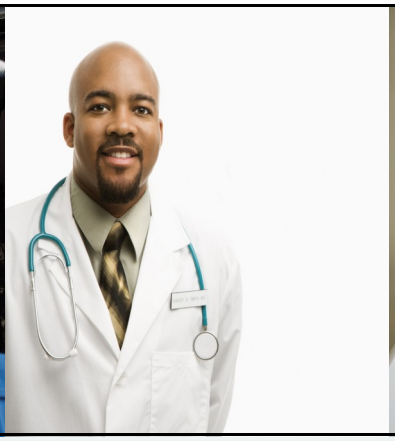

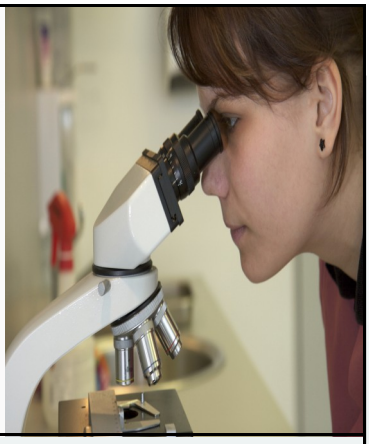

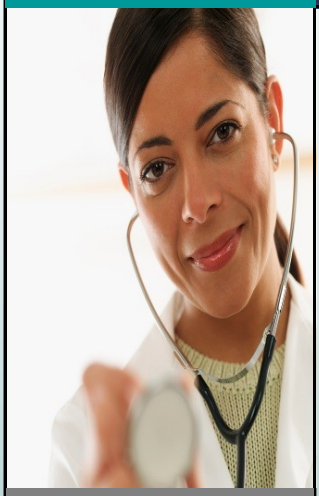

MISSISSIPPI DIVISION OF MEDICAID

PROVIDER BILLING HANDBOOK

April 2009 Edition

MISSISSIPPI MEDICAID
PROVIDER BILLING PROCEDURES HANDBOOK

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STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

Dear Provider,

The Division of Medicaid (DOM) is committed to ensuring that the necessary policies and procedures pertaining to the Mississippi Medicaid Program are available to you, and are presented in a clear and concise manner. We are also committed to ensuring that all Medicaid or prospective Medicaid providers have the essential information and resources necessary for conducting business as it relates to this program.

The Provider Billing Procedures Handbook contains contact information, billing procedures, and associated billing form for each provider type. However, the handbook must be used in conjunction with the Mississippi Medicaid Provider Policy Manual and other policy related instruments. Issues concerning policy and the specific procedures for which Medicaid reimburses should be referred to the Policy Manual and Fee schedules.

Providers are also encouraged to register through the Division of Medicaid's web portal and consult the respective websites for up-to-date Medicaid information, as it relates to a specific service or program area. DOM has plans to expand the scope of this handbook by providing specific billing instructions based on its policies and procedures for each Medicaid service or program area. Continue to utilize the resources available to you through the DOM Policy Manual, DOM and ACS websites, DOM staff, associated organizations, and this billing procedures handbook, as continuous resources and until this handbook can be expanded.

The Division of Medicaid appreciates the work that you provide to our Medicaid beneficiaries, and your efforts in assisting us in optimizing accessible and quality health care for some of the most vulnerable individuals in the state.

Sincerely,

Robert L. Robinson

Introduction to Mississippi Medicaid Provider Billing Handbook

The Mississippi Medicaid Provider Billing Handbook is designed to provide guidance and assistance to providers in submitting beneficiary claims to the Mississippi Division of Medicaid (DOM). The handbook will provide step-by-step instructions on completing the claims forms so that DOM can reimburse, you, the provider, more quickly. It is available as a hard copy document or electronically. You may obtain a hard copy of the handbook, at a minimal cost, by contacting the fiscal agent's Provider and Beneficiary Services Unit toll-free at 1-800-884-3222, or you may download the electronic version at http://www.medicaid.ms.gov. This handbook must be used in conjunction with the Mississippi Medicaid Provider Policy Manual. Key Medicaid reimbursement issues are addressed in the Policy Manual, and fee schedules are also found on the http://www.medicaid.ms.gov website.

The Handbook is divided into nine sections, as described below:

Section I. General Billing Information contains all of the contact information that a provider should need in billing a Medicaid claim. This section provides a point of contact for almost any question that requires a response, and should be used as a quick reference for essential billing information.

Section II. CMS-1500 Claim Form Instructions includes provider instructions for the specific claim form – CMS-1500 Version (08/05). If you need information pertaining to a particular field of a claim form, you should consult this section. If you have questions, contact the Provider and Beneficiary Services Unit toll-free at 1-800-884-3222.

Section III. UB-04 Claim Form Instructions includes provider instructions for the specific claim form – UB-04. If you need information pertaining to a particular field of a claim form, you should consult this section. If you have questions, contact the Provider and Beneficiary Services Unit toll-free at 1-800-884-3222.

Section IV. American Dental Association (ADA) Dental Claim Form Instructions includes provider instructions for the specific claim form – 2006 ADA Dental Claim. If you need information pertaining to a particular field of a claim form, you should consult this section. If you have questions, contact the Provider and Beneficiary Services Unit toll-free at 1-800-884-3222.

Section V. Pharmacy Billing Instructions includes provider instructions for billing claims in the Envision Point of Sale (POS) System (including NCPDP Payor Sheet), the MS Envision Web Portal, and on the specific claim form – Mississippi Title XIX Pharmacy Invoice. If you need information pertaining to a particular field of a claim form, you should consult this section. If you have questions, contact the Pharmacy Help Desk toll-free at 1-866-759-4108.

