Title 23: Medicaid

Part 200: General Provider Information

Chapter 4: Provider Enrollment

Rule 4.1: Definitions

A. Providers: All health care entities including individual practitioners, institutional providers, and providers of medical equipment or goods related to care that are currently enrolled in the Medicaid program.

B. National Provider Identifier (NPI): A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers as noted in 45 C.F.R. § 162. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA.

C. Sole Proprietor: A Sole Proprietor is a form of business in which one (1) person owns all of the assets of the business and is solely liable for all debts on an individual basis. As a result of the National Provider Identifier (NPI) requirements, a Sole Proprietor must apply for their NPI as individuals. Medicaid will no longer issue a group number to an individual effective with the adoption of this rule revision. The subpart concept does not apply to a sole proprietorship, even one (1) with multiple locations, because the sole proprietorship is not an organization as defined in the final NPI Rule. An individual Medicaid provider number and the appropriate NPI issued by the Centers for Medicare & Medicaid Services (CMS) are entered into the Medicaid system with the individual's social security number (SSN); and if applicable, the Federal Employer Identification Number (FEIN) assigned to it. If this number is used as a Medicaid provider billing number, income or earnings information are reported to the IRS for this SSN or FEIN, as applicable. Deferred compensation is only available via a sole proprietor's SSN.

D. Group/Organization: A Group/Organization provider is not an individual/sole proprietor. This may include hospitals, long-term care facilities, laboratories, home health agencies, ambulance companies, and group practices; suppliers of durable medical equipment or pharmacies. Any subpart of the group/organization must apply for a different Medicaid provider number as determined by the provider type per Medicaid rule. A group provider requesting individual providers/servicing providers to be affiliated to their billing provider number must be approved Medicaid providers. For monies to be reported to the IRS on its Tax Identification, the group provider should be the biller, unless otherwise restricted by the Division of Medicaid. Group providers that have various servicing locations should apply to Medicaid to become a provider according to their enumeration application with CMS. The provider should also apply to Medicaid to become a provider according to the conduct of their own standard transactions and as required by the Division of Medicaid‘s program rules.

E. Effective Date: The earliest date a provider may begin billing for services.

F. Officer: Any person whose position is listed as being that of an officer in the provider's "articles of incorporation" or "corporate bylaws" or anyone who is appointed by the board of directors as an officer in accordance with the provider's corporate bylaws.

G. Director: A member of the provider's "board of directors." It does not necessarily include a person who may have the word "director" in his/her job title. Moreover, where a provider has a governing body that does not use the term "board of directors," the members of that governing body will still be considered "director". Thus, if the provider has a governing body titled "board of trustees," as opposed to "board of directors," the individual trustees are considered "directors" for Medicaid enrollment purposes.

H. Managing/Directing Employee: A managing/directing employee may be a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the entity, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the entity.

I. Authorized Official: An appointed official to whom the organization has granted the legal authority to enroll it in the Medicaid program, to make changes or updates to the organization's status in the Medicaid program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicaid program. Examples include: chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner.

J. Delegated Official: An individual who is delegated by an authorized official with the authority to report changes and updates to the entity's enrollment record. A delegated official must be an individual with an "ownership or control interest," or be a W-2 managing employee of the entity. Documentation in the application or as an attachment must be included with the application. A change of a delegated official will only be made to the file with the appropriate documentation signed by a documented authorized official.

K. Majority Interest: Ownership interest greater than fifty percent (50%) of the voting interest in a business enterprise.

Source: 42 C.F.R. Part 455, Subpart E; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2019.

Rule 4.2: Conditions of Participation

A. Providers must comply with the following conditions to participate in the Mississippi Medicaid program:

1. All providers must complete provider agreements and/or provider enrollment application packages per the requirements of the Division of Medicaid.

2. The provider must be licensed and/or certified by the appropriate federal and/or state authority, as applicable.

3. Agree to furnish required documentation of the provider's business transactions per 42 C.F.R. § 455.105(b) to the Division of Medicaid or to the Department of Health & Human Services (HHS) within thirty-five (35) days of the date on the request.

