/2018	Part 207: Institutional Long-Term Care, Chapter 2: Nursing Facility, Rule 2.6: Per Diem	This Administrative Code is being submitted to include respiratory therapy services in the list of items and services included in the Division of Medicaid's per diem rates, to correspond with SPA 18-0001 and be in compliance with 42 C.F.R. § 483.65
7/1/2018	Part 225: Telemedicine, Chapter 1: Telehealth Services, Rule 1.2: General Provider Information, Rule 1.5: Reimbursement	This Administrative Code is being filed to add Board Certified Behavior Analysts (BCBAs) and Board Certified Behavior Analyst-Doctorals (BCBA-Ds) as a provider of Autism Spectrum Disorder (ASD) services to EPSDT-eligible beneficiaries within their scope of practice via telehealth services. Telehealth services will allow EPSDT-eligible beneficiaries easier access to receive ASD services without having to travel to another geographical
5/1/2018	Part 213: Therapy Services, Chapter 3: Outpatient Speech-Language Pathology (Speech Therapy), Rule 3.1: Provider Enrollment Requirements	This Administrative Code is being filed to clarify the requirements for providers of speech-language pathology.

Effective Date	Part/Chapter/Rule	Summary
4/1/2018	Part 207: Institutional Long Term Care, Chapter 2: Nursing Facility, Rule 2.19: Disaster Procedures, Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Rule 3.12: Disaster Procedures	This Administrative Code is being filed to revise the disaster procedures language instructing Medicaid certified nursing facility and Medicaid certified intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) to transfer beneficiaries, in the event of a disaster, to facilities listed in their Mississippi State Department of Health (MSDH) approved Emergency Operations Plan (EOP)
4/1/2018	Part 205: Hospice Services, Chapter 1: Program Overview, Rules 1.1-1.10 and to add New Rule 1.11	This Administrative Code is being filed to clarify and update the requirement on physician signatures to more closely resemble Medicare requirements, define the timeframe for submission of paperwork to UM/QIO for prior authorizations and adds language regarding concurrent hospice and waiver services.
4/1/2018	Part 101: Coverage Groups and Processing Applications and Reviews Redetermination Processes, Chapters 1 – 15.	This Administrative Code filing is being submitted to revise and rewrite Part 101 to reflect changes that are either the direct result of the Affordable Care Act (ACA) or a change initiated by CMS as a result of the ACA.
4/1/2018	Part 100: General Provisions, Chapter 8: Coverage of the Categorically Needy in Mississippi, Rules 8.1 -8.17.	This Administrative Code is being filed to move Chapter 8 from Part 100 to Part 101, Chapter 1.
4/1/2018	Part 200: General Provider Information, Chapter 3: Beneficiary Information, Rule 3.2: Eligibility, Chapter 5: General, Rule 5.3: Wellness Program.	This Administrative Code is being filed to revise the deemed eligible newborn policy in Title 23, Part 200, Rule 3.2 and remove the pregnant women exclusion of receiving an annual examination in Title 23, Part 200, Rule 5.3 to be in compliance with the Affordable Care Act (ACA).

Effective Date	Part/Chapter/Rule	Summary
12/1/2017	Part 208: Home and Community-Based Services (HCBS) Long-Term Care, Chapter 5: Home and Community-Based Services (HCBS) Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver, Rule 5.5: Covered Services and Rule 5.7: Reimbursement.	This administrative code filing is to require ID/DD providers to use the Division of Medicaid's Electronic Visit Verification (EVV) system, MediKey, for payment of In-Home Respite and Home and Community Supports and to ensure that persons receive these services according to the person's approved plan of services and supports (PSS).
12/1/2017	Part 207: Institutional Long Term Care, Chapter 2: Nursing Facility, Rule 2.11: Resident Funds and Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Rule 3.8: Resident Personal Funds.	This administrative code is being submitted to reflect state law, Mississippi Code Ann. § 43-13-120, and the Attorney General's opinion regarding the process of handling funds of residents of long-term care facilities who die intestate and leave no known heirs.
11/1/2017	Part 222: Maternity Services, Chapter 1: General, Rule 1.11: Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services.	This administrative code is being submitted to correspond with SPA 17-0003 SBIRT which allows the Division of Medicaid to provide early intervention services for pregnant women with nondependent substance use and to prevent problematic substance use disorders as requested by ReNew Mississippi.
8/1/2017	Part 207: Institutional Long-Term Care, Chapter 3: Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs).	This Administrative Code filing is being filed to remove outpatient treatment that occurs two (2) or more days per week, including dialysis, chemotherapy or treatment for a catastrophic illness, from the home/therapeutic leave day limit in an (ICF/IID). This filing also includes a new rule for provider enrollment requirements for ICF/IIDs and changes all references

Effective Date	Part/Chapter/Rule	Summary
8/1/2017	Part 207: Institutional Long-Term Care, Chapter 2: Nursing Facility and New Rule 3.12: Disaster Procedures to Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).	This Administrative Code filing establishes national emergency preparedness requirements in accordance with 42 C.F.R. § 483.73 for Medicaid certified nursing facilities and 42 C.F.R. § 483.475 for Medicaid certified intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) to (1) ensure adequate planning for both natural and man-made disasters, (2) coordinate with federal, state, tribal, regional, and local emergency preparedness systems to maintain an integrated response to a disaster or emergency situation, and (3) ensure the
8/1/2017	Part 207: Institutional Long-Term Care, Chapter 2: Nursing Facility, Rules 2.6: Per Diem, 2.9 Resident Assessment Instrument.	This administrative code filing adds language to clarify the requirements of completing Section S in the minimum data set (MDS). While states are mandated to complete all federally required MDS 3.0 items, there is flexibility in adding optional Section S item sets. This filing requires that Section S be completed on all nursing facility residents to determine which
4/1/2017	Part 207: Institutional Long-Term Care, Chapter 2: Nursing Facility, Rule 2.10: Case Mix Reimbursement and Case Mix Review, Rule 2.15: Ventilator Dependent Care	This administrative code filing adds language to Rule 2.10 to clarify the clinical documentation requirements that affect case mix review results and revises Rule 2.15 to clarify that the ventilator dependent care (VDC) add-on rate is only for in-state nursing facilities.
1/1/2017	Part 103: Resources, Chapter 1: Introduction to Resources, Rule 1.10: Liberalized Resource Policy Overview; Chapter 2: Ownership Interest, Rule 2.9: Verifying Current Market Value (CMV); Chapter 5: Trust Provisions, Rule 5.17: Income Trusts; Chapter 6: Annuities, Rule 6.4: Treatment of Annuities Purchased on or after 2/8/2006.	This Administrative Code filing is being submitted to clarify that annuities purchased by an institutionalized individual or his/her spouse during the 5-year look-back period must name the Division of Medicaid as a remainder beneficiary. It also inserts missing language regarding payment due to the Division of Medicaid in the month of entry into a nursing facility for someone under an Income Trust.

Effective Date	Part/Chapter/Rule	Summary
1/1/2017	Part 202: Hospital Services, Chapter 4: Organ Transplants, Rule 4.1: Transplant Procedures, Rule 4.2 Organ Acquisition, Rule 4.3: Fundraising, Rule 4.4: Prior Approval, Rule 4.5: Facility Criteria, Rule 4.6: Documentation Requirements, Rule 4.7: Reimbursement, Rule 4.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), Rule 4.9: Cornea Transplant, Rule 4.10: Heart Transplant, Rule 4.11: Heart/Lung Transplant, Rule 4.12: Kidney Transplant, Rule 4.13: Liver Transplant, Rule 4.14: Single Lung Transplant, Rule 4.15: Bilateral Lung Transplant, Rule 4.16: Bone Marrow Transplant, Rule 4.17: Peripheral Stem Cell Transplant, and Rule 4.18: Small Bowel Transplant.	Mississippi Code Ann. § 43-13-117 gives the Mississippi Division of Medicaid (DOM) authority to include inpatient hospital services into managed care. This administrative code filing removes language that the Division of Medicaid is responsible for payment of inpatient transplant services for beneficiaries enrolled in a Coordinated Care Organization (CCO) to correspond with SPA 15-018, effective December 1, 2015. This filing also removes outdated transplant criteria and references national guidelines for organ specific criteria.
1/1/2017	Part 208: Chapter 1: HCBS Elderly and Disabled (E&D) Waiver Rules 1.1, 1.4, 1.6, New Rule 1.13; Chapter 2: HBCS Independent Living (IL) Waiver, Rules 2.1, 2.5, New Rule 2.12; Chapter 3: HCBS Assisted Living (AL) Waiver, Rules 3.4, 3.6, New Rule 3.15; Chapter 4: HCBS Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver, Rules 4.1, 4.5, New Rule 4.12; Chapter 5: HCBS Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver, Rule 5.3, 5.5, 5.8, 5.12, New Rule 5.14; Chapter 7: 1915(i) HCBS, Rule 7.3, 7.5, 7.6, 7.8, 7.9, New Rule 7.10.	This filing is to comply with 42 CFR §§ 441.301(c), 441.710(a)(1)-(2). On January 16, 2014, the Centers for Medicare and Medicaid Services (CMS) issued a final rule, effective March 17, 2014, which amends the requirements for qualities of home and community-based (HCB) settings. These requirements reflect CMS's intent that individuals receive services and supports in settings that are integrated in and support full access to the greater community. The final rule requires the use of a person-centered planning process to develop a participant/beneficiary's annual Plan for Services and Supports (PSS).

