

Mississippi Secretary of State
700 North Street P. O. Box 136, Jackson, MS 39205-0136

ADMINISTRATIVE PROCEDURES NOTICE FILING

AGENCY NAME Division Of Medicaid		CONTACT PERSON Emily Thompson	TELEPHONE NUMBER 601-359-4122	
ADDRESS 550 High Street, Suite 1000		CITY Jackson	STATE MS	ZIP 39201
EMAIL Emily.thompson@medicaid.ms.gov	SUBMIT DATE 6/7/10	Name or number of rule(s): 2010-007		

Short explanation of rule/amendment/repeal and reason(s) for proposing rule/amendment/repeal: _____

No Deficit is projected at this time

Specific legal authority authorizing the promulgation of rule: Miss. Code Ann. §43-13-121(1972), as amended §43-13-117

List all rules repealed, amended, or suspended by the proposed rule: State Plan Attachment 4.19-B, Page 3

ORAL PROCEEDING:

An oral proceeding is scheduled for this rule on Date: _____ Time: _____ Place: _____

Presently, an oral proceeding is not scheduled on this rule.

If an oral proceeding is not scheduled, an oral proceeding must be held if a written request for an oral proceeding is submitted by a political subdivision, an agency or ten (10) or more persons. The written request should be submitted to the agency contact person at the above address within twenty (20) days after the filing of this notice of proposed rule adoption and should include the name, address, email address, and telephone number of the person(s) making the request; and, if you are an agent or attorney, the name, address, email address, and telephone number of the party or parties you represent. At any time within the twenty-five (25) day public comment period, written submissions including arguments, data, and views on the proposed rule/amendment/repeal may be submitted to the filing agency.

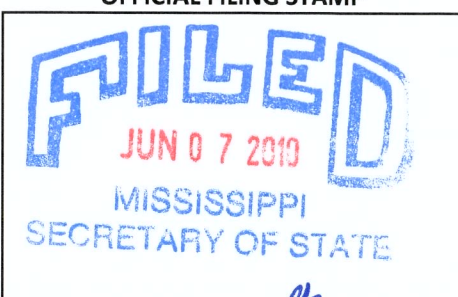

ECONOMIC IMPACT STATEMENT:

Economic impact statement not required for this rule. Concise summary of economic impact statement attached.

TEMPORARY RULES	PROPOSED ACTION ON RULES	FINAL ACTION ON RULES
<input type="checkbox"/> Original filing <input type="checkbox"/> Renewal of effectiveness To be in effect in _____ days Effective date: <input type="checkbox"/> Immediately upon filing <input type="checkbox"/> Other (specify): _____	Action proposed: <input type="checkbox"/> New rule(s) <input type="checkbox"/> Amendment to existing rule(s) <input type="checkbox"/> Repeal of existing rule(s) <input type="checkbox"/> Adoption by reference Proposed final effective date: <input type="checkbox"/> 30 days after filing <input type="checkbox"/> Other (specify): _____	Date Proposed Rule Filed: _____ Action taken: <input type="checkbox"/> Adopted with no changes in text <input type="checkbox"/> Adopted with changes <input type="checkbox"/> Adopted by reference <input checked="" type="checkbox"/> Withdrawn <input type="checkbox"/> Repeal adopted as proposed Effective date: <input type="checkbox"/> 30 days after filing <input type="checkbox"/> Other (specify): _____

Printed name and Title of person authorized to file rules: Robert Robinson

Signature of person authorized to file rules: 

OFFICIAL FILING STAMP <div style="border: 1px solid black; height: 150px; width: 100%;"></div> Accepted for filing by	DO NOT WRITE BELOW THIS LINE OFFICIAL FILING STAMP <div style="border: 1px solid black; height: 150px; width: 100%;"></div> Accepted for filing by	OFFICIAL FILING STAMP <div style="border: 1px solid black; padding: 10px;">  </div> Accepted for filing by 
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The entire text of the Proposed Rule including the text of any rule being amended or changed is attached.

State of Mississippi
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

Independent Laboratory and X-Ray Services

Payment is made from a statewide uniform fee schedule based on 70 percent of the Medicare fee schedule with adjustments as authorized by the state Legislature.

Independent laboratory and x-ray services for EPSDT recipients, if medically necessary, that exceed the limitations and scope for Medicaid recipients, as covered in this Plan, are reimbursed according to the methodology in the above paragraph.

The Division of Medicaid, as required by state law, shall reduce the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service.

From April 1, 2010, through June 30, 2010, and/or in the event expenditure reductions or cost containment measures are implemented, the Division of Medicaid may reduce the rate of reimbursement to providers for any service up to an additional fifteen percent (15%) of the allowed amount for that service including Medicare crossover claims.

TN No. 2010-007
Supercedes
TN No. 2002-06

Date Received _____
Date Approved _____
Date Effective April 1, 2010