4. Agree to abide by the requirements of 42 C.F.R., PARTS 405, 424, 438, 447, 455, 457, 498, and 1007 of the Affordable Care Act (ACA) concerning the following:

    a) Provider Screening Procedures (42 C.F.R. § 424.518) which based on the category of the provider type can include license verifications; database checks of eligible professionals, owners, managing employees etc.; fingerprinting and criminal background checks; unscheduled or unannounced site visits based on required screening rules.

    b) Provider Application Fees (42 C.F.R. § 424.514).

    c) Temporary Moratorium (42 C.F.R. § 424.570).

    d) Provider Termination (42 C.F.R. § 455.416).

    e) Payment Suspensions (42 C.F.R. § 455.23).

5. The provider agrees to review, complete and submit a completed re-validation document as required by the policies of Division of Medicaid. All providers must undergo a revalidation screening process at least once every five years in accordance with 42 C.F.R. § 455.414.

6. All professional and institutional providers participating in the Medicaid program are required to keep records that fully disclose the extent of services rendered and billed under the program. These records must be retained for a minimum of five (5) years in order to comply with all federal and state regulations and laws. When there is a change of ownership or retirement, a provider must continue to maintain all Medicaid beneficiary records, unless an alternative method for maintaining the records has been established and approved by the Division of Medicaid. Upon request, providers are required to make such records available to representatives of the Division of Medicaid and others as provided by law in validation of any claims. The Division of Medicaid staff shall have immediate access to the provider's physical location, facilities, records, documents, and any other records relating to medical care and services rendered to beneficiaries during regular business hours. Providers must maintain records as indicated in Part 200 Chapter 1, Rule 1.3: Maintenance of Records.

7. The provider must comply with the requirements of the Social Security Act and federal regulations concerning: (a) disclosure by providers of ownership and control information;

and (b) disclosure of information by a provider's owners of any persons with convictions of criminal offenses against Medicare, Medicaid, or the Title XX services program. If the Division of Medicaid ascertains that a provider has been convicted of a felony under federal or state law for an offense that the Division of Medicaid determines is detrimental to the best interests of the program or of Medicaid beneficiaries, the Division of Medicaid may refuse to enter into an agreement with such provider, or may terminate or refuse to renew an existing agreement.

8. The provider must agree to accept payment for Medicaid covered services in accordance with the rules and regulations for reimbursement, as declared by the Secretary of Health and Human Services and by the state of Mississippi, and established under the Mississippi Medicaid program.

9. The provider must agree to accept, as payment in full, the amount paid by the Medicaid program for all services covered under the Medicaid program within the beneficiary's service limits with the exception of authorized deductibles, co-insurance, and co-payments. All services covered under the Medicaid program will be made available to the beneficiary. Beneficiaries will not be required to make deposits or payments on charges for services covered by Medicaid. A provider cannot pick and choose procedures for which the provider will accept Medicaid. At no time shall the provider be authorized to split services and require the beneficiary to pay for one type of service and Medicaid to pay for another. All services provided to Medicaid beneficiaries will be billed to Medicaid where Medicaid covers said services, unless some other resources, other than the beneficiary or the beneficiary's family, will pay for the service.

10. For most medical services rendered, the provider must agree to take all reasonable measures to determine the legal liabilities of third parties including Medicare and private health insurance to pay for Medicaid covered services, and if third party liability is established, to bill the third party before filing a Medicaid claim. Exceptions to this rule are outlined in Part 306 Third Party Recovery. For the purpose of this provision, the term "third party" includes an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the medical costs of injury, disease or disability of a Medicaid beneficiary and to report any such payments as third parties on claims filed for Medicaid payment.

11. Participating providers of services under the Medicaid program, i.e., physicians, dentists, hospitals, nursing facilities, pharmacies, etc., must comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age of Discrimination Act of 1975. Under the terms of these Acts, a participating provider or vendor of services under any program using federal funds is prohibited from making a distinction in the provision of services to beneficiaries on the grounds of race, color, national origin or handicap. This includes, but is not limited to, distinctions made on the basis of race, color, national origin, age or handicap with respect to: (a) waiting rooms, (b) hours of appointment, (c) order of seeing patients, or (d) assignment of patients to beds, rooms or sections of a facility. The Division of Medicaid is responsible for routine and complaint investigations dealing with these two (2) Acts.