Effective Date	Part/Chapter/Rule	Summary
11/1/2016	Part 207: Institutional Long-Term Care, Chapter 2: Nursing Facility, Rule 2.6: Per Diem; Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Rule 3.4: Per Diem.	This Administrative Code filing is being submitted to clarify that oxygen tanks and its contents are included in the per diem. Additionally, this filing removes the term Private from Nursing Facility for the Severely Disabled (NFSD) to correspond with SPA 15-004.
11/1/2016	Part 305: Program Integrity, Chapter 1: Program Integrity, Rules 1.1: Fraud and Abuse, New Rule 1.2: Fraud, Waste and Abuse, New Rule 1.3: Overpayments, New Rule 1.4: Corrective Action Plan (CAP), New Rule 1.5: Improper Payments Due to Inaccurate Eligibility Information, New Rule 1.6: Medicaid Eligibility Quality Control.	This Administrative Code filing is being submitted to clarify that interest may be charged by the Division of Medicaid for improper payments and to move duplicative information in Part 100 to Part 305.
11/1/2016	Part 100: General Provisions, Chapter 6: Improper Payments, Rules 6.1: Types of Improper Payments, 6.2: Reporting an Improper Payment, 6.3: Claims Against Estates; Chapter 7: Quality Control, Rule 7.1: Quality Control Reviews.	This Administrative Code filing is to move duplicative information located in Miss. Admin. Code Part 100 to Miss. Admin. Code Part 305.

Effective Date	Part/Chapter/Rule	Summary
10/1/2016	Part 223: Early and Periodic Screening, Diagnosis and Treatment (EPSDT); Chapter 1: General, Rule 1.1: Program Description, Rule 1.2: Provider Enrollment and Participation Requirements, Rule 1.3 Early and Periodic Screening Services, Rule 1.4: Periodicity Schedule, Rule 1.5: Screening Components, Rule 1.6: Documentation Requirements for EPSDT Screenings, Rule 1.7: Diagnostic and Treatment Program Services, New Rule 1.8: Reimbursement	This filing revises language to require EPSDT providers to conduct periodic screenings and medically necessary interperiodic visits in accordance with the EPSDT Periodicity Schedule as recommended by the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule to correspond with SPA 15-017 EPSDT.
10/1/2016	Part 300: Appeals, Chapter 1: Appeals, Rule 1.1: Administrative Hearings for Providers	This administrative code filing revises language making the time period for a provider to file a court level appeal of a Division of Medicaid final decision from thirty (30) days to sixty (60) days.

Effective Date	Part/Chapter/Rule	Summary
8/1/2016	Title 23: Medicaid, Part 208: Home and Community-Based Services (HCBS) Long-Term Care, Chapter 1: Home and Community-Based Services (HCBS) Elderly and Disabled (E&D) Waiver, Chapter 2: Home and Community-Based Services (HCBS) Independent Living (IL) Waiver, Chapter 3: Home and Community-Based Services (HCBS) Assisted Living (AL) Waiver, Chapter 4: Home and Community-Based Services (HCBS) Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) Waiver, Chapter 5: Home and Community-Based Services (HCBS) Intellectual Disabilities/Developmental Disabilities Waiver, Rules 1.2: Eligibility, 2.2: Eligibility, 3.2: Eligibility, 4.2: Eligibility, 5.1: Eligibility.	This Administrative Code Filing updates the language of the eligibility categories for home and community-based waiver services.
7/28/2016	Withdrawn Title 23: Part 214: Pharmacy Services, Chapter 1: General Pharmacy, Rule 1.7: Refills/Renewals of Prescription Drugs	This Administrative Code filing withdraws Rule 1.7: Refills/Renewals of Prescription Drugs as proposed on 5/26/16 APA 22038.
6/1/2016	Part 200: General Provider Information, Chapter 2: Benefits, Rule 2.2: Non-Covered Services	This Administrative Code filing allows persons enrolled in home and community-based services (HCBS) waivers who elect to receive hospice care to receive HCBS waiver services which are non-duplicative of any service rendered through hospice. Persons may receive non-duplicative HCBS waiver services in coordination with hospice services. This filing also renames

Effective Date	Part/Chapter/Rule	Summary
6/1/2016	Part 205: Hospice Services, Chapter 1: Program Overview, Rule 1.1: General and Rule 1.4: Election, Enrollment, and Revocation	This Administrative Code filing allows persons enrolled in Home and Community-Based Services (HCBS) waivers who elect to receive hospice care to receive HCBS waiver services which are non-duplicative of any service rendered through hospice. Persons may receive non-duplicative HCBS waiver services in coordination with hospice services.
6/1/2016	Part 208: Home and Community Based Services (HCBS) Long Term Care, Chapter 1: HCBS Elderly and Disabled Waiver; Rule 1.2: Eligibility, Chapter 2: HCBS Independent Living Waiver; Rule 2.2: Eligibility, Chapter 3: HCBS Assisted Living Waiver; Rule 3.2: Eligibility, Chapter 4: HCBS Traumatic Brain Injury/Spinal Cord Injury Waiver; Rule 4.2: Eligibility, Chapter 5: HCBS Intellectual Disabilities/Developmental Disabilities Waiver; Rule: 5.1: Eligibility	This Administrative Code filing allows persons enrolled in home and community-based services (HCBS) waivers who elect to receive hospice care to receive HCBS waiver services which are non-duplicative of any service rendered through hospice. Persons may receive non-duplicative HCBS waiver services in coordination with hospice services. This filing also renames "participants" to "persons".
5/1/2016	Part 225: Telemedicine, Chapter 1: Telehealth Services, Rule 1.2: General Provider Information and Rule 1.5: Reimbursement	This Administrative Code filing adds Licensed Professional Counselors (LPCs) to the list of enrolled Medicaid providers who are eligible to provide telehealth services at a distant site or originating site.
5/1/2016	Part 203: Physician Services, Chapter 2: Physician-Administered Drugs and Implantable Drug System Devices, Rules 2.1: Covered Services, 2.3: Botulinum Toxins A and B, 2.4: Xolair, 2.5: Hyaluronate Joint Injection and 2.6: 17 Alpha-Hydroxyprogesterone and Chapter 4: Surgery, Rules 4.13: Implantable Testosterone Pellets (Testopel) and Rule 4.14: Insertion of Retisert (Fluocinolone Acetonide Intravitreal Implant)	This Administrative Code filing removes the specific coverage requirements of the physician-administered drugs and implantable drug system devices in Miss. Admin. Code Part 203: Physician Services, Chapter 2: Physician-Administered Drugs, Rules 2.3, 2.4, 2.5, and 2.6 and Chapter 4: Surgery, Rules 4.13 and 4.14 but adds language to refer to the universal rule for physician-administered drugs and implantable drug system devices. This filing also adds Miss. Admin. Code Part 203, Rule 2.1.A.5.

Effective Date	Part/Chapter/Rule	Summary
4/1/2016	Part 207: Institutional Long-Term Care Facilities, Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Rule 3.4: Per Diem	This Administrative Code filing includes language requiring Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) to notify the resident and the resident's guardian or legal representative of a transfer or discharge in an easily understood written notice. This filing also requires ICF/IIDs to maintain documentation of a transfer or discharge including reasons for the transfer or discharge, and to provide sufficient preparation and orientation to beneficiaries prior to a
4/1/2016	Part 200: General Provider Information, Chapter 3: Beneficiary Information, Rule 3.1: Eligibility Groups	This Administrative Code filing adds language for the coverage of dental services and eyeglasses, frames, lenses and contact lenses for pregnant beneficiaries as required by the Affordable Care Act (ACA) and chiropractic, podiatry, dental services and eyeglasses, frames, lenses and contact lenses for beneficiaries enrolled in the Healthier Mississippi Waiver (HMW)
4/1/2016	Part 217: Vision Services, Chapter 1: General, Rules 1.4: Non-Covered Services	This Administrative Code filing removes language for the non-coverage of eyeglasses, frames, lenses and contact lenses for pregnant beneficiaries required by the Affordable Care Act (ACA) and for beneficiaries enrolled in the Healthier Mississippi Waiver (HMW) to correspond with the approved SPA 13-0019 eff. 01/01/2014 and the 07/24/2015 renewal of the HMW
4/1/2016	Part 100: General Provisions, Chapter 8: Coverage of the Categorically Needy in Mississippi	This Administrative Code filing provides clarification language of eligibility groups, includes the agency responsible for eligibility certification and adds new rule 8.11: Hospital Presumptive Eligibility and new rule 8.17: Optional Waiver
4/1/2016	Part 208: Home and Community Based Long-Term Care, Chapter 6: Bridge to Independence (B2I), Rule 6.2: Eligibility	This Administrative Code filing adds language requiring that a transitioning person’s residence must pass a U.S. Department of Housing and Urban Development Housing Quality Standards inspection to participate in the Bridge to Independence (B2I)