Section VI. Third Party Liability includes procedures for recovery of third party liability (TPL) which refers to the legal obligation of third parties, i.e., certain individuals, entities (private insurance), or programs (Medicare), to pay all or part of the expenditures for medical assistance furnished under a State plan in covered in this section. By federal law, the Medicaid program is intended to be the payer of last resort.

Section VII. The Remittance Advice (RA) is a computer-generated document that displays the status of all claims submitted to the fiscal agent along with a detailed explanation of adjudicated claims. The RA is available weekly.

Section VIII. Adjustment/Void Request and Claim Inquiry Forms contains the forms used to submit inquiries and make corrections to Medicaid claims. Detailed instructions are included for completing and filing these forms.

Section IX. Appendix includes a collection of forms to be used by the providers for interaction with the fiscal agent and the DOM. The forms can be copied by the Medicaid provider.

Quick Reference Billing Tips

As a provider to the Mississippi Medicaid program, our goal is to help you work easier, faster, and more efficiently. We have provided quick reference billing tips that you will need to bill Medicaid successfully. It is not a substitute for the detailed instructions in the Medicaid Provider Billing Handbook or Provider Policy Manual. Instructions in this reference are general and are meant to direct the user to the comprehensive instructions in the provider billing handbook.

<table>
<tr><th colspan="2">How To …</th></tr>
<tr><td>Obtain a Mississippi Medicaid Provider Number</td><td>You may obtain a complete application at (https:/ / msmedicaid.acs-inc.com) or by calling ACS at 1-800-884-3222.

Providers complete the Medicaid provider enrollment/ application package and submit it to:

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, MS 39225</td></tr>
<tr><td>Obtain a National Provider Identifier

National Provider Identifier (NPI) is a 10 digit number and the standard unique identifier for health care providers.</td><td>You may obtain your NPI through the National Plan and Provider Enumeration System (NPPES) as listed below:

<table><tr><th>By Telephone</th></tr><tr><td>1-800-465-3203 (NPI Toll-Free)
1-800-692-2326 (NPI TTY)</td></tr><tr><th>By E-mail</th></tr><tr><td>https://nppes.cms.hhs.gov</td></tr><tr><th>By Mail</th></tr><tr><td>NPI Enumerator
PO Box 6059
Fargo, ND 58108-6059</td></tr></table></td></tr>
<tr><td>Register through the Web Portal

The Web Portal is the electronic approach to rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information.</td><td>Go to: (https:/ / msmedicaid.acs-inc.com)

Once the site has been accessed, providers should click on the link titled, Web Account Registration, which is on the left side of the web portal homepage, and complete the appropriate fields to become a registered web portal user.</td></tr>
</table>

How To ...	
Download WINASAP2003 Software Free software to submit MS Medicaid Claims electronically.	Go to: (www.acs-gcro.com) **Must have completed the EDI (Electronic date Interchange) Submitter Enrollment Packet.** **EDI Questions and Assistance 1-866-225-2502**
Obtain Provider Billing Forms CMS-1500 UB-04 Dental Pharmacy Medicare Crossover Part A Medicare Crossover Part B	If you are not sure which form to use, please see the Provider Billing Manual at (http://www.medicaid.ms.gov) under Provider Manuals or call 1-800-884-3222. **CMS-1500, UB-04, and Dental forms are not supplied by the Division of Medicaid or by the fiscal agent. You may obtain these forms at an office supply or printing company.**
Refer to the Mississippi Medicaid Provider Billing Procedure Handbooks	Go to: (http://www.medicaid.ms.gov). These handbooks give general information on the Medicaid program, claims submission, and more.
Refer to the Mississippi Medicaid Provider Policy Manuals	Go to: (http://www.medicaid.ms.gov). These manuals give detailed information on what services are covered for a provider type, what services require prior authorization (PA), and how to bill for services.
Find Fee Schedules	The Fee Schedule provides the Medicaid provider with information about covered procedure codes, maximum fees allowed, prior authorization requirements for select services, and maximum service limits/ units. Some Mississippi Medicaid fee schedules are available for download from the Internet on the DOM web site at http://www.medicaid.ms.gov or at the website of the fiscal agent http://msmedicaid.acs-inc.com.

READY TO BILL	
Check Beneficiary's Eligibility	Anyone receiving covered services should have a Medicaid identification card at the time of service. If the beneficiary cannot present an ID card at the time of service, eligibility can be determined through use of either of the following services: Automated Voice Response System (AVRS) at 1-866-597-2675 Provider/ Beneficiary Services Call Center at 1-800-884-3222 Envision web portal at http:/ / msmedicaid.acs-inc.com . MEVS transaction using PC software or POS swipe card verification device provided by switch vendors (Section 1.10 contains contact information for vendors authorized for MEVS services). Eligibility and service limits should be verified each time a service is provided whether or not the beneficiary is able to present an ID card. **Co-payments - Certain services require a co-payment from the beneficiary. See Provider Billing Procedure Handbook.**
Filing Claims	When filing claims: ● Use correct beneficiary Medicaid ID number ● Bill with accurate coding (i.e., ICD-9, CPT, diagnosis, revenue, modifiers, units, status, etc.) ● Claims filed within 12 months 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. Corrected claims must be submitted no later than two years from the initial date of service. ● Medicare Crossover Claims time limit is 180 days from the Medicare pay date. **Providers are encouraged to submit their claims as soon as possible after the dates of services. For more specific information regarding timely filing refer to the Mississippi Medicaid Provider Billing Handbook section 1.12.**