12. Participating providers are prohibited from making a distinction in the provision of services to Medicaid beneficiaries on the grounds of being Medicaid beneficiaries. This includes, but is not limited to, making distinctions with regard to waiting rooms, hours of appointment, or order of seeing patients, third party sources (pursuant to federal regulations), and quality of services provided, including those provided in a facility.

13. The provider must agree that claims submitted will accurately reflect both the nature of the service and who performed the service.

14. The provider must maintain a copy of the Administrative Code for Mississippi Medicaid and all revisions.

15. Participating providers must be eligible to participate in the Medicaid program as determined by DHHS-Office of Inspector General (DHHS-OIG). Certain individuals and entities are ineligible to participate in the Medicaid program on the basis of their exclusion as sanctioned by DHHS-OIG by authority contained in Sections 1128 and 1156 of the Social Security Act. The effect of exclusion is that no program payment will be made for any items or services, including administrative and management services, furnished, ordered or prescribed by an excluded individual or entity under the Medicare, Medicaid, and State Children's Health Insurance Programs during the period of the exclusion. Program payments will not be made to an entity in which an excluded person is serving as an employee, administrator, operator, or in any other capacity, for any services including administrative and management services furnished, ordered, or prescribed on or after the effective date of the exclusion. In addition, no payment may be made to any business or facility that submits bills for payment of items or services provided by an excluded party. The exclusion remains in effect until the subject is reinstated by action of the DHHS-OIG. It is the responsibility of each Medicaid provider to assure that no excluded person or entity is employed in a capacity which would allow the excluded party to order, provide, prescribe, or supply services or medical care for beneficiaries, or allow the excluded party to hold an administrative, billing, or management position involving services or billing for beneficiaries.

B. Out of State Providers - Out of state providers must comply with all applicable program policies required by the Division of Medicaid and all applicable provider enrollment criteria in this Part. Home state requirements may not be substituted for Mississippi requirements. Retro-eligibility for emergency services must meet all provider enrollment criteria and the program rules.

Source: 42 C.F.R. Part 455, Subpart E; 42 C.F.R. §§ 431.52, 431.107; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121.

History: Revised eff. 12/01/2019.

Rule 4.4: Effective Date of Provider Agreement and Provider Agreement Termination

A. Each provider or organization furnishing services under the Mississippi Medicaid State Plan must enter into a provider agreement with the Mississippi Division of Medicaid.

B. The effective date of the provider agreement is the earliest day of the following options:

1. The date all required screening has been completed by the Division of Medicaid if the provider cannot provide documentation that all required screenings have been completed by a:

a) Medicare contractor, or

b) Medicaid agency or Children's Health Insurance Program (CHIP) of another state,

2. Up to one hundred twenty (120) days prior to the date of the submission of a completed Mississippi Medicaid Enrollment application if the provider can produce documentation that all required screenings were completed on the date of submission of the completed application by a:

a) Medicare contractor, or

b) Medicaid agency or Children's Health Insurance Program (CHIP) of another state,

3. The date of Medicare certification if the provider requests enrollment in the Medicaid program within one hundred twenty (120) days from the date the Medicare Tie-in Notice was issued to the provider, or

4. The first day of the month in which the Division of Medicaid receives the provider's completed enrollment application if the provider requests enrollment after one hundred twenty (120) days of the issuance of the Medicare Tie-in Notice.

C. Reserved

D. The Division of Medicaid does not make payments to any provider or organization prior to the date of a valid Medicaid provider agreement. This rule applies for any services rendered regardless of any time period provided for under any timely filing provision.

E. Timely filing requirements apply to all claims submitted by all providers. [Refer to Miss. Admin. Code Part 200, Rule 1.6]

F. Providers of the following state plan services will continue to receive payment for up to thirty (30) days after the effective date of termination of a provider agreement for services furnished to a beneficiary who was admitted before the effective date of the termination to permit time for an orderly transfer of Medicaid beneficiaries:

1. Inpatient hospital services,

2. Nursing facility (NF) services,

3. Psychiatric residential treatment facility services (PRTF),

4. Intermediate care facilities for the intellectually and/or developmentally disabled (ICF/ IDD) facility services, and

5. Home health services and hospice services furnished under a plan established before the effective date of termination.