Effective Date	Part/Chapter/Rule	Summary
3/2/2016 Emergency Filing	Part 203: Physician Services, Chapter 2: Physician-Administered Drugs and Implantable Drug System Devices, Rules 2.1: Covered Services, 2.3: Botulinum Toxins A and B, 2.4: Xolair, 2.5: Hyaluronate Joint Injection and 2.6: 17 Alpha-Hydroxyprogesterone and Chapter 4: Surgery, Rules 4.13: Implantable Testosterone Pellets (Testopel) and Rule 4.14: Insertion of Retisert (Fluocinolone Acetonide Intravitreal Implant)	This Administrative Code filing removes the specific coverage requirements of the physician-administered drugs and implantable drug system devices in Miss. Admin. Code Part 203: Physician Services, Chapter 2: Physician-Administered Drugs, Rules 2.3, 2.4, 2.5, and 2.6 and Chapter 4: Surgery, Rules 4.13 and 4.14 but adds language to refer to the universal rule for physician-administered drugs and implantable drug system devices. This filing also adds Miss. Admin. Code Part 203, Rule 2.1.A.5.
1/1/2016	Part 214: Pharmacy Services, Chapter 1: General Pharmacy, Rule 1.2: Pharmacy Services	This Administrative Code filing is to include within Part 214, Rule 1.2: Pharmacy Services a reference to immunization coverage located in Part 224: Immunizations.
1/1/2016	Part 224: Immunizations, Chapter 1: General, Rule 1.1: New Vaccines, Rule 1.2: Tuberculin Skin Test, Rule 1.3: Vaccines for Children, Rule 1.4: Vaccines for Adults, Rule 1.5: Nursing Facility Residents, Rule 1.7: Vaccines Available Through the Pharmacy Venue	This Administrative Code filing is to include coverage language for the Measles, Mumps, and Rubella (MMR) and Varicella vaccines according to the indications and guidelines of the Centers for Disease Control and Prevention (CDC) for beneficiaries nineteen (19) and older.
1/1/2016	Part 219: Laboratory Services, Chapter 1: General, Rule 1.10: Tuberculosis (TB) Testing	This Administrative Code filing amends Rule 1.2: Tuberculin Skin Test to include coverage language for interferon-gamma release assays (IGRA) which are currently covered and to relocate this rule from Part 224: Immunizations to Part 219: Laboratory Services, Rule 1.10: Tuberculosis (TB) Testing.

Effective Date	Part/Chapter/Rule	Summary
1/1/2016	Part 213: Therapy Services, Chapter 1: Physical Therapy, Rules 1.3: Covered Services, 1.4: Non-Covered Services, 1.5: Assistants, Aides and Students; Chapter 2: Occupational Therapy, Rules 2.3: Covered Services, 2.4: Non-Covered Services; Chapter 3: Outpatient Speech-Language Pathology (Speech Therapy), Rules 3.3: Covered Services, 3.4: Non-covered Services	This Administrative Code filing is to allow (1) a state licensed therapist to supervise up to four (4) assistants at a time during a work day, (2) reimbursement for assistants to provide services in settings other than an outpatient hospital, and (3) reimbursement for student-assisted physical therapy, occupational therapy, speech-language pathology or audiology services as long as the state licensed therapist is supervising no more than one (1) student at a time during a work day.
12/1/2015	Part 200: General Provider Information, Chapter 2: Benefits, Rule 2.2: Non-Covered Services	This Administrative Code filing clarifies the exclusion of legally responsible individuals, as defined by the Division of Medicaid, from providing services to beneficiaries. This filing removes language from Part 200, Rule 2.2 which is found in Parts 200: General Provider Information, 203: Physician Services, 214: Pharmacy Services, 215: Home Health Services, and 224: Immunizations. This filing includes language regarding compliance with background checks and excluded individuals as required by the Vulnerable Persons Act. Non-substantive change made by adding language for clarification to rule 2.2.F.
12/1/2015	Part 202: Hospital Services, Chapter 1: Inpatient Services, Rule 1.3: Prior Authorization of Inpatient Hospital Services	This Administrative Code filing includes language for the requirement of hospitals to notify the Division of Medicaid within five (5) calendar days of a newborn's birth via the Newborn Enrollment Form located on the Division of Medicaid's website.
12/1/2015	Part 218: Hearing Services, Chapter 1: General, Rule 1.3: Bone Anchored Hearing Aid	This Administrative Code filing is to include language for coverage of a non-implantable auditory osseointegrated device (AOD) for beneficiaries under the age of five (5) with certain types of hearing loss.

Effective Date	Part/Chapter/Rule	Summary
12/1/2015	Part 209: Durable Medical Equipment and Medical Supplies, Chapter 1: Durable Medical Equipment, Rule 1.24: External Speech Processor	This Administrative Code filing is to provide coverage language for batteries, replacement parts, and repairs for a non-implantable Auditory Osseoingrated Device (AOD). This filing also corrects a clerical error of referencing an incorrect rule number.
12/1/2015	Part 211: Federally Qualified Health Centers, Chapter 1: General, Rule 1.5: Reimbursement Methodology	This Administrative Code filing adds language for reimbursement of an additional fee per completed transmission for telehealth services provided by a Federally Qualified Health Center (FQHC) or FQHC look-alike acting as the originating site to correspond with State Plan Amendment (SPA) 15-003 eff. 01/01/2015.
12/1/2015	Part 212: Rural Health Clinics, Chapter 1: General, Rule 1.4: Reimbursement Methodology	This Administrative Code filing adds language for reimbursement of an additional fee per completed transmission for telehealth services provided by a Rural Health Clinic (RHC) acting as the originating site to correspond with State Plan Amendment (SPA) 15-003 eff. 01/01/2015. Non-substantive change was made to rule 1.4.A.1.d. which adds the word percent.
12/1/2015	Part 207: Institutional Long Term Care, Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Rule 3.2: Provider Enrollment/Provider Agreement	This Administrative Code filing removes time-limited provider agreement language for an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and includes language for hearings and appeals when an ICF/IID no longer meets the applicable Conditions of Participation as determined by Mississippi State Department of Health (MSDH) and Centers for Medicare and Medicaid Services (CMS).
12/1/2015	Part 202: Hospital Services, Chapter 5: Hospital Procedures, Rule 5.6: Hysterectomy	This Administrative Code filing removes language requiring a thirty (30) day waiting period before performing a hysterectomy procedure per 42 CFR § 441.255.

Effective Date	Part/Chapter/Rule	Summary
12/1/2015	Part 200: General Provider Information, Chapter 5: General, New Rule 5.6: Diabetes Self-Management Training (DSMT)	This Administrative Code filing relocates Rule 2.11: Diabetes Self-Management Training (DSMT) from Title 23: Medicaid, Part 202: Hospital Services to New Rule 5.6 in Title 23: Medicaid, Part 200: General Provider Information and removes language which limits DSMT coverage to the outpatient hospital setting to any provider who is a current Mississippi Medicaid provider, located in the State of Mississippi, and accredited by the American Diabetes Association (ADA) or the American Association of Diabetes Educators (AADE). Non-substantive change to rule 5.6.G. which adds a description to the acronym EPSDT.
12/1/2015	Part 202: Hospital Services, Chapter 2: Outpatient Services, Rule 2.11: Diabetes Self-Management Training (DSMT)	This Administrative Code filing relocates Rule 2.11: Diabetes Self-Management Training (DSMT) from Title 23: Medicaid, Part 202: Hospital Services to New Rule 5.6 in Title 23: Medicaid, Part 200: General Provider Information and removes language which limits DSMT coverage to the outpatient hospital setting to any provider who is a current Mississippi Medicaid provider, located in the State of Mississippi, and accredited by the American Diabetes Association (ADA) or the American Association of Diabetes Educators (AADE).
12/1/2015	Part 204: Dental Services, Chapter 2: Oral Surgery, Rule 2.3: Surgical Extractions	This Administrative Code filing is to revise language regarding coverage of medically necessary surgical extractions.
10/1/2015	Part 221: Family Planning and Family Planning Related Services, Chapter 2: 1115(a) Family Planning and Family Planning Related Waiver Services, Rule 2.1: Purpose, Rule 2.2: Eligibility.	This Administrative Code filing is to revise the verbiage for eligibility for Family Planning and Family Planning Related Waiver Services to be consistent with State Plan Amendment (SPA) 13-0019 Modified Adjusted Gross Income (MAGI) Based Eligibility Group.

Effective Date	Part/Chapter/Rule	Summary
9/1/2015	Part 203: Physician Services; Chapter 2: Physician Administered Drugs and Implantable Drug System Devices; Rule 2.2: Drug Rebates; Rule 2.6: 17 Alpha-Hydroxyprogesterone Caproate Injections (17-P)	This Administrative Code filing is to include language regarding the Division of Medicaid's authority to recoup monies when an audit determines that an incorrect NDC number was billed and to clarify coverage of 17-P.
9/1/2015	Part 204: Dental Services, Chapter 1: General, Rule 1.11: Dental Services Provided in a Hospital	This Administrative Code filing revises Rule 1.11: Dental Services Provided in a Hospital to reflect that the Division of Medicaid currently covers dental treatment in the Ambulatory Surgical Center (ASC) setting and includes the requirement for prior authorization of certain dental procedures in the ASC
9/1/2015	Part 208: Home and Community Based Services (HCBS) Long Term Care, Chapter 6: Bridge to Independence (B2I), Rule 6.2: Eligibility and Rule 6.3: Covered Services	This Administrative Code filing is to amend language to correspond with the Center for Medicare and Medicaid Services (CMS) approved Bridge to Independence (B2I) Operational Protocol (OP), effective November 4, 2014.
9/1/2015	Part 208: Home and Community Based Services (HCBS), Long Term Care, Chapter 5: HCBS Intellectual Disabilities/Developmental Disabilities Waiver, Rules 5.1-5.13	This Administrative Code filing is to update the current administrative code with the changes made during the 1915(c) Intellectual Disabilities/Developmental Disabilities (ID/DD) Home and Community-Based Services Waiver renewal, eff. July 1, 2013.
7/1/2015	New Part 225: Telemedicine Services, New Chapter 1: Telehealth Services, New Chapter 2: Remote Patient Monitoring, New Chapter 3: Teleradiology, New Chapter 4: Continuous Glucose Monitoring Services	This Administrative Code filing is to add New Part 225: Telemedicine which includes coverage language for telehealth, remote patient monitoring, teleradiology and continuous glucose monitoring services. Although Chapter 3: Teleradiology is a New Chapter, the language is struck from Part 220: Radiology and moved to the New Chapter 3 with revisions.

