Title 23: Division of Medicaid

Part 306: Third Party Recovery

Part 306 Chapter 1: Third Party Recovery

Rule 1.3: Billing

A. Providers must file a claim with the third party prior to billing Medicaid. Documentation of payment or denial must be submitted to the Division of Medicaid with the claim including but not limited to:

   1. The explanation of benefits (EOB),

   2. Any amount paid by the third party, and

   3. If the claim is denied by the third party, the reason for the denial.

B. In the event there is no response from the third party source in sixty (60) days from the date of submittal, the provider may submit the claim to Medicaid as directed in Miss. Admin. Code Part 306, Rule 1.3.J.

C. When a Medicaid beneficiary is covered by a private insurance policy whose administrator has a preferred provider organization (PPO) in which the Medicaid provider:

   1. Does not participate, the provider must submit the claim to the Division of Medicaid with a statement indicating the provider is not a member of a particular PPO, the insurance company name and address, and specific third party filing data and follow the Division of Medicaid's instruction regarding the claim.

   2. Does participate, the Division of Medicaid does not reimburse for the difference between a third party payment and the provider's charges as the provider has agreed to accept the PPO's payment as payment in full.

D. The provider must obtain or make reasonable efforts to obtain an assignment of benefits from the beneficiary prior to billing third party insurance.

E. If a provider is unable to obtain an assignment of benefits, the provider must submit the claim to the Division of Medicaid and include the third party information.

F. The provider must file and obtain Medicare payment for the service or obtain a Medicare denial before the Division of Medicaid can pay the claim.

G. If the beneficiary has Medicare A, B, and/or C and private insurance, the provider must bill Medicare and the private insurer prior to submitting the claim to Medicaid.

H. If Medicare coverage is found after Medicaid has paid the claim, the Division of Medicaid will recoup the payments from the provider and the provider must bill Medicare.

I. The provider must attach the EOB from the third party to the claim submitted to the Division of Medicaid.

J. The provider must make every effort to acquire payment from the third party source before filing the claim with Medicaid. When a provider bills a third party insurer and does not receive a response, the provider must:

1. Submit a written inquiry to the third party if no response has been received within thirty (30) days from the date of original claim submission,

2. File the claim with the Division of Medicaid, attaching a completed copy of the "TPL Edit Override Attachment: No Response Form" if no response has been received in sixty (60) days from the date of original claim submission. This form must be signed and dated by the provider or an authorized provider representative. The claim is adjudicated according to the Medicaid payment policies.

K. If a provider receives payment from a third party and the Division of Medicaid for the same service, the provider must refund the full Medicaid payment and may refile the claim with Medicaid if the third party payment is less than Medicaid fee.

L. For hospitals having a PPO contract with an insurance company with payments subject to retroactive adjustments, the amount to be reported as third party liability on the claim must be as follows:

1. If the third party insurer pays a final amount, which is not subject to change, then the third party payment should be reported as the third party liability amount.

2. If the third party insurer makes an interim payment, which may be adjusted or settled later based on contractual agreements with the provider, the maximum third party reimbursement should be reported as the third party liability amount.

a) If future settlements with other third party insurers result in the provider refunding amounts to the third party insurer, the Division of Medicaid makes no additional payment.

b) If future settlements with third party insurers result in the third party insurer making an additional payment to the provider, the following should be adhered to:

1) If third party liability amounts have been reported as benefits as required in item Miss. Admin. Code Part 306, Rule 1.3.O.2, no amounts are due the Division of Medicaid.

2) If third party liability amounts have been reported at less than the maximum

amount payable by the third party insurer, the provider will be liable for the overpayment by the Division of Medicaid, plus interest and penalty when applicable.

Source: 42 CFR §§ 433.139, 433.145-433.148; Miss. Code Ann. § 43-13-121.

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