G. The facilities listed in Miss. Admin. Code Part 200, Rule 4.1.D. must:

1. Notify all Medicaid beneficiaries, families, and/or sponsors in writing within forty-eight (48) hours of notice of termination of Medicaid participation,

2. Submit to the Division of Medicaid a current list of Medicaid beneficiaries who are receiving Medicaid services along with the name, address and telephone number of the family and/or the sponsor, when available, and the beneficiary's attending physician.

3. Assist the beneficiaries, families and the facility in making other facility arrangements for the beneficiaries.

H. Reinstatement may be granted after a provider has been terminated by the licensing or certification board, Office of Inspector General, the Centers for Medicare and Medicaid services (CMS), or the Division of Medicaid when conditions of reinstatement have been satisfied by the sanctioning entity. Notification of re-instatement from the appropriate entity must be provided with an application for re-instatement to participate in the Medicaid program.

Source: 42 C.F.R. §§ 431.108, 489.55, 489.57; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2019.

Title 23: Medicaid

Part 200: General Provider Information

Chapter 4: Provider Enrollment

Rule 4.1: Definitions

A. Providers: All health care entities including individual practitioners, institutional providers, and providers of medical equipment or goods related to care that are currently enrolled in the Medicaid program.

B. National Provider Identifier (NPI): A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers as noted in 45 C.F.R. 162. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA.

C. Sole Proprietor: A Sole Proprietor is a form of business in which one (1) person owns all of the assets of the business and is solely liable for all debts on an individual basis. As a result of the National Provider Identifier (NPI) requirements, a Sole Proprietor must apply for their NPI as individuals. Medicaid will no longer issue a group number to an individual effective with the adoption of this rule revision. The subpart concept does not apply to a sole proprietorship, even one (1) with multiple locations, because the sole proprietorship is not an organization as defined in the final NPI Rule. An individual Medicaid provider number and the appropriate NPI issued by the Centers for Medicare & Medicaid Services (CMS) are entered into the Medicaid system with the individual's social security number (SSN); and if applicable, the Federal Employer Identification Number (FEIN) assigned to it. If this number is used as a Medicaid provider billing number, income or earnings information are reported to the IRS for this SSN or FEIN, as applicable. Deferred compensation is only available via a sole proprietor's SSN.

D. Group/Organization: A Group/Organization provider is not an individual/sole proprietor. This may includes hospitals, long-term care facilities, laboratories, home health agencies, ambulance companies, and group practices; suppliers of durable medical equipment or pharmacies. Any subpart of the group/organization must apply for a different Medicaid provider number as determined by the provider type per Medicaid rule. A group provider requesting individual providers/servicing providers to be affiliated to their billing provider number must be approved Medicaid providers. For monies to be reported to the IRS on its Tax Identification, the group provider should be the biller, unless otherwise restricted by the Division of Medicaid. Group providers that have various servicing locations should apply to Medicaid to become a provider according to their enumeration application with CMS. The provider should also apply to Medicaid to become a provider according to the conduct of their own standard transactions and as required by the Division of Medicaid's program rules.

E. Effective Date: The earliest date a provider may begin billing for services.

F. Officer: Any person whose position is listed as being that of an officer in the provider's "articles of incorporation" or "corporate bylaws" or anyone who is appointed by the board of directors as an officer in accordance with the provider's corporate bylaws.

G. Director: A member of the provider's "board of directors." It does not necessarily include a person who may have the word "director" in his/her job title. Moreover, where a provider has a governing body that does not use the term "board of directors," the members of that governing body will still be considered "director". Thus, if the provider has a governing body titled "board of trustees," as opposed to "board of directors," the individual trustees are considered "directors" for Medicaid enrollment purposes.

H. Managing/Directing Employee: A managing/directing employee may be a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of the entity, either under contract or through some other arrangement, regardless of whether the individual is a W-2 employee of the entity.

