1.12 Timely Filing

Fee-For-Service (Regular Medicaid) Claims Timely Filing

Effective July 1, 2019, all claims not paid by June 30, 2019 are subject to Miss. Admin. Code Part 200 Rule 1.6: Timely Filing, Rule 1.7: Timely Processing of Claims, and Rule 1.8: Administrative Review of Claims. These new rules can be viewed at http://www.sos.ms.gov/adminsearch/ACProposed/00024160b.pdf.

- Claims filed within three-hundred sixty-five (365) calendar days from the initial date of service, but denied, can be resubmitted with the transaction control number (TCN) from the original denied claim. The original TCN must be placed in the appropriate field on the resubmitted claim and be received by the Division of Medicaid within three-hundred and sixty-five (365) days from the date of the submittal of the original claim.

- If a provider is unable to submit a claim within three-hundred sixty-five (365) days from the date of service due to retroactive beneficiary eligibility, claims must be submitted within sixty (60) days of the eligibility determination.

- Claims by newly enrolled providers must be submitted within three hundred sixty-five (365) calendar days from the date of service and must be for services provided on or after the effective date of the provider's enrollment.

Timely Filing- Medicare Crossover Claims

Medicare crossover claims for coinsurance and/or deductible must be filed with DOM within 180 days of the Medicare Paid Date.

- Providers may submit a corrected claim within 180 days of the Medicare paid date.

- Providers may request an Administrative Review within thirty (30) calendar days of a denied Medicare crossover claim once the 180 day timely filing has been expired.

Mass Adjustments

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.

Administrative Claim Review

Providers may request an Administrative Review of a claim when:

- A beneficiary's retroactive eligibility prevents the provider from filing the claim timely and the provider submits the claim within sixty (60) days of the beneficiary's eligibility determination,

- The Division of Medicaid adjusts claims after timely filing and timely processing deadlines have expired, or

- The provider has submitted a Medicare crossover claim within one-hundred and eighty (180) days of the Medicare paid date and the provider is dissatisfied with the disposition of the claim.

Requests for Administrative Reviews must be submitted to the Office of Appeals at the Division of Medicaid and must include:

- Documentation of timely filing or documentation that the provider was unable to file the claim timely due to the beneficiary's retroactive eligibility,

- Documentation supporting the reason for the Administrative Review, and

- Other documentation as required or requested by the Division of Medicaid.

- Submit Administrative Reviews to:

  Division of Medicaid
  Attention: Office of Appeals
  550 High Street, Suite 1000
  Phone: 601-359-6050
  Fax: 601-359-9153

Timely Filing rules may be found on the Division of Medicaid website at www.medicaid.ms.gov (Administrative code Part 200; Chapter 1; Rules 1.6, 1.7 and 1.8).