Title 23: Division of Medicaid

Part 305: Program Integrity

Part 305 Chapter 1: Program Integrity

Rule 1.1: Definitions

A. Abuse is defined as beneficiary practices that result in unnecessary cost to the Medicaid program and/or provider practices that are inconsistent with sound fiscal, business, or medical practices that result in:

1. An unnecessary cost to the Mississippi Medicaid Program,

2. Reimbursement for services that are not medically necessary, or

3. Reimbursement for services that fail to meet professionally recognized standards for health care.

B. Administrative Appeal is defined in Miss. Admin. Code Title 23, Part 300.

C. Beneficiary error is defined as the beneficiary's incomplete, incorrect or misleading information because the beneficiary misunderstood, was unable to comprehend the relationship of the facts about the situation to eligibility requirements or there was other inadvertent failure on the beneficiary's part to supply the pertinent or complete facts affecting Medicaid or Children's Health Insurance Program (CHIP) eligibility.

D. Corrective Action Plan (CAP) is defined as a documented plan that includes a well-defined identification of the problem, a specific time frame for the remedy to be implemented, specific actions taken to remedy the defined problem, plan on how to prevent the problem from recurring and the consequences if the problem is not resolved. At a minimum, the CAP must include:

a) The specific obligations violated,

b) The specific actions taken that address correction of the behavior that led to the violation(s),

c) The duration of the CAP which must be greater than ninety (90) calendar days, and

d) The means by which compliance with the CAP will be monitored and assessed.

E. Credible allegation of fraud is defined as an allegation from any source that has indicia of reliability in which the Division of Medicaid has verified through facts and evidence including, but not limited to, alleged fraud from:

1. Fraud hotline complaints,

2. Claims data mining, and/or

3. Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

F. Demand Letter is defined as a notification that a provider is required to refund improper payments.

G. Fraud is defined as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person, or an act that constitutes fraud as defined by federal or state law.

H. Incorrect payment is defined as an error in reimbursement which results in an overpayment or underpayment which may be due to a billing error, systems error and/or human error.

I. Overpayment is defined as any payment which results in a provider receiving any amount of reimbursement to which the provider is not legally entitled to receive.

J. Peer Review (PR) is defined as a retrospective review of medical records by the Division of Medicaid's Utilization Review/Quality Improvement Organization (UM/QIO) to assess if:

a) Services and items were reasonable and medically necessary;

b) The quality of services met professionally recognized standards of health care;

c) The beneficiary received the appropriate health care in a safe, appropriate and cost-effective setting based on the beneficiary's diagnosis and severity of the symptoms;

d) Services were provided economically and only when and to the extent they were medically necessary; and

e) The utilization billing and coding practices and/or overall utilization patterns of a provider for beneficiaries being reviewed are appropriate.

K. Peer Review Consultant (PRC) is defined as the medical reviewer in a comparable specialty as the provider or a certified professional coder (CPC) when appropriate.

L. Peer Review Panel (PRP) is defined as at least three (3) providers, at least one (1) of whom practices in the same class group as the subject provider; Selection of the PRP members shall ensure that their objectivity and judgment will not be affected by personal bias for or against the subject provider or by direct economic competition or cooperation with the subject provider.

M. Reconsideration Review is defined as an impartial review of the case by a Peer Review

Consultant not involved in the initial Peer Consultant Review determination, at the request of the Division of Medicaid, a provider, or as part of a UM/QIO follow-up.

N. Waste is defined as the overutilization, underutilization, or misuse of resources.

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

History: Revised eff. 08/01/2026. Revised eff. 03/01/2023; Revised and moved language to Rules 1.2-1.4, and 1.6 eff. 11/01/2016; Revised Miss. Admin. Code Part 305, Rule 1.1.D. eff. 10/01/2014; Miss. Admin. Code Part 305, Rule 1.1.B.3. and D.1. revised effective 08/15/2013 to comply with the Medical Assistance Participation Agreement Section C.

Rule 1.2: Fraud, Waste, and Abuse

A. The Division of Medicaid investigates suspected cases of fraud, waste, and abuse.

B. The Division of Medicaid makes a formal, written fraud referral to the Medicaid Fraud Control Unit (MFCU) as required under federal and/or state law or regulations.

C. The Division of Medicaid suspends all payments to a provider when the Division of Medicaid determines there is a credible allegation of fraud as required under federal and/or state law or regulations.