Effective Date	Part/Chapter/Rule	Summary
7/1/2015	Part 209: Durable Medical Equipment (DME) and Medical Supplies, Chapter 1: DME, Rule 1.26: Glucose Monitor, Chapter 2: Medical Supplies, Rule 2.1: Medical Supplies, Rule 2.2: Covered Medical Supplies. Non-substantive changes made to Rules 2.3, 2.4, and 2.5	This Administrative Code Filing filing is to add coverage language to Rule 1.26 for a continuous glucose monitoring system (CGMS), rename Rule 2.1 and add coverage language to Rule 2.2.C.2. for CGMS medical supplies.
7/1/2015	Part 220: Radiology, Chapter 1: General, Rule 1.4: Teleradiology	This Administrative Code filing is to move Miss. Admin. Code Part 220: Radiology, Rule 1.4: Teleradiology to New Part 225: Telemedicine, New Chapter 3: Teleradiology, New Rules 3.1-
7/1/2015	Part 100: General Provisions, Chapter 9: Administrative Rules, New Rules 9.1: Public Notice, 9.2 Public Records and 9.5: Public Hearings	This Administrative Code filing is to include new rules detailing the Division of Medicaid's compliance with state and federal regulations regarding providing public notice prior to making submissions to the Centers for Medicare and Medicaid Services (CMS), establishing an official written policy regarding requests for public records in accordance with the Public Records Act and outlining the procedures for holding public hearings for the purpose of allowing the public an opportunity to provide input.
7/1/2015	Part 207: Institutional Long Term Care; Chapter 2: Nursing Facility; Rules 2.7: Admission Requirements, 2.9: Resident Assessment-Minimum Data Set (MDS), 2.10: Case Mix Reimbursement, 2.15: Ventilator Dependent Care, 2.16: Therapy Services	This Administrative Code filing is to update the language to correspond with State Plan Amendment (SPA) 15-004 Nursing Facility Reimbursement. There were non-substantive changes made to rules 2.15: Ventilator Dependent Care and 2.16: Therapy Services.

Effective Date	Part/Chapter/Rule	Summary
7/1/2015	Part 221: Family Planning and Family Planning Related Services, Chapter 1: Family Planning and Family Planning Related State Plan Services, Rules: 1.2: Freedom of Choice, 1.4: Covered Services, 1.5: Non-Covered Services, 1.6: Documentation/Record Maintenance, New Rule 1.8: Reimbursement; Chapter 2: 1115(a) Family Planning and Family Planning Related Waiver Services, 2.1: Purpose, 2.2: Eligibility, 2.3: Freedom of Choice, 2.4: Covered Services, 2.5: Non-Covered Services, 2.6: Quality Assurance, 2.9: Documentation/Record Maintenance, New Rule 2.10: Reimbursement	This filing is to revise language to correspond with the Family Planning Waiver.
6/1/2015	Part 306: Third Party Recovery, Chapter 1: Third Party Recovery, Rule 1.1: General. Non-substantive changes to Rules: 1.2, 1.3, 1.4, 1.5, and 1.6.	This Administrative Code filing is to clarify the definition of Third Party to mirror the definition in 42 CFR § 433.136. Non-substantive changes to include the appropriate CFR citations in the sources have also been included.
6/1/2015	Part 211: Federally Qualified Health Centers (FQHC), Chapter 1: General, Rule 1.1: Provider Enrollment Requirements, Rule 1.2: Service Limits, Rule 1.3: Covered Services, Rule 1.5: Reimbursement Methodology and Rule 1.6: Documentation Requirements. Non-substantive changes made to Rules 1.4, and 1.7.	This Administrative Code filing includes language to correspond with SPA 2013-032 approved by Centers for Medicare and Medicaid Services (CMS) on August 8, 2014, which allows for an additional payment for certain services during extended office hours outside the Division of Medicaid's definition of "office hours" and removes Federally Qualified Health Center (FQHC) and FQHC look-alike encounters from the physician visit limit of twelve (12) visits per state fiscal year.

Effective Date	Part/Chapter/Rule	Summary
6/1/2015	Part 212: Rural Health Clinics (RHC), Chapter 1: General, Rule 1.2: Service Limits, Rule 1.3: Covered Services, Rule 1.4: Reimbursement Methodology, Rule 1.7: Pregnancy Related Eligibles. Non-substantive changes made to Rules 1.5, 1.6, and 1.8.	This Administrative Code filing includes language to correspond with SPA 2013-033 approved by Centers for Medicare and Medicaid Services (CMS) on August 5, 2014, which allows for an additional payment for certain services during extended office hours outside the Division of Medicaid's definition of "office hours" and removes Rural Health Clinic (RHC) encounters from the physician visit limit of twelve (12) visits per state fiscal year.
6/1/2015	Part 200: General Provider Information, Chapter 3: Beneficiary Information, Rule 3.4: Eligibility for Medicare and Medicaid	This Administrative Code filing is to include, for purposes of reimbursement, co-payments charged by a Medicare Part C plan are considered to be coinsurance as instructed by the Center for Medicare and Medicaid Services (CMS) guidance regarding compliance with 42 U.S.C. § 1396a.
6/1/2015	Part 203: Physician Services, Chapter 1: General, Rule 1.4: Physician Office Visits	This Administrative Code filing removes language referencing the pending approval from Centers for Medicare and Medicaid Services (CMS) for Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) to receive an alternate payment method of reimbursement for encounters occurring outside the Division of Medicaid's definition of regularly scheduled office hours. State Plan Amendment (SPA) 2013-032 FQHC Reimbursement and SPA 2013-033 RHC Reimbursement were approved in August 2014 allowing this alternate payment method of reimbursement; therefore, this language is being removed.
04/01/2015	Part 224: Immunizations, Chapter 1: General, New Rule 1.6: Vaccines for Pregnant and Postpartum Beneficiaries	This Administrative Code filing amends Part 224: Immunizations, Chapter 1: General to add New Rule 1.6 Vaccines for Pregnant and Postpartum Beneficiaries to allow coverage for the administration of the tetanus-diptheria-acellular-pertussis (Tdap) vaccine to pregnant and postpartum beneficiaries.

Effective Date	Part/Chapter/Rule	Summary
04/01/2015	Part 201: Transportation Services, Chapter 2: Non-Emergency Transportation (NET) (Non-Ambulance), Rule 2.1: NET Broker Program, Rule 2.6: Driver Requirements	This Administrative Code filing amends Part 201: Transportation, Chapter 2: Non-Emergency Transportation (NET) Non-Ambulance, Rule 2.1: Net Broker Program for clarification of the NET Driver background check requirements.
04/01/2015	Part 202: Hospital Services, Chapter 2: Outpatient Services, Rule 2.11: Diabetes Self-Management Training (DSMT)	This Administrative Code filing amends Part 202: Hospital Services, Chapter 2: Outpatient Services to include New Rule 2.11 for the coverage of Diabetes Self-Management Training (DSMT) in compliance with Miss. Code Ann. §§ 43-13-117, 43-13-121.
02/01/2015	Part 204: Dental Services, Chapter 2: Oral Surgery, Rule 2.4: Alveoloplasty	This Administrative Code filing adds language to clarify coverage criteria for Alveoloplasty to Part 204: Dental Services, Chapter 2: Oral Surgery, Rule 2.4.
01/02/2015	Part 207: Institutional Long Term Care, Chapter 2.15: Ventilator Dependent Care, New Rule 2.18: Individualized, Resident Specific Custom Manual and/or Custom Motorized/Power Wheelchairs Uniquely Constructed or Substantially Modified for a Specific Resident.	This Administrative Code filing is the revision of Rule 2.6 and Rule 3.4 and is to clarify the coverage and reimbursement of DME and medical supplies in a long-term care facility. Rule 2.15 is amended to include an established reimbursement per diem rate in addition to the standard per diem rate to nursing facilities, excluding Private Nursing Facilities for the Severely Disabled (PNF-SD), for residents requiring Ventilator Dependent Care (VDC), effective January 1, 2015. The Administrative Code filing of the New Rule 2.18 and New Rule 3.10 is to add coverage and reimbursement for an individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a