READY TO BILL	
Claim Submission Methods	Claim submission methods: • Electronically through the Web Portal • Electronically through WINASAP • Electronically using a Batch Vendor or Clearinghouse (EDI cut off is 5:00 p.m. Thursdays) • Paper Claims should be submitted to the Division of Medicaid P.O. Box 23076 Jackson, MS 39225
REMINDERS!!!	As a participating provider you must: • Determine the patient's identity. • Verify the patient's age. • Verify the patient's eligibility. • Accept, as payment in full, the amount paid by Mississippi Medicaid. • Bill any and all other third-party carriers.
Remittance Advice (RA)	When claims process they either pay, deny, or suspend and are reflected on the Remittance Advice (RA). The last page of the RA contains a legend that provides a descriptive list of edit codes necessary for interpreting denied claims. RAs are available on the Web Portal each Monday for the previous week's adjudicated claims. RAs remain on the Web Portal for 90 days to allow continuous access. You may also request RAs through the Provider/ Beneficiary Call Center at 1-800-884-3222 or your assigned Provider Field Representative. For a complete listing of the current denial edits, visit the DOM website http:// www.medicaid.ms.gov at the News for Providers link at the shortcut Exception Codes and Descriptions.

WHERE TO FIND INFORMATION WHEN …	
Claims Deny	Not complying with the above mentioned requirements for filing claims could cause your claim to deny. If you have questions concerning an edit received on a denied claim, contact the Provider/ Beneficiary Services Call Center at 1-800-884-3222. **Claims that deny should be researched. There are a number of reasons claims may deny. If the denial is correctable, the claim should be resubmitted immediately.**
Claims Suspend	***Claims that suspend should not be re-submitted.*** If a second claim is submitted while the initial claim is in a suspended status, both claims will suspend. Please allow the suspended claim to be processed and to be reported on the RA as paid or denied before additional action is taken.
Adjusting and Voiding a Claim	An Adjustment/ Void Request Form can be downloaded at http:/ / www.medicaid.ms.gov under the link Medicaid Provider Information. Claims can also be adjusted or voided though the web portal: https:/ / msmedicaid.acs-inc.com. **Electronically filed claims *cannot* be adjusted with an Adjustment/Void Request Form. *Denied claims cannot be adjusted or voided.* If a claim paid at -0- dollars, it is considered to be a paid claim and not denied.**
Claims are Reconsidered	The claims reconsideration process is designed to address claim inquiries for: • Service not covered by Medicaid • Authorization denied or service not authorized within specified Medicaid guidelines • Service denied as not being medically necessary • Repayment of identified overpayments. **For claim reconsideration contact:** **ACS** P. O. Box 23076 Jackson, MS 39225 601-206-3000 or 1-800-884-3222 https:/ / msmedicaid.acs-inc.com

WHAT TO DO WHEN…	
Updating TPL Information	If you believe there is an error in a beneficiary's private insurance record or if you need to inform DOM of a change in a beneficiary's private insurance information, please submit the request to update the beneficiary's file to the Bureau of Recovery (BR). Bureau of Recovery staff will research and update the beneficiary file appropriately. The request to update the information may be submitted to BR via the web portal at https:// msmedicaid.acs-inc.com under the link **Report Third Party Insurance** or by fax at **601-359-6632**. Be sure to include the following information on your request: • Provider Name/ NPI • Contact Phone Number • Beneficiary Name and Medicaid ID number • Policy Holder Name • Policy Number • Carrier Name
Reporting Medicare Information	If you need to report a change or an update of Medicare coverage of a dual eligible beneficiary, contact **DOM Bureau of Recovery** (BR) at **1-800-421-2408** or **601-359-6095**. BR staff will research the request and update the beneficiary's file accordingly.
Reporting Changes to Provider File	If you need to update pertinent provider information such as mailing address, phone numbers, or fax numbers, you may use the change of address form located at the DOM website, http:// www.medicaid.ms.gov at the Forms link, or utilize the Provider Update link under Provider Submission Options on the web portal at https:// msmedicaid.acs-inc.com.

MEDICAL NECESSITY CONTACT INFORMATION	
Treatment Authorization Number (TAN)	**Health Systems of Mississippi (HSM)** is the UM/ QIO for the Division of Medicaid. The purpose of the UM/ QIO is to evaluate medical necessity for specific Medicaid services (see Mississippi Medicaid Provider Billing Procedure Handbook). **Health Systems of Mississippi** 175 East Capitol Street Suite 250, Lockbox 13 Jackson, MS 39201 1-866-740-2221 or 601-360-4949 http:/ / www.hsom.org
Prior Authorization (PA) Requests	Prior Authorization (PA) requests can be made through Health Systems of Mississippi (HSM, (contact information provided above), Health Information Designs (HID) and the Division of Medicaid (DOM). **Health Information Designs (HID)** provides Pharmacy prior authorizations (PAs) designed to encourage appropriate use of cost-effective pharmaceuticals for Medicaid beneficiaries. **Health Information Designs** P.O. Box 320506 513 Liberty Road Flowood, MS 39232 1-800-355-0486 or 601-709-0000 http:/ / www.hidmsmedicaid.com **PAs provided by Division of Medicaid Program Areas.** Contact Information for specific Medicaid services/ programs requiring prior authorizations can be found in Section 1.6 of this Manual.