D. The Division of Medicaid notifies providers of suspension of payments within five (5) days of the suspension unless requested in writing by a law enforcement agency to temporarily withhold such notice.

E. The Division of Medicaid will:

1. Make a referral to the appropriate law enforcement agency if there is reason to believe that a beneficiary has defrauded the Medicaid program.

2. Conduct a full investigation if there is reason to believe that a beneficiary has abused the Medicaid program or if an applicant made a false statement or failed to disclose a material fact in his/her Medicaid application.

Source: 42 §§ C.F.R. 455.21, 455.23; Miss. Code Ann. §§ 43-13-121, 43-13-129.

History: Revised eff. 08/01/2026. New rule, language moved from Miss. Admin. Code Part 305 Rule 1.1 eff. 11/01/2016.

Rule 1.3: Overpayments

A. Providers must notify the Division of Medicaid's Office of Program Integrity in writing within thirty (30) calendar days of the discovery of any overpayments.

1. Any self-disclosure of overpayments submitted to the Division of Medicaid must include the following information:a) Name and address of the affected provider,

b) A provider which is entity owned, controlled, or otherwise part of a system or network must include:

    1) A description or diagram of any pertinent business/legal relationships,

    2) The names and addresses of any related and/or affected entities, corporate divisions, departments, or branches, and

    3) The name and address of the disclosing entity's designated representative,

c) Medicaid provider number(s) associated with claims,

d) Tax identification number(s),

e) Payee identification number(s),

f) Affected claims submitted in Excel or Access which must include the following information:

    1) Beneficiary name,

    2) Claim transmittal control number (TCN),

    3) Procedure code,

    4) Dates of service,

    5) Billed amount,

    6) Paid amount,

    7) Paid date, and

    8) Refund amount,

g) A report that includes a full description of the information being disclosed, the person who identified the overpayment and the manner in which the individual discovered it,

h) A detailed account of the provider's investigation of the overpayment,

i) A statement disclosing whether the provider is under investigation by any

government agency or contractor,

j) A statement detailing the provider's explanation of the cause of the overpayment,

k) A certification that the information submitted to the Division of Medicaid is based upon a good faith effort to disclose a billing inaccuracy and is true and correct, and

l) The methodology used in determining the amount of the overpayment.

2. The provider must submit additional information to the Office of Program Integrity as requested in order to verify the information submitted including the financial impact.

3. Any issues discovered during the verification process which are outside the scope of the self-disclosure may be treated as new matters subject to further investigation.

4. Refunds to the Division of Medicaid for overpayments must be conducted through the claims payment adjustment process or in the form of a refund check within thirty (30) calendar days of the overpayment discovery.

5. Self-disclosure does not release the provider from any other cause of action, civil or criminal, by another state agency or department of the United States under applicable law and regulations regarding these payments.

B. The Division of Medicaid, or designee, will send a demand letter via certified mail return receipt requesting the refund of overpayments discovered through audit or investigation:

1. On or before thirty (30) calendar days following the receipt of the demand letter, sent via certified mail, or thirty (30) calendar days from the date of the letter if the provider does not sign the certified mail notice, the provider must:

a) Request an administrative hearing [Refer to Miss. Admin. Code Part 300], or

b) Refund the overpayment by:

1) A lump sum payment,

2) Offsetting against current payments through the claims payment adjustment process until overpayment is recovered,

3) A repayment agreement executed between the provider and the Division of Medicaid, or

4) Any other method of recovery available to and deemed appropriate by

the Division of Medicaid.

2. Providers that fail to refund overpayments as described in Miss. Admin. Code Part 305, Rule 1.3.B.1.b) within the thirty (30) calendar day timeframe, may:

   a) Be placed under investigation for waste and/or abuse of the Medicaid program, and

   b) Be subject to charges for any allowable interest under state law which will begin accruing thirty-one (31) calendar days after receipt of the demand letter sent via certified mail, or thirty (30) calendar days from the date of the letter if the provider does not sign the certified mail notice.

C. The Division of Medicaid will accept reimbursement for overpayments without penalty in the event that:

   1. Overpayments are disclosed voluntarily and in good faith, and

   2. The acts that led to the overpayments were not the result of fraudulent or abusive conduct.

D. The Division of Medicaid will refund any payment recovered in error.

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

History: Revised eff. 08/01/2026. New rule, language moved from Miss. Admin. Code Part 305 Rule 1.1 eff. 11/01/2016.