Effective Date	Part/Chapter/Rule	Summary
01/02/2015	Part 209: Durable Medical Equipment and Medical Supplies, Chapter 1: Durable Medical Equipment, Rule 1.4: Reimbursement, Rule 1.47: Wheelchairs and Chapter 2: Medical Supplies, Rule 2.2: Covered Medical Supplies.	This Administrative Code filing removes all Institutional Long Term Care (LTC) facilities Durable Medical Equipment (DME) and medical supply coverage and reimbursement from Title 23, Part 209. This coverage and reimbursement will be addressed in Title 23, Part 207: Institutional Long Term Care effective January 2, 2015. Title 23, Part 209 will only address coverage and reimbursement for outpatient DME and medical supplies.
01/02/2015	Part 222: Maternity Services, Chapter 1: General, Rule 1.1: Maternity Services, Rule 1.2: Multiple Birth Deliveries, and Rule 1.5: Billing for Maternity Services	This Administrative Code filing amends Title 23: Medicaid, Part 222: Maternity Services, Chapter 1: General, Rule 1.1: Maternity Services by adding coverage criteria and reimbursement for medically necessary elective deliveries prior to one (1) week before the treating physician's expected date of delivery and removing Rule 1.2: Multiple Birth Deliveries and Rule 1.5: Billing for Maternity Services.
11/01/2014	Part 103: Resources, Chapter 7: OBRA and DRA Transfer Policy	This Administrative Code filing amends Part 103: Resources, Chapter 7: OBRA and DRA Transfer Policy to clarify language.
11/01/2014	Part 103: Resources, Chapter 6: Annuities	This Administrative Code filing amends Part 103: Resources, Chapter 6: Annuities to clarify language.
11/01/2014	Part 103: Resources, Chapter 5: Trust Provisions	This Administrative Code filing amends Part 103: Resources, Chapter 5: Trust Provisions to separate trusts and transfer of assets policy, and clarify language.

Effective Date	Part/Chapter/Rule	Summary
11/01/2014	Part 214: Pharmacy Services, Chapter 1: General Pharmacy, New Rule 1.13: Retrospective Drug Utilization Review (DUR), New Rule 1.14: Participating Federally Qualified Health Center (FQHC) Providers, and New Rule 1.15: 340B Program; Non-substantive changes made to Rules 1.1-1.4 and 1.6-1.12.	This Administrative Code filing (1) adds New Rule 1.13 to outline the DUR process (2) adds New Rule 1.14 requiring all drugs purchased at discounted prices in an in-house pharmacy of an FQHC be reported and billed and (3) adds New Rule 1.15 340B Program. Non-substantive changes made to rules 1.1-1.4 and 1.6-1.12.
11/01/2014	Part 200: General Provider Information, Chapter 4: General Provider Enrollment, Rule 4.10: 340B Providers	This Administrative Code filing removes Rule 4.10. B, E, F, and J to correspond with the withdrawal of SPA 14-015.
10/01/2014	Part 203: Physician Services, New Chapter 10: Implantable Medical Devices, New Rule 10.1: Skin and Soft Tissue Substitutes	This Administrative Code filing includes coverage language and criteria for the use of skin and soft tissue substitutes currently covered by the Division of Medicaid.
10/01/2014	Part 219: Laboratory Services, Chapter 1: General, New Rule 1.9: Genetic Testing	This Administrative Code filing establishes criteria for coverage of genetic testing by the Division of Medicaid and requires prior authorization (PA) by the Utilization Management/Quality Improvement Organization (UM/QIO) for medical necessity.
10/01/2014	Part 200: General Provider Information, Chapter 2: Benefits, Rule 2.2: Non-Covered Services	This Administrative Code filing adds language to include procedures, products and services for conditions and indications that are non-covered services and language for non-covered services for the Home and Community Based-Services (HCBS) waivers.

Effective Date	Part/Chapter/Rule	Summary
10/01/2014	Part 305: Program Integrity, Chapter 1: Program Integrity, Rule 1.1: Fraud and Abuse	This Administrative Code filing includes language to require all provider demand letters for repayment of overpayment be sent via certified mail which allows the Division of Medicaid to document the date of receipt of the demand letter and uphold the thirty (30) day response time.
09/30/2014	Part 203: Physician Services, Chapter 1: General, New Rule 1.11: Global Packaging WITHDRAWN	This Administrative Code filing withdraws Rule 1.11.
09/01/2014	Part 100: General, Chapter 2: Agency Duties, Rule 2.1, New Chapter 9: Administrative Rules, New Rule 9.3: Declaratory Opinions and New Rule: 9.4: Oral Proceedings.	This Administrative Code filing includes the procedures for requesting a Declaratory Opinion and Oral Proceedings as required by Miss. Code. Ann. § 25-43-2.103.
09/01/2014	Part 103: Resources, Chapter 4: Countable Resources, New Rule 4.21 Entrance Fees To Continuing Care Retirement Communities and New Rule 4.22: Disqualification For Long Term Care Assistance For Individuals with Substantial Home Equity.	This Administrative Code filing addresses the countablity of entrance fees to continuing care retirement communities and the exclusion of long term care coverage for individuals with substantial home equity. These rules are new to the Administrative Code but have been Medicaid policy since 2008. The effective date of this filing will revert back to the effective date of SPA 2008-003, July 1, 2014.
09/01/2014	Part 102: Non-Financial Requirements, Chapter 3: Aliens, Rule 3.9: Requirements for 40 Qualifying Quarters.	This Administrative Code filing removes the requirement for certain classes of aliens to have forty (40) qualifying quarters (QQ) of work coverage under the Social Security Act (SSA). This is a change required by the Centers for Medicare and Medicaid Services (CMS) for the Affordable Care Act (ACA)-

Effective Date	Part/Chapter/Rule	Summary
09/01/2014	Part 202: Hospital Services, Chapter 1: Inpatient Services, New Rule 1.18: Review for Medical Necessity and/or Independent Verification and Validation (IV&V).	This Administrative Code filing Part 202: Hospital Services, Chapter 1: Inpatient Services is to add new Rule: 1.18 to define Review for Medical Necessity and/or Independent Verification and Validation (IV&V) in the inpatient setting and the provider's appeal rights.
09/01/2014	Part 300: Appeals, Chapter 1: Appeals, New Rule 1.5: Independent Verification and Validation (IV&V).	This Administrative Code filing adds a new Rule to include the appeal rights for providers who are dissatisfied with final administrative decisions of the Division of Medicaid relating to disallowances as a result of a review for medical necessity or Independent Verification and Validation (IV&V) decision described in Miss. Admin. Code Part 202, Rule 1.18.A.
07/01/2014	Part 214: Pharmacy Services, Chapter 1: General Pharmacy, Rule 1.3: Drugs Subject to Exclusion or Otherwise Restricted.	This Administrative Code filing removes barbiturates and benzodiazepines from the list of excluded or otherwise restricted drugs in Miss. Admin. Code Part 214, Chapter 1, Rule 1.3.
07/01/2014	Part 211: Federally Qualified Health Centers, Chapter 1: General, Rule 1.1: Provider Enrollment/Requirements	This Administrative Code final filing amends Part 211: Federally Qualified Health Centers, Chapter 1: General, Rule 1.1: Provider Enrollment/Requirements to include language clarification for determining effective date of the Federally Qualified Health Centers (FQHC) provider agreement.
07/01/2014	Part 212: Rural Health Clinics, Chapter 1: General, Rule 1.1: Provider Enrollment Requirements.	This Administrative Code filing amends Part 212: Rural Health Clinics, Chapter 1: General, Rule 1.1: Provider Enrollment Requirements to include language clarification for determining effective date of the Rural Health Clinics (RHC) provider agreement.

Effective Date	Part/Chapter/Rule	Summary
07/01/2014	Part 203: Physician Services, Chapter 2:Physician-Administered Drugs and Implantable Drug System Devices, Rule 2.1: Covered Services, Rule 2.2: Drug Rebates and Rule 2.3: Botulinum Toxins A and B.	This Administrative Code filing (1) renames Miss. Admin. Code Part 203, Chapter 2 to Physician Administered Drugs and Implantable Drug System Devices and define these terms; (2) describe coverage which now includes drug wastage; (3) refer to the Miss. Admin. Code Part 200, Rule 4.10 340B providers effective 07/01/2014; and (4) add the diagnoses neurogenic detrusor over activity and chronic migraine headaches and remove nystagmus for the indication of indication for Botulinum Toxins A.
06/01/2014	Part 208: Home and Community-Based Services (HCBS) Long Term Care, Chapter 6: Bridge to Independence (B2I), Rules 6.1-6.5	This Administrative Code filing adds Chapter 6: Bridge to Independence (B2I) and new Rules 6.1-6.5 to Part 208: Home and Community-Based Services (HCBS) as a covered service when certain criteria are met and to correspond with the Money Follows the Person (MFP) demonstration grant awarded April 1, 2011, with an operational start date of January 1, 2012.
05/01/2014	Part 216: Dialysis Services, Chapter 1: Dialysis Services, Rules 1.2, 1.3, 1.5, And 1.6.	This Administrative Code filing changes the payment methodology for freestanding and hospital-based dialysis centers from a composite rate system to a prospective payment system (PPS) effective January 1, 2014 to correspond with SPA 14-003 and to clarify documentation requirements for dialysis centers effective May 1, 2014.
05/01/2014	Part 208: Home and Community Based Services (HCBS) Long Term Care, Chapter 3: HCBS Assisted Living Waiver, Rules 3.1-3.11, New rules 3.12-3.14	This Administrative Code filing modifies Title 23, Part 208, Chapter 3: Assisted Living Waiver to reflect changes in the renewal of the Assisted Living Waiver by the Centers of Medicare and Medicaid (CMS) effective October 1, 2013.
05/01/2014	Part 209: Durable Medical Equipment and Medical Supplies, Chapter 1: Durable Medical Equipment, Rules 1.15 and 1.28; Chapter 2: Medical Supplies, Rules 2.2 and 2.3.	This Administrative Code filing complies with the Affordable Care Act (ACA) by revising Title 23: Medicaid, Part 209: Durable Medical Equipment and Medical Supplies, Chapter 1: Durable Medical Equipment, Rule 1.15: Breast Pumps and Chapter 2: Medical Supplies, Rule 2.2: Covered Medical