IMPORTANT REMINDER	
Maintenance of Records	All professional and institutional providers participating in the Medicaid program are required to keep records that fully disclose the extent of services rendered and billed under the program. These records must be retained for a minimum of five years in order to comply with all federal and state regulations and laws.

<table>
<tr><th colspan="2">IMPORTANT CONTACT INFORMATION</th></tr>
<tr><td>Division of Medicaid
Walter Sillers Building, Suite 1000
550 High Street
Jackson, MS 39201
601-359-6050 or 1-800-884-3240
http:/ / www.medicaid.ms.gov</td><td>ACS
P.O. Box 23076
Jackson, MS 39225
601-206-3000 or 1-800-884-3222

https:/ / msmedicaid.acs-inc.com</td></tr>
<tr><td>Provider/Beneficiary Call Center

Available to answer questions regarding Medicaid eligibility verification, covered services, and billing inquiries

Monday – Friday
8 AM -5PM CST
1-800-884-3222</td><td>ACS Provider Field Representative

Complex inquiries may require special assistance. Please contact the Provider Field Representative assigned to the territory of your billing location.

If you do not know the name of your Provider Field Representative, please contact the ACS Call Center at 1-800-884-3222.</td></tr>
<tr><td>Health Systems of Mississippi
175 East Capitol Street
Suite 250, Lockbox 13
Jackson, MS 39201
1-866-740-2221 or 601-360-4949
http:/ / www.hsom.org</td><td>Health Information Designs
P.O. Box 320506
513 Liberty Road
Flowood, MS 39232
1-800-355-0486 or 601-709-0000
http:/ / www.hidmsmedicaid.com</td></tr>
<tr><td colspan="2">Pharmacy Helpdesk
Agents are available at the pharmacy helpdesk to assist providers with the following services:
• Problems with reversal/ backing out a POS claim
• Claim submission problems
• Questions regarding prescription drug billing.

Monday – Friday
8 AM -5PM CST
1-866-759-4108</td></tr>
<tr><td colspan="2">Please visit the Mississippi Medicaid website http:/ / www.medicaid.ms.gov at the Contact Us link for a complete listing of important contact information.</td></tr>
</table>

National Correct Coding Initiative (NCCI)

CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. The Affordable Care Act of 2010 required state Medicaid programs to incorporate compatible NCCI methodologies in their systems for processing Medicaid claims.

NCCI associated modifiers may be appended if and only if appropriate, based on clinical circumstances, and in accordance with the NCCI policies and HCPCS/CPT Manual instructions/definitions for the modifier/procedure code combination.

You may find the CMS National Correct Coding Initiative in Medicaid webpage at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html. The Medicaid NCCI Policy Manual should be reviewed for more on the appropriate use of modifiers.

Global Surgical Package Edit

The global surgical package, also referred to as global surgery, includes necessary services and products normally furnished by the "same physician" during the pre-operative, intra-operative, and post-operative periods. It also includes evaluation and management (E&M) visits related to a procedure based on an assigned post-op period by the Centers for Medicare and Medicaid (CMS). The "same physician" is defined as physicians and/or other qualified health care professionals of the same group, the same specialty, reporting the same federal tax identification number, and reimbursed on a fee-for-service basis.

Mississippi Medicaid Global Periods

MS Global Package Value	Value Description
000	The zero (0) day global period is assigned to endoscopic and minor procedures and includes the Evaluation and Management (E&M) services on the day of the procedure.
010	The ten (10) day global period is assigned to minor procedures and includes the Evaluation and Management (E&M) services on the day of the procedure and

MS Global Package Value	Value Description
	during the ten (10) day post-operative period following the day of the procedure. It also includes any procedure(s) assigned a zero (0), ten (10), or ninety (90) day global period performed during the ten (10) day post-operative period.
045	The forty-five (45) day global period for maternity services includes the Evaluation and Management (E&M) services on the day of the delivery and forty-five (45) days after the day of delivery. It also includes any procedure(s) assigned a zero (0), ten (10), or ninety (90) day global period performed during the forty-five (45) day post-delivery period.
090	The ninety (90) day global period assigned to major procedures includes the Evaluation and Management (E&M) services on the day prior to or the day of the procedure during the ninety (90) day post-operative period following the day of the procedure. It also includes any procedure(s) assigned a zero (0), ten (10), or ninety (90) day global period performed during the ninety (90) day post-operative period.
999	The global concept does not apply to this code.

To identify the assigned value for each code, see the Mississippi Medicaid Global Surgical Period code list located at www.medicaid.ms.gov. You can verify the coverage of the CPT/HCPCS codes at www.ms-medicaid.com.

Global Surgical Modifiers

Evaluation and Management Modifiers	Description
24	Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period. Append only to evaluation and management codes.

Evaluation and Management Modifiers	Description
25	Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service. Append only to evaluation and management codes.
57	An evaluation and management service that resulted in the initial decision for surgery. Append only to evaluation and management codes on claims with 90 day major surgery codes.

Procedure or Service Modifiers	Description
58	Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period. Append only to procedure or service codes.
78	Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period. Append only to procedure or service codes.
79	Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period. Append only to procedure or service codes.

The forty-five (45) day global period for uncomplicated maternity services includes the Evaluation and Management (E&M) services on the day of the delivery and forty-five (45) days after the day of delivery.

Medical complications of pregnancy including, but not limited to, cardiovascular problems, neurological complications, pulmonary complications, gastrointestinal complications, complications related to diabetes, thromboembolic phenomena and/or hypertension, including preeclampsia, toxemia or eclampsia, may be reported separately and must be billed with an appropriate modifier.

