Title 23: Division of Medicaid

Part 200: General Provider Information

Part 200 Chapter 1: General Administrative Rules for Providers

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:

a) Received prior authorization, if required, from the Utilization Management/Quality Improvement Organization (UM/QIO) within 90 days of the system add date of the eligibility determination, and

b) Filed the claim within ninety (90) days of the system add 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: Revised eff. 08/01/2020; New Rule eff. 07/01/2019.

Chapter 3: Beneficiary Information

Rule 3.3: Beneficiary Retroactive Eligibility

A. Retroactive eligibility is available to individuals during all or part of a three (3) month period before application for Medicaid. Applicants must meet financial and need requirements.

B. Medicaid covered services paid for by a beneficiary during the three (3) month period may be refunded at the option of the provider of services and billed to Medicaid when eligibility is validated in accordance with timely filing requirements.

C. Medically necessary services rendered which require authorization during the period of retroactive eligibility cannot be denied due to failure to secure prior authorization. In accordance with timely filing requirements, authorization must be obtained and the claim must be filed within ninety (90) days of the system add date of eligibility determination.

Source: Miss. Code Ann. § 43-13-117.

History: Revised eff. 08/01/2020.