Effective Date	Part/Chapter/Rule	Summary
		Supplies, Rule 2.3: Non-Covered Medical Supplies to provide coverage for manual breast pumps and supplies and for language clarification. Chapter 1, Rule 1.28: Hospital Beds is being amended for language clarification.
05/01/2014	Part 204: Dental Services, Chapter 1: General, Rules: 1.3, 1.10 (removed), 1.14.	This Administrative Code filing reflects the Medicaid coverage of certain types of analgesia and sedation for dental procedures in a dental office-based setting effective May 1, 2014, with prior authorization (PA) from the Utilization Management/Quality Improvement Organization (UM/QIO).
05/01/2014	Part 200: General Provider Information, Chapter 4: Provider Enrollment, New Rule 4.10: 340B Providers	This Administrative Code filing to Part 200: General Provider Information, Chapter 4: Provider Enrollment, Rule 4.10: 340B Providers is a new rule to comply with Sec. 340B of the Public Health Service Act (Pub. L. 102-585), as amended by the Patient Protection and Affordable Care Act (Pub. L. 111-148). Final filing adopted with the change addressing Contract Pharmacies per comments received.
05/01/2014	Part 219: Laboratory Services, Chapter 1: General Rule, 1.2: Independent Laboratory Services	This Administrative Code filing is a technical change to clarify the language to Part 219: Laboratory Services, Chapter 1: General, Rule 1.2: Independent Laboratory Services to reflect the APR-DRG payment methodology, not a per diem payment, is considered full payment for inpatient hospital services to correlate with SPA 2012-008 effective October 1, 2012.
05/01/2014	Part 200: General Provider Information, Chapter 3: Beneficiary Information, Rule 3.7: Beneficiary Cost Sharing	This Administrative Code filing is a technical change to clarify the language to Part 200: General Provider Information, Chapter 3: Beneficiary Information, Rule 3.7: Beneficiary Cost Sharing to reflect APR-DRG payment methodology, not a per diem payment, is considered full payment for inpatient hospital services to correlate with SPA 2012-008 effective October 1, 2012.
05/01/2014	Part 202: Hospital Services, Chapter 5: Hospital Procedures,	This Administrative Code filing adds clarification language to Title 23: Medicaid, Part 202: Hospital Services, Chapter 5:

Effective Date	Part/Chapter/Rule	Summary
	Rule 5.6: Hysterectomy	Hospital Procedures, Rule 5.6: Hysterectomy. This filing includes specific coverage and documentation requirements for a hysterectomy as required by federal law 42 CFR Part 441, Subpart F.
04/01/2014	Part 102: Non-Financial Requirements, Chapter 5: Categorical Eligibility, Rules 5.5, 5.6; Chapter 6: General Eligibility Requirements, Rules 6.3, 6.4, 6.9, 6.10 6.11, 6.16, 6.17, 6.18, 6.35; Chapter 8: Non-Financial Requirements Rules 8.1, 8.2, 8.3, 8.5, 8.6, 8.8.	This Administrative Code filing is a technical correction to include Medicaid and CHIP eligibility related provisions required by the Affordable Care Act (ACA).
04/01/2014	Part 208: Home and Community Based Services (HCBS) Long Term Care, Chapter 7: 1915(i) HCBS Services, Rules 7.1-7.9	This Administrative Code filing adds Chapter 7: 1915(i) Home and Community Based Services (HCBS) to Part 208: Home and Community Based Services (HCBS), Long Term Care (LTC). The new rules are being filed to correspond with SPA 2013-001 1915(i) HCBS effective 11/01/2013.
02/01/2014	Part 202: Hospital Services, Chapter 2: Outpatient Services, Rule 2.10 Phase II Cardiac Rehabilitation Services	This Administrative Code filing adds the new Rule 2.10: Phase II Cardiac Rehabilitation to Title 23: Medicaid, Part 202: Hospital Services, Chapter 2: Outpatient Services with an effective date of 02/01/2014. This filing includes coverage provisions for an outpatient hospital physician supervised cardiac rehabilitation (CR) program for beneficiaries who have had one of the qualifying cardiovascular “episodes” based on 42 CFR § 410.49, implemented by CMS on January 1, 2010.
01/01/2014	Part 206 Mental Health Services, Chapter 1: Community Mental Health Services, Rule 1.11: Intensive Outpatient Psychiatric Services	This Administrative Code filing revises Rule 1.11: Intensive Outpatient Psychiatric (IOP) Services. This revision is to clarify the definition of Intensive Outpatient Psychiatric Services and provider responsibilities for this service as outlined in the State Plan Amendment (SPA) 2012-003 effective July 1, 2012, with an effective date January 1, 2014.
01/01/2014	Part 220 Radiology Services, Chapter 1: General, Rules 1.2, 1.7-	This Administrative Code filing modifies Title 23: Medicaid,

Effective Date	Part/Chapter/Rule	Summary
	1.11	Part 220: Radiology, Chapter 1: General, Rules 1.2, 1.7-1.10 and add Rule 1.11 for clarification and to incorporate the CMS framework that establishes criteria for performing PET scans. The effective date is January 1, 2014.
12/01/2013	Part 200 General Provider Information, Chapter 3: Beneficiary Information, Rule 3.1: Eligibility Groups	This Administrative Code filing of Title 23: Medicaid, Part 200: General Provider Information, Chapter 3: Beneficiary Information, Rule 3.1: Eligibility Groups makes a technical change to remove the language "Therapy in a free standing clinic, and" from Rule 3.1.C.3.d.1.v): Excluded Services to comply with the CMS approved benefit package for the Healthier Mississippi waiver effective October 1, 2004, and to include Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) to Rule 3.1.C.3.d.1.v): Long term care services.
12/01/2013	Part 206: Mental Health Services, Chapter 2: MYPAC, Rules 2.1-2.10, and New Rule 2.11.	This Administrative Code filing amends Title 23, Part 206: Mental Health Services, Chapter 2: MYPAC to reflect the approval of State Plan Amendment (SPA) 2012-003 Rehabilitation Option. Mississippi Youth Programs Around the Clock (MYPAC), a five year demonstration grant, ended enrollment of new beneficiaries on September 30, 2012. The Division of Medicaid submitted to the Centers for Medicare and Medicaid Services (CMS) SPA 2012-003 Rehabilitation Option with an effective date of July 1, 2012, to continue MYPAC services after the end of the demonstration grant. To avoid duplication of services, MYPAC services under the State Plan are effective November 1, 2012, to coincide with the operational start date.
11/01/2013	Part 202: Hospital Services, Chapter 2: Outpatient Services, Rule 2.3: Emergency Room Outpatient Visits and Rule 2.4: Outpatient (23 hour) Observation Services	This Administrative Code filing revises Part 202: Hospital Services, Chapter 2: Outpatient Services, Rule 2.3.B by deleting "non-emergent visits" to correspond with SPA 2012-009, effective 09/01/2013, and to clarify language regarding an emergency department visit that results in an inpatient hospital

Effective Date	Part/Chapter/Rule	Summary
		admission to correspond to SPA 2012-008, effective 10/01/2013. Revised Rule: 2.4.D.2 by updating language to include Electronic Health Record documentation. Revised Rule: 2.4.E to clarify language regarding outpatient observation to correspond to SPA 2012-008, effective 09/01/2013.
11/01/2013	Part 300: Appeals, Chapter 1: Appeals, Rule 1.1: Administrative Hearings for Providers	This Administrative Code filing revises language for clarification and consistency.
11/01/2013	Part 203: Physician Services, Chapter 1: General, Rule 1.4: Physician Office Visits	This Administrative Code allows for additional reimbursement for scheduled physician office visits during "provider established office hours" which are outside the Division of Medicaid's definition of "office hours", effective 11/01/2013.
10/01/2013	Part 102 Non Financial Requirements: Chapter 1 Residency: Rule 1.11 Determination of Residency (Under Age 21)	This Administrative Code filing allows for ACA required changes for a child's residency to correspond with SPA 2013-0022 Residency effective 01/01/2014.
10/01/2013	Part 104 Income: Chapter 1: Introduction to Income	This Administrative Code filing is a technical change to separate existing chapters 1-10 from new chapters 11-14. Rule 1.1: Income Rules revised. Chapter 11: Introduction to Income – FCC Program defines the ACA required MAGI rules for determining income and exceptions to using IRS rules for MAGI determination. Chapter 12: Income That Does Not Count Under IRS Rules - FCC Program defines income that does not count or is partially excluded using MAGI and IRS rules for determining eligibility under the ACA. Chapter 13: Income that Counts under the IRS Rules- FCC Program Defines income that counts using MAGI and IRS rules for determining eligibility under the ACA. Chapter 14: Verification of Income- FCC Programs defines verification of income rules as mandated by the ACA. To correspond with SPA 2013-0021 MAGI Income Methodology effective 01/01/2014.