I. Authorized Official: An appointed official to whom the organization has granted the legal authority to enroll it in the Medicaid program, to make changes or updates to the organization's status in the Medicaid program, and to commit the organization to fully abide by the statutes, regulations, and program instructions of the Medicaid program. Examples include: chief executive officer, chief financial officer, general partner, chairman of the board, or direct owner.

J. Delegated Official: An individual who is delegated by an authorized official ~~of~~ with the authority to report changes and updates to the entity's enrollment record. A delegated official must be an individual with an "ownership or control interest," or be a W-2 managing employee of the entity. Documentation in the application or as an attachment must be included with the application. A change of a delegated official will only be made to the file with the appropriate documentation signed by a documented authorized official.

K. Majority Interest: Ownership interest greater than fifty percent (50%) of the voting interest in a business enterprise.

Source: 42 C.F.R. Part 455, Subpart E; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 1~~1~~2/01/2019.

Rule 4.2: Conditions of Participation

A. Providers must comply with the following conditions to participate in the Mississippi Medicaid program:

1. All providers must complete provider agreements and/or provider enrollment application packages per the requirements of the Division of Medicaid.

2. The provider must be licensed and/or certified by the appropriate federal and/or state authority, as applicable.

3. Agree to furnish required documentation of the provider's business transactions per 42 C.F.R. § 455.105(b) to the Division of Medicaid or to the Department of Health & Human Services (HHS) within thirty-five (35) days of the date on the request.

4. Agree to abide by the requirements of 42 C.F.R., PARTS 405, 424, 438, 447, 455, 457, 498, and 1007 of the Affordable Care Act (ACA) concerning the following:

   a) Provider Screening Procedures (42 C.F.R. § 424.518) which based on the category of the provider type can include license verifications; database checks of eligible professionals, owners, managing employees etc; fingerprinting and criminal background checks; unscheduled or unannounced site visits based on required screening rules.

   b) Provider Application Fees (42 C.F.R. § 424.514).

   c) Temporary Moratorium (42 C.F.R. § 424.570).

   d) Provider Termination (42 C.F.R. § 455.416).

   e) Payment Suspensions (42 C.F.R. § 455.23).

5. The provider agrees to review, complete and submit a completed re-validation document as required by the policies of Division of Medicaid. All providers must undergo a revalidation screening process at least once every five years in accordance with 42 C.F.R. § 455.414.

6. All professional and institutional providers participating in the Medicaid program are required to keep records that fully disclose the extent of services rendered and billed under the program. These records must be retained for a minimum of five (5) years in order to comply with all federal and state regulations and laws. When there is a change of ownership or retirement, a provider must continue to maintain all Medicaid beneficiary records, unless an alternative method for maintaining the records has been established and approved by the Division of Medicaid. Upon request, providers are required to make such records available to representatives of the Division of Medicaid and others as provided by law in validation of any claims. The Division of Medicaid staff shall have immediate access to the provider's physical location, facilities, records, documents, and any other records relating to medical care and services rendered to beneficiaries during regular business hours. Providers must maintain records as indicated in Part 200 Chapter 1, Rule 1.3, Maintenance of Records.

7. The provider must comply with the requirements of the Social Security Act and federal regulations concerning: (a) disclosure by providers of ownership and control information;

and (b) disclosure of information by a provider's owners of any persons with convictions of criminal offenses against Medicare, Medicaid, or the Title XX services program. If the Division of Medicaid ascertains that a provider has been convicted of a felony under federal or state law for an offense that the Division of Medicaid determines is detrimental to the best interests of the program or of Medicaid beneficiaries, the Division of Medicaid may refuse to enter into an agreement with such provider, or may terminate or refuse to renew an existing agreement.

8. The provider must agree to accept payment for Medicaid covered services in accordance with the rules and regulations for reimbursement, as declared by the Secretary of Health and Human Services and by the state of Mississippi, and established under the Mississippi Medicaid program.

