Title 23: Division of Medicaid

Part 200: General Provider Information

Chapter 1: General Administrative Rules for Providers

Rule 1.6: Timely Filing

A. The Division of Medicaid requires providers to submit claims no later than three hundred sixty-five (365) calendar days from the date of service.

B. Claims for services submitted by newly enrolled providers must be submitted within three hundred sixty-five (365) calendar days from the date of service and must be for services provided on or after the effective date of the provider's enrollment.

C. If a claim for payment under Medicare has been filed in a timely manner, the Division of Medicaid will process a Medicaid claim relating to the same services within one hundred eighty (180) calendar days after the agency or the provider receives notice of the disposition of the Medicare claim.

D. If a provider fails to meet the timely filing requirements, the beneficiary cannot be billed for those services.

Source: 42 C.F.R. § 447.45; Miss. Code Ann. §§ 43-13-113, 43-13-117, 43-13-121.

History: New rule eff. 07/01/2019.

Rule 1.7: Timely Processing of Claims

A. The Division of Medicaid defines a clean claim as a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

    1. Claims with errors originating in the Division of Medicaid's claims system are considered clean claims.

    2. The following are not considered clean claims:

        a) Claims from providers under investigation for fraud or abuse, or

        b) Claims under review for medical necessity.

B. The Division of Medicaid processes claims in accordance with federal and state timely processing requirements.

C. The Division of Medicaid processes all claims within three hundred sixty-five (365) calendar days from the date of receipt except:

1. If a claim for payment under Medicare has been filed in a timely manner, the Division of Medicaid will process a Medicaid claim relating to the same services within one hundred eighty (180) calendar days of the Medicare paid date.

2. Retroactive adjustments paid to providers who are reimbursed under a retrospective payment system.

3. When the claim is from a provider that is under investigation for fraud or abuse.

4. When payments are made to carry out:

   a) A court order,

   b) Hearing decision, or

   c) Agency corrective actions taken to resolve a dispute.

5. To extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

D. The processing period begins on the date a claim is timely received by the Division of Medicaid and ends three hundred sixty-five (365) calendar days from the date the original claim is received by the Division of Medicaid.

E. Providers may submit a corrected claim during the processing period.

F. Providers may request an administrative hearing if they are dissatisfied with the disposition of their claim as described in Miss. Admin. Code, Title 23, Part 300, Rule 1.1.

Source: 42 C.F.R. § 447.45; Miss. Code Ann. §§ 43-13-113, 43-13-117, 43-13-121.

History: New rule eff. 07/01/2019.

Rule 1.8: Administrative Reviews for Claims

A. Providers may request an Administrative Review regarding claims within thirty (30) calendar days of the denial of a claim when:

1. The provider is unable to meet the timely filing requirement due to retroactive beneficiary eligibility and has filed the claim within sixty (60) days of the date of the eligibility determination,

2. The Division of Medicaid adjusts claims after timely filing and timely processing deadlines have expired, or

3. A Medicare crossover claim has been filed within one hundred eighty (180) calendar days from the Medicare paid date and the provider is dissatisfied with the disposition of the Medicaid claim.

B. Requests for an Administrative Review must include:

1. Documentation of timely filing or documentation that the provider was unable to file the claim timely due to the beneficiary's retroactive eligibility,

2. Documentation that explains the facts that support the provider’s position as to how the denied claim meets one (1) or more of the requirements in Miss. Admin. Code, Title 23, Part 200, Rule 1.8.A. and the reasons the provider believes he/she complied with Medicaid regulations, and

3. Other documentation as required or requested by the Division of Medicaid.

C. Providers may appeal certain decisions made by the Division of Medicaid as described in Miss. Admin. Code, Title 23, Part 300.

Source: Miss. Code Ann. §§ 43-13-113, 43-13-117, 43-13-121.

History: New Rule eff. 07/01/2019.

Title 23: Division of Medicaid

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~~Part 200~~ Chapter 1: General Administrative Rules for Providers

Rule 1.6: Timely Filing

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C. If a claim for payment under Medicare has been filed in a timely manner, the Division of Medicaid will ~~pay~~ process a Medicaid claim relating to the same services within one hundred eighty (180) calendar days after the agency or the provider receives notice of the disposition of the Medicare claim.

D. If a provider fails to meet the timely filing requirements, the beneficiary cannot be billed for those services.

Source: 42 C.F.R. § 447.45; Miss. Code Ann. §§ 43-13-113, 43-13-117, 43-13-121.

History: New rule eff. 07/01/2019.

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2. The following are not considered clean claims:

a) Claims from providers under investigation for fraud or abuse, or

b) Claims under review for medical necessity.

B. The Division of Medicaid ~~pays~~processes claims in accordance with federal and state timely processing requirements.

C. The Division of Medicaid ~~pays~~processes all claims within three hundred sixty-five (365) calendar days from the date of receipt except:

1. If a claim for payment under Medicare has been filed in a timely manner, the Division of Medicaid will ~~pay~~process a Medicaid claim relating to the same services within one hundred eighty (180) calendar days ~~after the agency or the provider receives notice of the disposition of the Medicare claim~~of the Medicare paid date.

2. Retroactive adjustments paid to providers who are reimbursed under a retrospective payment system.

3. When the claim is from a provider that is under investigation for fraud or abuse.

4. When payments are made to carry out:

   a) A court order,

   b) Hearing decision, or

   c) Agency corrective actions taken to resolve a dispute.

5. To extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

D. The processing period begins on the date a claim is timely ~~submitted~~ received ~~to~~ by the Division of Medicaid and ends three hundred sixty-five (365) calendar days from the date the original claim is ~~submitted to~~received by the Division of Medicaid.

E. Providers may submit a corrected claim during the processing period ~~if the claim was denied for any reason except medical necessity~~.

F. Providers may request an administrative hearing ~~reconsideration~~ if they are dissatisfied with the disposition of their claim as described in Miss. Admin. Code, Title 23, Part ~~200~~300, Rule 1.1~~8~~.

Source: 42 C.F.R. § 447.45; Miss. Code Ann. §§ 43-13-113, 43-13-117, 43-13-121.

History: New rule eff. 07/01/2019.

Rule 1.8: ~~Reconsideration of~~Administrative Reviews for Claims

A. Providers may request ~~reconsideration of claims~~an Administrative Review regarding claims within thirty (30) calendar days of the denial of a claim when:

1. The provider is unable to meet the timely filing requirement due to retroactive beneficiary eligibility and has filed the claim within sixty (60) days of the date of the eligibility determination,

2. The Division of Medicaid adjusts claims after timely filing and timely processing deadlines have expired, or

3. A Medicare crossover claim has been filed within one hundred eighty (180) calendar days from the Medicare paid date and the provider is dissatisfied with the disposition of the Medicaid claim.

B. Requests for ~~reconsideration of claims~~an Administrative Review must include:

1. Documentation of timely filing or documentation that the provider was unable to file the claim timely due to the beneficiary's retroactive eligibility,

2. Documentation that explains the facts that support the provider's position as to how the denied claim meets one (1) or more of the requirements in Miss. Admin. Code, Title 23, Part 200, Rule 1.8.A. and the reasons the provider believes he/she complied with Medicaid regulations ~~supporting the reason for the reconsideration~~, and

3. Other documentation as required or requested by the Division of Medicaid.

C. Providers may appeal certain decisions made by the Division of Medicaid as described in Miss. Admin. Code, Title 23, Part 300.

Source: Miss. Code Ann. § 43-13-113, 43-13-117, 43-13-121.

History: New Rule eff. 07/01/2019.