Effective Date	Part/Chapter/Rule	Summary
10/01/2013	Part 105: Budgeting, Chapter 1: Introduction to Budgeting-FCC Program, Chapter 2: Extended Medicaid for Parents and Caretaker Relatives	This Administrative Code filing for Part 105: Budgeting, Chapter 1: Introduction to Budgeting-FCC describes ACA required rules for MAGI based budgeting in order to determine eligibility. Chapter 2: Extended Medicaid for Parents and Caretaker Relatives describes pre-ACA budgeting rules for extending Medicaid eligibility for up to twelve (12) months for adults and children who lose Medicaid eligibility under certain specific conditions. Under ACA rules, extended Medicaid continues to apply for increased earnings and spousal support. To correspond with SPA 2013-0021 MAGI Income Methodology effective 01/01/2014.
10/01/2013	Part 101: Application and Redetermination Processes, Chapter 1 Introduction, Rule1.1: General Information, 1.2: Access to the Application and Renewal Process, Rule 1.4: Assistance with Application and Renewal, Chapter 3: Filing Application, Rule 3.3: Application File Date, Chapter 4: Determination of Eligibility, Rule 1.4: Determination of Eligibility for Medicaid, CHIP and other Insurance Affordability Programs, Chapter 5: Standard of Promptness, Rule 5.1: Regional office Responsibility, Rule 5.4: Timely Processing Program, Chapter 6: Disposition of Application, Rule 6.1: Making and Eligibility Decision, Rule 6.2: Supervisory Review, Rule 6.4: Verification of Age, Chapter 7: Eligibility Dates, Rule 7.2: Beginning Dates of CHIP Eligibility, Chapter 8: Application of Employees and Family Members, Part 100: General Provisions, Chapter 2: Agency Duties, Rule 2.1: Duties of the Division of Medicaid, Part 102: Non- Financial Requirements, Chapter 6: General Eligibility Requirements	This Administrative Code filing allows for mandates from the ACA. Rule 1.1: General Information, Rule 1.2: Access to the Application and Renewal Process, Rule 1.4: Assistance with Application and Renewal. Rule 3.3: Application and File Date, Rule 4.1: Determination of Eligibility for Medicaid, CHIP and other affordability Programs, Rule 5.1: Regional office Responsibility, Rule 5.4: Timely Processing Program has been removed to comply with ACA. Rule 6.1: Making and Eligibility Decision has been changed to accommodate for ACA requirement of reasonable compatibility. Rule 6.2: Supervisory Review has been removed as a requirement for every case. Rule 6.4 ACA requires change to rely on Electronic Data Base Match. Rule 7.2: Beginning Dates of CHIP Eligibility amended to reflect technical changes effective CHIP dates. Chapter 8: Application of Employees and Family Members has been deleted due to it being an internal process and not a federal mandate. This Administrative Code filing, Rule 2.1, is an ACA requirement for the Division of Medicaid to enter into an agreement with the Federal Market place to exchange information. To correspond with SPA 2013-0020 Eligibility Process with an effective date of 01/01/2014.
10/01/2013	Part 100: General Provisions, Chapter 8: Coverage of the	This Administrative Code filing adds a new chapter for covered

Effective Date	Part/Chapter/Rule	Summary
	Categorically Needy in Mississippi	categories of eligibility. New ACA requirements to implement MAGI financial methodology for families and children covered groups effective 01/01/2014.
10/01/2013	Part 102: Non- Financial Requirements, Chapter 6: General Eligibility Requirements, Rule 6.17: Emancipated Children, Rule 6.18: Minor Parents.	This Administrative Code filing modifies Rule 6.17: Emancipated Children, Rule 6.18: Minor Parents as ACA changed to use MAGI budgeting Methodology. To correspond with SPA 2013-0021 Eligibility Process with an effective date of 01/01/2014.
10/01/2013	Part 100: General Provisions, Chapter 2: Agency Duties, Rule 2.1: Duties of the Division of Medicaid	This Administrative Code filing modifies Rule 2.1.A. transitioning the administration of CHIP to the Division of Medicaid effective 01/01/2013. To correspond with CHIP SPA 2013-008.
10/01/2013	Part 202: Hospital Services, Chapter 1: Inpatient Services, Rule 1.4: Covered Services, Rule 1.8: Sterilization and New Chapter 5: Hospital Procedures, New Rules 5.1-5.6	This Administrative Code filing moves Rules 1.4.B.1-6 Inpatient Hospital Procedures from Chapter 1: Inpatient Hospital to Chapter 5: Hospital Procedures because procedures listed are not limited to only inpatient hospital and to clarify language within those existing rules. Rule 1.8: Sterilization moved to Rule 5.3 and removed Hysterectomy from the title and added Rule 5.6 Hysterectomy and to clarify language in Rule 1.8.A.4, B.3, C.1, C.2, and C.3.
10/01/2013	Part 221: Family Planning Services, Chapter 1: General, Rule 1.4: Covered Services	This Administrative Code filing to Family Planning, Rule 1.4.B.4: Covered Services revises the rule to refer to Rule 5.3: Sterilization.
08/15/2013	Part 305: Program Integrity, Chapter 1: Program Integrity, Rule: 1.1 Fraud and Abuse	This Administrative Code filing makes a correction to Title 23: Part 305: Program Integrity, Chapter 1: Program Integrity, Rule 1.1: Fraud and Abuse to correspond with Medicaid's Medical Assistance Participation Agreement signed by providers.
07/15/2013	Part 200: General Provider Information, Chapter 2: Benefits,	This Administrative Code filing adds Rule 2.2. B and C to include the three never events in inpatient hospital (SPA 2011-

Effective Date	Part/Chapter/Rule	Summary
	Rule: 2.2. Non-Covered Services	004), outpatient hospital (SPA 2011-006) and other types of healthcare settings (SPA 2012-001). This filing complies with the CMS mandated SPA 2011-004 and SPA 2011-006 effective 10/01/2011 and SPA 2012-001 effective 06/01/2012 and according to MS Code Ann. § 25-43-1.103 subparagraph 4. Non-substantive revisions were made to Rule 2.2 A.
07/01/2013	Part 220: Radiology, Chapter 1: General, Rule: 1.2, 1.7 -1.10	This Administrative Code filing modifies Part 220 Radiology, Chapter 1 General, Rule 1.2 and add new Rules 1.7-1.10 to require prior authorization for certain outpatient advanced imaging procedures by the Division of Medicaid's Utilization Management / Quality Improvement Organization (UM/QIO) except when performed during an inpatient hospitalization, during an emergency room visit or during a twenty-three (23) hour observation period. According to the SOS APA § 25-43-1.103, the effective date is 04/01/2013, to correspond with the approved SPA 2013-007.
07/01/2013	Part 214: Pharmacy Services, Chapter 1: General Pharmacy, Rule: 1.3, 1.4, Rule 1.6, and 1.12	This Administrative Code filing modifies four Rules in Title 23: Medicaid, Part 214: Pharmacy Services, Chapter 1: General Pharmacy as follows: Rule 1.3 Drugs Subject to Exclusion or Otherwise Restricted – include specific section modified in 01/01/2013 filing. Rule 1.4: Prior Authorization – include clarification language as well as the add seventy-two (72) hour emergency drug supply verbiage inadvertently omitted in the 04/01/2012 compilation filing. Rule 1.6: Prescription Requirements – requested by Program Integrity to include language regarding recoupment of funds

Effective Date	Part/Chapter/Rule	Summary
		for hard copy prescriptions not written on tamper-resistant pad/paper. Added language requiring the NPI must be included on prescription claims for individual providers required with SPA 2012-004 Provider Screening and Enrollment. Rule 1.12: Beneficiary Signature – include verbiage inadvertently omitted in the 01/01/2012 compilation filing.
06/01/2013	Part 208 HCBS Chapter 1, E & D Waiver, Rule 1.3 Provider Enrollment	This Administrative Code filing includes language inadvertently omitted in the 01/01/13 filing reflecting changes in the Elderly and Disabled Waiver approved by CMS 07/01/12.
06/01/2013	Part 214 Pharmacy, Chapter 1 General Pharmacy, Rule 1.3, 1.6 and 1.11	This Administrative Code filing revises Rules 1.3 and 1.6 and add new Rule 1.11 to be in compliance with State Plan Amendment 2013-011 Prescribed Drugs effective date 01/01/2013 according to § 25-43-1.103 subparagraph 4. Final Filed with Secretary of State 04/25/2013.
04/01/2012	Part 212: Rural Health Clinics, Chapter 1:General, Rule 1.1: Provider Enrollment Requirements	This Administrative Code filing adds language to Title 23: Part 212: Rural Health Clinics, Chapter 1: General, Rule 1.1: Provider Enrollment Requirements that was inadvertently omitted in the compilation filing April 1, 2012.
04/01/2013	Part 201 Transportation Services Chapter 2: Non-Emergency Transportation (NET), Rule 2.1-2.7	This Administrative Code filing is for technical corrections, language clarification and policies inadvertently omitted in the April 1, 2012, Title 23 Medicaid compilation filing.

