MISSISSIPPI DIVISION OF
MEDICAID

Mississippi Medicaid

Provider Reference Guide

For Part 305

Program Integrity

This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.

TABLE OF CONTENTS

FRAUD AND ABUSE

SELF-DISCLOSURE:

To the extent that payments can be returned through the claims payment adjustment process, the claims adjustment process will be followed. Otherwise, providers should send refund checks, made payable to the Division of Medicaid within sixty (60) days of the overpayment discovery.

Please note that self-disclosure will not absolve the provider of criminal culpability.

SUSPENSION OF PAYMENTS

In section 6402(h) of the Affordable Care Act, the Congress amended section 1903(i)(2) of the Act to provide the Federal Financial Participation (FFP) in the Medicaid program shall not be made with respect to any amount expended for items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished by an individual or entity to whom a State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity as determined by the State in accordance with these regulations, unless the State determines in accordance with these regulations that good cause exists not to suspend such payments.

RECOVERY AUDIT CONTRACTORS (RACS) PROGRAM

Payments to RAC contractors for the identification of overpayments will only be made from amounts recovered. Contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register. This program may be adjusted pursuant to future regulation/guidance promulgated by CMS.

Through its procurement process the State will establish the following:

a. Qualifications of Medicaid RACs;

b. Required personnel;

c. Contract duration;

d. RAC responsibilities;

e. Timeframes for completion of audits/recoveries;

f. Audit look-back periods;

g. Coordination with other contractors and law enforcement;

h. Appeals process for RACs to follow;

i. Contingency fee considerations;

j. other terms and conditions as necessary

FORMS

MEDICAID PROVIDER SELF DISCLOSURE FORM

Provider Name:_____ Provider Number:_____
Address: _____
City_____ State:_____ ZIP Code:_____

Related entities, affected corporate divisions, departments or branches:

_____
_____

Provider Identification Number(s) associated with claims:_____

Tax ID
number(s):_____

Description of the matter being disclosed: _____

_____
_____
_____

Person who identified the overpayment: _____

How it was discovered: _____

_____
_____
_____
_____

Summary of provider's review of the overpayment: _____

_____
_____
_____

Is the provider under investigation by any government agency or contractor? Yes__No __

I certify that the information submitted on this form and any other documentation related to this disclosure submitted to DOM is based upon a good faith effort to disclose a billing inaccuracy and is true and correct.

Signature_____ Date_____

Mail or fax form to: Division of Medicaid, Bureau of Program Integrity, Suite 1000, Walter Sillers Building, 550 High Street, Jackson, MS 39201, (601) 576-4162, Fax (601) 576-4161