9. The provider must agree to accept, as payment in full, the amount paid by the Medicaid program for all services covered under the Medicaid program within the beneficiary's service limits with the exception of authorized deductibles, co-insurance, and co-payments. All services covered under the Medicaid program will be made available to the beneficiary. Beneficiaries will not be required to make deposits or payments on charges for services covered by Medicaid. A provider cannot pick and choose procedures for which the provider will accept Medicaid. At no time shall the provider be authorized to split services and require the beneficiary to pay for one type of service and Medicaid to pay for another. All services provided to Medicaid beneficiaries will be billed to Medicaid ~~only~~ where Medicaid covers said services, unless some other resources, other than the beneficiary or the beneficiary's family, will pay for the service.

10. For most medical services rendered, the provider must agree to take all reasonable measures to determine the legal liabilities of third parties including Medicare and private health insurance to pay for Medicaid covered services, and if third party liability is established, to bill the third party before filing a Medicaid claim. Exceptions to this rule are outlined in Part 306, Third Party Recovery. For the purpose of this provision, the term "third party" includes an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the medical costs of injury, disease or disability of a Medicaid beneficiary and to report any such payments as third parties on claims filed for Medicaid payment.

11. Participating providers of services under the Medicaid program, i.e., physicians, dentists, hospitals, nursing facilities, pharmacies, etc., must comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age of Discrimination Act of 1975. Under the terms of these Acts, a participating provider or vendor of services under any program using federal funds is prohibited from making a distinction in the provision of services to beneficiaries on the grounds of race, color, national origin or handicap. This includes, but is not limited to, distinctions made on the basis of race, color, national origin, age or handicap with respect to: (a) waiting rooms, (b) hours of appointment, (c) order of seeing patients, or (d) assignment of patients to beds, rooms or sections of a facility. The Division of Medicaid is responsible for routine and complaint investigations dealing with these two (2) Acts.

12. Participating providers are prohibited from making a distinction in the provision of services to Medicaid beneficiaries on the grounds of being Medicaid beneficiaries. This includes, but is not limited to, making distinctions with regard to waiting rooms, hours of appointment, or order of seeing patients, third party sources (pursuant to federal regulations), and quality of services provided, including those provided in a facility.

13. The provider must agree that claims submitted will accurately reflect both the nature of the service and who performed the service.

14. The provider must maintain a copy of the Administrative Code for Mississippi Medicaid and all revisions.

15. Participating providers must be eligible to participate in the Medicaid program as determined by DHHS-Office of Inspector General (DHHS-OIG). Certain individuals and entities are ineligible to participate in the Medicaid program on the basis of their exclusion as sanctioned by DHHS-OIG by authority contained in Sections 1128 and 1156 of the Social Security Act. The effect of exclusion is that no program payment will be made for any items or services, including administrative and management services, furnished, ordered or prescribed by an excluded individual or entity under the Medicare, Medicaid, and State Children's Health Insurance Programs during the period of the exclusion. Program payments will not be made to an entity in which an excluded person is serving as an employee, administrator, operator, or in any other capacity, for any services including administrative and management services furnished, ordered, or prescribed on or after the effective date of the exclusion. In addition, no payment may be made to any business or facility that submits bills for payment of items or services provided by an excluded party. The exclusion remains in effect until the subject is reinstated by action of the DHHS-OIG. It is the responsibility of each Medicaid provider to assure that no excluded person or entity is employed in a capacity which would allow the excluded party to order, provide, prescribe, or supply services or medical care for beneficiaries, or allow the excluded party to hold an administrative, billing, or management position involving services or billing for beneficiaries.

B. Out of State Providers - Out of state providers must comply with all applicable program policies required by the Division of Medicaid and all applicable provider enrollment criteria in this Part. Home state requirements may not be substituted for Mississippi requirements. Retro-eligibility for emergency services must meet all provider enrollment criteria and the program rules.

~~1. The Division of Medicaid will enroll an out-of-state provider using the results of the provider screenings performed by the Medicaid agency in the state in which the out-of-state provider is located in order to cover medical services:~~

~~a) That are needed because of an emergency medical condition as defined in Miss. Admin. Code Title 23, Part 201, Rule 1.2.G.,~~

~~b) That are needed because the beneficiary's health would be endangered if they were required to travel to their state of residence,~~

~~c) That the Division of Medicaid has determined, on the basis of medical advice, are needed and more readily available in the other state, or~~

~~d) When it is general practice for beneficiaries in a particular locality to use medical resources in the other state.~~

~~2. Out-of-state providers must enroll as a provider with the Division of Medicaid and submit claims within three hundred sixty-five days from the date of service.~~

~~3. Out-of-state providers must adhere to the Division of Medicaid's policies and procedures.~~

Source: 42 C.F.R. Part 455, Subpart E; 42 C.F.R. §§ 431.52, 431.107; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121.