Surgical complications post-delivery, including, but not limited to, post-partum hemorrhage,

management of a post-partum hematoma, management of episiotomy or wound breakdown and/or genitourinary fistulae may be reported separately and must be billed with an appropriate modifier.

Example: *Modifier 24*

Patient has treatment for a heel fracture. This surgical procedure has 90 global days. The patient sees the same physician 30 days later with a sprained ankle; usage of the 24 modifier on the visit would be appropriate since the sprained ankle is not related to the heel fracture.

Example: *Modifier 25*

Patient's office visit is for sore throat. During the examination, the patient complains of shoulder pain. Due to severe arthritis, the physician injects the joint (minor procedure); the 25 modifier could be added to the visit.

Example: *Modifier 57 - Major surgery = 90-day global.*

Patient presents with severe lower leg pain. It is decided during the examination the patient needs immediate major surgery today to remove arterial blood clot. The physician can bill for an E&M service and the major surgery.

Example: *Modifier 58*

Patient presents with large sacral ulcer. Debridement of the ulcer is performed. At the time of the debridement the surgeon plans to treat the ulcer with a skin graft at a later date. During the post-operative period, the surgeon performs a graft procedure to treat the ulcer site. This would be an appropriate use of modifier 58.

Example: *Modifier 78*

Patient has open-heart surgery. Two days later, patient returns to the operating room due to complications. This would be an appropriate use of modifier 78.

Example: *Modifier 79*

Patient has vaginal delivery of infant. The same or next day the delivering physician performs a tubal ligation. This would be an appropriate use of modifier 58 for same day surgery or modifier 79 for surgery any day during the post-delivery period.

Split Global Surgical Package Edit

A split global surgical package period is when the surgical care and the post-operative management are performed by different physicians and/or qualified health care professionals through an agreement

The agreement for the transfer of care must be in the form of a letter, discharge summary, chart notation or other written documentation and retained in each physician's beneficiary medical record. Each portion of the Global Surgical Package must be appropriately designated on the claim as follows:

Modifier 54 - The surgical care portion of the Global Surgical Package is calculated at eighty-five percent (85%) of the Medicaid allowable. No separate benefits are allowed for pre-operative management as it is inclusive in the allowance for the surgical care.

Modifier 55 - The post-operative management portion of the Global Surgical Package is calculated at fifteen percent (15%) of the Medicaid allowable.

Section I. General Billing Information

This section contains contact information, to include telephone numbers, mailing addresses, and website addresses, which will provide a point of contact for almost any question that requires a response, and it provides a quick reference for essential billing information.

The information provided is not an all inclusive policy discussion. More detailed policy information is provided in the Mississippi Medicaid Provider Policy Manual.

1.1 Mississippi Division of Medicaid

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to needy citizens. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

The Mississippi Division of Medicaid (DOM) can be contacted through the internet, by telephone, or by written correspondence. Providers may use the telephone numbers provided below to reach the DOM offices during business hours. The DOM web site at http:/ / www.medicaid.ms.gov provides valuable and current information, such as provider fee schedules, provider billing manuals, policy manuals, and provider bulletins.

DOM Mailing Address
Division of Medicaid
Walter Sillers Building, Suite 1000 550 High Street Jackson, Mississippi 39201

DOM Frequently Called Telephone Numbers	
Division of Medicaid	601-359-6050 or 1-800-421-2408
Maternal & Child Health Bureau (MS Cool Kids EPSDT Services)	601-359-6150
Provider & Beneficiary Relations Bureau	601-359-6133
Recovery Bureau	601-359-6095

1.10 Eligibility

Anyone receiving covered services should have a Medicaid identification card at the time of service. If the beneficiary cannot present an ID card at the time of service, eligibility can be determined through use of either of the following services:

- Automated Voice Response System (AVRS) at 1-866-597-2675
- Provider/ Beneficiary Services Call Center at 1-800-884-3222
- Envision web portal at https:/ / msmedicaid.acs-inc.com
- MEVS transaction using personal computer (PC) software or point of service (POS) swipe card verification device provided by switch vendors.

Eligibility should be verified each time a service is provided whether or not the beneficiary is able to present an ID card.

Medicaid Eligibility Verification Services

Medicaid Eligibility Verification Services (MEVS) transactions may be submitted using PC software or POS devices provided by MEVS switch vendors. When using a POS device the Medicaid card can be swiped through the terminal's card reader slot, or the beneficiary's access information can be entered by hand. This option is not available when using PC software or automated voice response. Various switch vendors offer differing methods for gaining access to the eligibility system. They communicate with the Envision claims processing system to obtain detailed beneficiary eligibility and coverage information. MEVS information is available 24 hours a day, seven days per week. There is a charge for each transaction and rates depend on the MEVS switch vendor selected. Vendors authorized for MEVS services are shown below.

VENDOR	CONTACT INFORMATION
Envoy Corporation	**1-800-366-5716**
Healthcare Data Exchange Corporation	**1-610-219-1784**
Medifax/The Potomac Group Inc.	**1-800-444-4336**
National Data Corporation	**1-800-218-1500**

Mississippi Medicaid Benefits and Categories of Eligibility (COE)

Whether verifying eligibility of beneficiaries through the web portal, the AVRS, the call center or through a MEVS transaction, the chart listed below is for assistance in determining what benefits and exclusions apply to the category of eligibility for which the beneficiary is deemed eligible for Medicaid services.

