Title 23: Division of Medicaid

Part 200: General Provider Information

Chapter 1: General Administrative Rules for Providers

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. If the Division of Medicaid adjusts claims after the processing period has ended, providers may submit a written request for an Administrative Review within ninety (90) calendar days of the date of the remittance advice (RA). Providers must submit additional documentation to support claims payment.

G. 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: Added Miss. Admin. Code Rule 1.7.F. eff. 10/01/2019; New rule eff. 07/01/2019.