History: Revised eff. 1~~1~~2/01/20~~1~~9.

Rule 4.4: Effective Date of Provider Agreement and Provider Agreement Termination

A. Each provider or organization furnishing services under the Mississippi Medicaid State Plan must enter into a~~n~~ provider agreement with the Mississippi Division of Medicaid.

B. The effective date of the provider agreement is the earliest day of the following options:

1. The date all required screening has been completed by the Division of Medicaid if the provider cannot provide documentation that all required screenings have been completed by a:

   a) Medicare contractor, or

   b) Medicaid agency or Children's Health Insurance Program (CHIP) of another state,

2. Up-to one hundred twenty (120) days prior to ~~T~~the date of the submission of a completed Mississippi Medicaid Enrollment application if the provider can produce documentation that all required screenings were completed on the date of submission of the completed application by a:

   a) Medicare contractor, or

   b) Medicaid agency or Children's Health Insurance Program (CHIP) of another state,

3. The date of Medicare certification if the provider requests enrollment in the Medicaid program within one hundred twenty (120) days from the date the Medicare Tie-in Notice was issued to the provider, or

4. The first day of the month in which the Division of Medicaid receives the provider's completed enrollment application if the provider requests enrollment after one hundred twenty (120) days of the issuance of the Medicare Tie-in Notice.

~~C.~~ Reserved ~~For out-of-state providers, completed applications and claims must be submitted within three hundred and sixty-five (365) days of the date of service. The effective date of the provider agreement will be:~~

~~1. The date of the service if the service was an emergency or if the beneficiary's health would be endangered if they were required to travel to their state of residence, or~~

~~2. The date determined in Miss. Admin. Code Part 200, Rule 4.4.B.~~

D. The Division of Medicaid does not make payments to any provider or organization prior to the date of ~~the execution~~ a valid Medicaid provider agreement. This rule applies for any services rendered regardless of any time period provided for under any timely filing provision.

E. Timely filing requirements apply to all claims submitted by all providers. [Refer to Miss. Admin. Code Part 200, Rule 1.6]

~~E~~F. Providers of the following state plan services will continue to receive payment for up to thirty (30) days after the effective date of termination of a provider agreement for services furnished to a beneficiary who was admitted before the effective date of the termination to permit time for an orderly transfer of Medicaid beneficiaries:

1. Inpatient hospital services,

2. Nursing facility (NF) services,

3. Psychiatric residential treatment facility services (PRTF),

4. Intermediate care facilities for the intellectually and/or developmentally disabled (ICF/ IDD) facility services,

~~5. Assisted Living Facility services~~, and

~~6~~5. Home health services and hospice services furnished under a plan established before the effective date of termination.

~~F~~G. The facilities listed in Miss. Admin. Code Part 200, Rule 4.1.D. must:

1. Notify all Medicaid beneficiaries, families, and/or sponsors in writing within forty-eight (48) hours of notice of termination of Medicaid participation,

2. Submit to the Division of Medicaid a current list of Medicaid beneficiaries who are receiving Medicaid services along with the name, address and telephone number of the family and/or the sponsor, when available, and the beneficiary's attending physician.

3. Assist the beneficiaries, families and the facility in making other facility arrangements for the beneficiaries.

~~G~~H. Reinstatement may be granted after a provider has been terminated by the licensing or certification board, Office of Inspector General, the Centers for Medicare and Medicaid services (CMS), or the Division of Medicaid when conditions of reinstatement have been satisfied by the sanctioning entity. Notification of re-instatement from the appropriate entity must be provided with an application for re-instatement to participate in the Medicaid program.

Source: 42 C.F.R. §§ 431.108, 489.55, 489.57; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 1~~1~~2/01/2019.