COE	COE DESCRIPTION	BENEFITS	EXCLUSIONS
001	SSI Individual via SDX	Full Medicaid Benefits	
002	SSI Retro Eligibility	Full Medicaid Benefits	
003	IV-E Foster Care/ Adoption Assistance Related	Full Medicaid Benefits	
005	SSI in Institution	Full Medicaid Benefits	
006	Protected SSI Child	Full Medicaid Benefits	
007	Protected Foster Care Child	Full Medicaid Benefits	
010	Nursing Home, under 300% FPL	Full Medicaid Benefits	
011	Long Term Hospital, under 300%	Full Medicaid Benefits	
012	Swing Bed, under 300% FPL	Full Medicaid Benefits	
013	NH, Eligible at Home	Full Medicaid Benefits	
014	Long Term Hospital, SSI Eligible at Home	Full Medicaid Benefits	
015	Swing Bed, SSI Eligible at Home	Full Medicaid Benefits	
019	Disabled Child at Home	Full Medicaid Benefits	
020	Emergency SSI Limitations Case	Full Medicaid Benefits	
021	Emergency Immigrant	Medicaid Benefits for Date of Service Only	All dates other than Date of Service
025	Working Disabled	Full Medicaid Benefits	
026	CWS Foster Care/ Adoption Assistance Child	Full Medicaid Benefits	
029	Family Planning	Limited Medicaid; Family Planning Benefits Only	All other benefits
031	Qualified Medicare Beneficiary (QMB)	Medicaid payment of Medicare Parts A and B • Premiums • Deductibles • Coinsurance	All other benefits
035	Qualified Working Disabled Individual (QWDI)	Medicaid payment of Medicare Parts A • Premium	Non-covered Medicare Services non-emergency transportation
045	Healthier MS Waiver Only (No Medicare)	Limited Medicaid Benefits - includes NET service	Long term care, hospice, dental, eyeglasses, podiatry, chiropractic, therapy at free-standing clinic

COE	COE DESCRIPTION	BENEFITS	EXCLUSIONS
051	Specified Low-Income Medicare (SLMB)	Medicaid payment of Medicare Part B Premium	All other Medicaid Benefits
054	Qualified Individual (QI-1)	Medicaid payment of Medicare Part B Premium	All other Medicaid Benefits
062	HCBS Assisted Living Waiver	Full Medicaid Benefits	
063	HCBS Elderly/ Disabled Waiver	Full Medicaid Benefits	
064	HCBS ID/ DD Waiver	Full Medicaid Benefits	
065	HCBS Independent Living Waiver	Full Medicaid Benefits	
066	TBI/ SCI Waiver (Traumatic Brain Injury/ Spinal Cord Injury)	Full Medicaid Benefits	
067	SED Waiver/ MYPAC	Full Medicaid Benefits	Mental Health benefits are only available through a MYPAC provider.
085	Medical Assistance – Intact Family	Full Medicaid Benefits	
087	Children up to Age 6	Full Medicaid Benefits	
088	Pregnant Women and children under Age 1, under 185% FPL	Full Medicaid Benefits, Except beneficiaries Age 21 and older	Eyeglasses & Dental for beneficiaries Age 21 and older
090	1973 Grandfathered Case	Full Medicaid Benefits	
091	Child Under Age 19, under 100%	Full Medicaid Benefits	
093	Cost of Living	Full Medicaid Benefits	
094	Disabled Adult Child-DAC	Full Medicaid Benefits	
095	Widow(er) 60+yrs	Full Medicaid Benefits	
096	Widow(er) 50+yrs	Full Medicaid Benefits	
099	Children Health Insurance Program (CHIP), under 200% FPL	No Medicaid Benefits, Administered by BC/ BS 1-877-870-3110	All
999	Converted record only-not enough information		
KK	K-Baby – Newborns, under 1yr old	Full Medicaid Benefits To 1 yr Birthday	No Benefits after 1yr Birthday

***If Medicare-eligible with full Medicaid benefits:** Pharmacy coverage is thru Medicare Part D. Medicaid only covers Medicare excluded drugs.

Medicaid Eligibility for Non-Qualified Immigrants - Emergency Medical Services Only

The Division of Medicaid must provide coverage to immigrants that are not otherwise eligible for Medicaid due to their immigration status. An immigrant who is undocumented or in the U.S. only on a temporary basis or one who cannot qualify under Medicaid's statutory categories of "qualified" aliens can be covered under the following circumstances:

A. **The immigrant must be otherwise eligible for Medicaid**, meaning the immigrant fits into a covered category of eligibility that is limited to:

- Children under age 19, or
- Pregnant women, or
- Low income adults (mother or father) with dependent children under age 18, or
- Disabled individuals (of any age), or
- Aged individuals (age 65 and over).

Immigrants that do not fit into any of the 5 broad categories described above **cannot** qualify for emergency medical services under Medicaid.

B. **An "emergency" medical condition must exist.** An emergency is defined as a medical condition, after sudden onset, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient's health in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunctions of any bodily organ or part.

The above definition does not include care and services related to either an organ transplant procedure or routine prenatal or post-partum care. An emergency medical condition does include labor and delivery.

C. **The time limit for filing an application for coverage is the same as any Medicaid application**. The applicant must file for the service in a timely manner because Medicaid can only certify eligibility for up to 3 months prior to the application. For example: If the emergency service occurred in June, application for coverage of the service through Medicaid must be filed by the end of September for the June emergency to be covered.