Effective Date	Part/Chapter/Rule	Summary
04/01/2013	Part 202 Hospital Services Chapter 4: Organ Transplant, Rule 4.17: Peripheral Stem Cell Transplant (PSCT)	This Administrative Code filing adds recurrent solid tumor to the specific diagnostic inclusion criteria for an autologous Peripheral Stem Cell Transplant, Part 202 Hospital Services, Chapter 4: Organ Transplant, Rule: 4.17 Peripheral Stem Cell Transplant (PSCT)
04/01/2013	Part 203 Physicians' Services Chapter 4: Surgery, Rule 4.23: Gastric Electrical Stimulation (GES)	This Administrative Code filing modifies Title 23, Part: 203 Physicians' Services, Chapter 4 Surgery, Rule 4.23 Gastric Electrical Stimulation (GES) which establishes coverage criteria. Currently, Medicaid reimburses for GES, however there are no coverage criteria for GES in the Administrative Code.
09/01/2012	Part 202 Hospital Services, Chapter 2 Outpatient Services, Rule 2.3 Emergency Room Outpatient Visits	This Administrative Code filing reverts to the language filed effective November 1, 2012, to unbundle services and ancillaries for all beneficiaries in the two lowest emergency department evaluation and management code descriptions for non-emergent emergency department visits. The effective date of this final filing is September 1, 2012, coinciding with the CMS approved SPA 2012-009 Hospital Outpatient Ambulatory Payment Classification (OP APC). Final Filed with the Secretary of State on 01/22/2013.
01/01/2013	Part 100 General Provisions: Chapter 1 Introduction: Rule 1.3 Current Structure	This Administrative Code filing revises Rule 1.3 E. Mississippi Legislative change transferring oversight authority of CHIP insurer to DOM SPA 008
01/01/2013	Part 202 Hospital Services Chapter 2: Outpatient Services, Rule 2.3: Emergency Room Outpatient Visits	This Administrative Code filing modifies Part 202 Hospital Services, Chapter 2.B. Outpatient Services, Rule 2.3: Emergency Room Outpatient Visits to clarify the original language by stating all services and ancillaries for beneficiaries over the age of (20) twenty are bundled into the two lowest emergency department evaluation and management code descriptions for non-emergent emergency department visits.
01/01/2013	Part 202 Hospital Services Chapter 1: Inpatient Services, Rule 1.13: Out-of-State Facilities	This Administrative Code filing modifies Chapter 1: Inpatient Services, Rule 1.13: Out-of-State Facilities language to be the

Effective Date	Part/Chapter/Rule	Summary
		same language as in Rule 4.7 B. for out-of-state transplant services and move the payment methodology language for "specialized services" to Rule 1.13 C from Rule 4.7 C.
01/01/2013	Part 202 Hospital Services Chapter 4: Organ Transplant, Rule 4.7: Reimbursement	This Administrative Code filing modifies Part 202: Hospital Services, Chapter 4: Organ Transplants, Rule 4.7: Reimbursement. This filing clarifies the payment methodology for out-of -state hospitals providing transplant services. Payment for transplant services is made under the MS APR-DRG payment methodology including a policy adjustor. Payment for transplant services not available in the state of Mississippi may be negotiated only if access to quality services is unavailable under the MS APR-DRG payment methodology. The negotiated Proposed Case Payment (PCP) is only applicable in extraordinary circumstances and is outlined under Section 2 and 3.
01/01/2013	Part 208 Home and Community Based Service (HCBS) Long Term Care Chapter 1: Elderly and Disabled Waiver	This Administrative Code filing modifies art 208 Chapter 1: Home and Community Based Service (HCBS) Elderly and Disabled Waiver (E&D) to clearly reflect changes in the approved Elderly and Disabled Waiver approved by The Centers of Medicare and Medicaid effective July 1, 2012.
01/01/2013	Part 208 Home and Community Based Service (HCBS) Long Term Care Chapter 2: Independent Living Waiver	This Administrative Code filing modifies Part 208 Chapter 2: Home and Community Based Service (HCBS) Independent Living Waiver (ILW) to clearly reflect changes in the approved Independent Living Waiver approved by The Centers of Medicare and Medicaid effective July 1, 2012.
01/01/2013	Part 209: Durable Medical Equipment	This Administrative Code filing modifies Title 23, Part 209 Durable Medical Equipment and Medical Supplies as follows: • Chapter 1, Rule 1.12 Bath Bench/Shower Chair – clarified language • Chapter 1, Rule 1.13 Battery and Battery Charger – removed "Medicaid does not cover replacement batteries

Effective Date	Part/Chapter/Rule	Summary
		for glucose monitors" • Chapter 1 DME, Rule 1.22 Diapers and Underpads – moved to Chapter 2 Medical Supplies, Rule 2.5 Diapers and Underpads • Chapter 1, Rule 1.26 Glucose Monitor and Replacement Battery – removed "when prior authorized" for coverage of a blood glucose monitor • Chapter 1, Rule 1.47 Wheelchair – clarified language and combined with Rule 1.49 • Chapter 1, Rule 1.48 Wheelchair Accessories – clarified language • Chapter 1, Rule 1.49 Wheelchairs, Drivers and Seating, Custom - this rule has been moved and combined with Rule 1.47 Wheelchairs • Chapter 1: Rule 1.51: Humidifier/Vaporizer – This was inadvertently not filed with the April 1, 2012, Compilation • Chapter 1, Rule 1.52 Pressure Reducing Support - This was inadvertently not filed with the April 1, 2012, Compilation • Chapter 2, Rule 2.2 Covered Medical Supplies – added sterile gloves as covered to insulin pump supplies, IV supplies, trach supplies and urinary catheter supplies • Chapter 2, Rule 2.5 Diapers and Underpads - The April 1, 2012, Compilation filing listed Diaper and Underpads under Durable Medical Equipment instead of Medical Supplies. Therefore, Chapter 1: Durable Medical Equipment, Rule 1.22 Diapers and Underpads moved to Chapter 2: Medical Supplies, Rule 2.5.
11/01/2012	Part 202 Hospital Services Chapter 2, Rule 2.3: Emergency Room Outpatient Visits	This Administrative Code filing modifies Part 202 Hospital Services, Chapter 2: Outpatient Services, Rule 2.3: Emergency Room Outpatient Visits to remove the six (6) non-emergent emergency room visits limit.

Effective Date	Part/Chapter/Rule	Summary
10/01/2012	Part 202 Hospital Services Chapter 1, Rule 1.1, 1.3, 1.4, 1.8 – 1.10, 1.13 – 1.16 and Chapter 4 Rules 4.1, 4.2, 4.4, 4.5, 4.7, 4.8, 4.12, 4.16 and 4.17	This Administrative Code filing modifies Part 202 Chapter 1, Rules 1.1, 1.3, 1.4, 1.8 – 1.10, 1.13 – 1.16 and Chapter 4, Rules 4.1 4.2, 4.4, 4.5, 4.7, 4.8, 4.12, 4.16 and 4.17 to reflect implementation of the Inpatient Hospital All Patient Refined Diagnosis Related Group (APR-DRG) payment methodology as authorized during the 2012 Legislative Session HB 421. This filing also removes the thirty (30) day inpatient hospital stay limit for adults.
10/01/2012	Part 203 Physician Services Chapter 9, Psychiatric Services Rule 9.5: Service Limits	This Administrative Code filing modifies Part 203 Chapter 9, Rule 9.5 to reflect the removal of the 30-day physician visit limit. The 2012 Legislative Session HB 421 authorized the removal of the 30-day hospital inpatient service limit due to the implementation of the Inpatient Hospital All Patient Refined Diagnosis Related Group (APR-DRG) payment methodology. The 30-day physician visit limit is also being discontinued.
10/01/2012	Part 304 Audit Chapter 1, Rule 1.1	This Administrative Code filing is to modify Part 304 Chapter 1, Rule 1.1 to update the specific records that hospitals should maintain due to the change to the APR-DRG hospital inpatient payment methodology authorized by the 2012 Legislative Session HB 421.
09/01/2012	Part 202 Hospital Services Chapter 2, Rule 2.3, 2.7 & 2.8	This Administrative Code filing modifies Part 202 Rule 2.3, Rule 2.7 and Rule 2.8 of the Medicaid Administrative Code to reflect implementation of the Outpatient Hospital Ambulatory Payment Classification (APC) payment methodology as authorized during the 2012 Legislative Session HB 421. This filing also clarifies the six (6) emergency room visits per fiscal year are for non-emergent visits.
07/01/2012	Part 214 Pharmacy Services Chapter 1, Rule 1.10:Preferred Drug List	This Administrative Code filing Rule was inadvertently not filed with the April 1, 2012, Division of Medicaid's Compilation filing required by APA Rule 3.2. Additionally, Rule 1.10 was amended with A.4 deleted due to not applicable to PDL which is

Effective Date	Part/Chapter/Rule	Summary
		also addressed under Rule 1.8. The language for B. was changed due to the Pharmacy Benefit Manager no longer existing. The CMS requirement for 24-hour PA review was added on E.