Immigrants that can qualify for emergency medical services should be directed to **apply for coverage of the emergency condition**, which is usually limited to one day of service coverage, at the **Medicaid Regional Office that serves the county where the immigrant resides.**

Retroactive Eligibility

If an individual meets certain financial and need requirements before applying for Medicaid, eligibility for Medicaid is possible during all or part of a **three month period before the date of the application**. This period is called **retroactive eligibility**.

When a beneficiary has paid a provider for a service for which the beneficiary would be entitled to have payment made under Medicaid, the provider has the option to refund the payment to the beneficiary and bill Medicaid for the service if the beneficiary furnishes valid eligibility identification (a valid Medicaid identification card for the dates of services provided) during the timely filing requirements (discussed in Section 1.12).

Some services provided during the period of retroactive eligibility are special services that require prior authorization. The services cannot be denied because of failure to secure such prior authorization, but the authorization must be obtained before payment can be made.

1.11 Newborns/Infants with Medicaid

Medicaid Eligibility and ID Numbers

A newborn whose mother is a Medicaid beneficiary is eligible for Medicaid for the first year of life. This includes infants born to immigrant mothers who are eligible only for emergency labor and delivery services. A newborn released for adoption is not automatically entitled to the one-year period of eligibility. The adoptive parent(s) may apply for Medicaid for the newborn at the Medicaid Regional Office that serves the county of residence of the parent(s).

In order to get a Medicaid ID number assigned for the baby as quickly as possible, the birthing hospital must complete the Request for Newborn Health Information Form and fax it to the Medicaid Regional Office in the mother's county of residence. The form should be faxed as soon as possible, no later than the mother's discharge from the hospital. The policy and form regarding these procedures are found in the Medicaid Provider Policy Manual, Section 25.08. If you have questions about the process for getting a Medicaid ID for a newborn, contact the fiscal agent's Provider and Beneficiary Services Call Center at 1-800-884-3222.

It is important for the birthing hospital to complete the Request for Newborn Health Information Form as soon as possible in order to bill for the hospital's services. The birthing hospital billing staff must have the baby's own Medicaid ID number in order to bill claims, and the birthing hospital should provide the baby's Medicaid ID number to any hospital to which the baby may have been transferred. All provider claims should be billed with the baby's own Medicaid ID number in order to ensure efficient claims processing, including hospital, physician, pharmacy, and any other provider claims.

In situations when the infant is less than one (1) year of age, lives with the mother who was a Medicaid eligible at the time of his/ her birth, and does not have his/ her own Medicaid ID number, claims may be billed with the baby's name, birth date, sex and the mother's Medicaid ID number with the "K" suffix added. THIS OPTION SHOULD ONLY BE USED AS A LAST RESORT. It is important for claims to be billed with the baby's own Medicaid ID number in order to ensure accurate claims processing; delayed payment or possible denials may result when billing the mother's Medicaid ID number with a "K".

Billing for Newborn Hospital Stays and Inpatient Services

Normal well-baby services provided in the hospital should be included on the mother's hospital claim for labor, delivery, and immediate postpartum services. Normal well-baby services provided in the hospital will not be reimbursed separately from the mother's hospital claim. Physician services provided to the normal newborn should be billed with the baby's own Medicaid ID number with appropriate CPT codes and modifier TH on each procedure code billed.

If a newborn requires hospitalization beyond the mother's hospital stay, usually three (3) days for a vaginal delivery and five (5) days for a Cesarean delivery, the hospital must obtain a Treatment

Authorization Number (TAN) from the Utilization Management/ Quality Improvement Organization (UM/ QIO) for the sick baby's hospital stay. The hospital must provide the baby's name and Medicaid ID number to the UM/ QIO in order to obtain a TAN; "Baby Boy" or "Baby Girl" is not acceptable for the baby's name. The UM/ QIO will not release the TAN to the hospital until the baby's own Medicaid ID number is provided; the TAN will not be issued with the mother's Medicaid ID number and the "K" suffix. Upon receipt of the newborn's own Medicaid ID number, it is the hospital's responsibility to provide that number to the UM/ QIO. Once the UM/ QIO receives the newborn's Medicaid ID number, the TAN will be released to the hospital and the fiscal agent, and the hospital can then submit their claim(s). On at least a bi-weekly basis, the UM/ QIO will send a list to hospitals informing them that a review or certification has occurred and that the newborn's Medicaid ID number is needed so that TAN information can be transmitted to the fiscal agent.

Newborns and Medicare

Medicaid does not reimburse separate hospital claim(s) for normal well-baby hospital services if the mother has Medicare Part A. Claims for the delivery and care of the mother and for the newborn must be billed to Medicare on the mother's hospital claim. Medicaid will reimburse for any Medicare coinsurance and deductible on a crossover claim in accordance with Medicaid policy for crossover claims payment.

1.12 Timely Filing

Claims for covered services must be filed within 12 months from the through/ ending date of service. Providers are encouraged to submit their claims as soon as possible after the dates of service.

The following are reasons allowing consideration for overriding the timely filing edit:

- Claims filed within 12 months 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. Corrected claims must be submitted no later than two years from the initial date of service. The appropriate field for each corresponding claim form is shown in the table below.

FORM	FIELD
CMS-1500	Field 22
UB-04	Field 64
ADA DENTAL	Field 35
CROSSOVER A	None
CROSSOVER B	None

- Claims over 12 months old can be processed if the beneficiary's Medicaid eligibility has been approved retroactively by the Division of Medicaid or the Social Security Administration through their application processes. When Medicaid is the primary coverage, claims can be filed as a hardcopy or electronically since proof of retroactive determination is no longer required.

- The 12-month filing limitation for newly enrolled providers begins with the date of issuance of the provider eligibility letter.

- Medicare crossover claims for coinsurance and/ or deductible must be filed with the Division of Medicaid within 180 days of the date of service.

- The 180-day filing limitation for Medicare/ Medicaid crossover claims will be determined using the Medicare payment register date as the date of receipt by Medicaid. Claims filed after the 180-day timely filing limitation will be denied. Claims over 180 days old can be processed if the beneficiary's Medicaid eligibility is retroactive. Paper crossover claims must be filed and processed within 180 days of the Medicaid retroactive eligibility determination date.

1.13 Fee Schedules

DOM provides a library of materials available for download and viewing. The intent of the Medicaid Provider Fee Schedule is to furnish the Medicaid provider with information about covered procedure codes, maximum fees allowed, prior authorization requirements for select services, and maximum service limits/ units.

Some Mississippi Medicaid fee schedules are available for download from the Internet on the DOM web site at http:/ / www.medicaid.ms.gov or at the website of the fiscal agent https:/ / msmedicaid.acs-inc.com.

1.14 Denied Claims

The most useful tool in troubleshooting denied claims is the Remittance Advice (RA) section. The last page of the RA contains a legend that provides a descriptive list of edit codes necessary for interpreting denied claims. Be reminded that edit codes may change as needed. For a complete listing of the current denial edits, visit the DOM website http:// www.medicaid.ms.gov at the Providers link and select News for Providers link. To aid in reducing the number of denied claims, providers should always:

- Verify beneficiary eligibility and service limits.
- Use correct Medicaid ID number (not a social security number or Medicare HIC number) that corresponds with the beneficiary name as listed in the Medicaid system.
- Bill with accurate coding (i.e. ICD-9, CPT, diagnosis, revenue, modifiers, units, status, etc.).
- File claims within appropriate time limits.

If a problem with a prior authorization (PA) or treatment authorization number (TAN) has caused your claim to deny, please follow these steps:

- Verify that the PA or TAN covers the dates of service billed and covers the procedure code(s) billed.
- If the PA or TAN covers the dates and procedures billed, verify with the fiscal agent that the PA or TAN has been added to the master Medicaid file. If the PA or TAN is on file, then resubmit the claims.
- If the PA or TAN is not on file, then the fiscal agent will advise on the further action required.

There may be an occasion when the fiscal agent staff may refer the provider to the Utilization Management/ Quality Improvement Organization (UM/ QIO) or to the appropriate bureau at the Division of Medicaid for additional information. If this occurs, please follow the instructions provided.

Not complying with the above mentioned requirements could cause your claim to deny. If you have questions concerning an edit received on a denied claim, contact the fiscal agent's Provider and Beneficiary Services Call Center at 1-800-884-3222.

****Special Note** Please remember denied claims cannot be voided or adjusted.**

1.2 Fiscal Agent

The Mississippi Division of Medicaid (DOM) presently works in conjunction with a fiscal agent to provide accurate and efficient claims processing and payment. In addition, both organizations work together to offer provider and beneficiary support to meet the needs of the Mississippi Medicaid community. The fiscal agent consists of technical and program staff. Technical staff maintains the claims processing operating system, and program staff assists with the actual processing of claims, payment, and customer service. Other functions include drug rebate analysis and utilization review.

The DOM and the fiscal agent have several systems in place to make contacting our offices easier for the provider. Having several different systems in place for providers to obtain needed information should decrease the time and effort required by providers to complete forms and requirements correctly and completely.

Telephone Contact

The fiscal agent provides telephone access to providers as shown below. These services include lines for provider inquiries, automated eligibility verification, and assistance with electronic claim submittal. Our call center is open Monday through Friday, 8 am-5 pm CST. The website includes a listing with the name and telephone number of the provider representative assigned to your specific area.

Fiscal Agent	Telephone Numbers
Provider/Beneficiary Services	**1-800-884-3222 or 601-206-3000**
Provider/Beneficiary Services Fax Number	**601-206-3015**
Automated Voice Response System(AVRS)	**1-800-884-3222 or 1-866-597-2675**
Electronic Data Interchange (EDI)	**1-800-884-3222**
Prescription Benefits Management (PBM)	**1-800-884-3222 or 601-206-3000**
Translation Service	**1-800-822-5552, Access Code 8166**

Mailing Contact Information

Providers may contact the fiscal agent via the mail at the addresses listed below. These post office boxes should be used for claim submittals, adjustment and void requests, provider and beneficiary services, and administrative correspondence. A financial mailbox is available for mail containing checks. Please send correspondences to the appropriate post office box. This will lessen the chance for errors and shorten the time required to complete your transactions.

Fiscal Agent	Mailing Addresses
All Claims	**P. O. Box 23076, Jackson, MS 39225**
Adjustment /Void Requests	**P. O. Box 23077, Jackson, MS 39225**
Provider/Beneficiary Services	**P. O. Box 23078, Jackson, MS 39225**
Administrative Mail	**P. O. Box 23080, Jackson, MS 39225**
Financial Correspondence (mail with checks)	**P. O. Box 6014, Ridgeland, MS 39158-6014**
Prescription Benefits Management	**P. O. Box 23076, Jackson, MS 39225**

Web Site Information

The Mississippi web portal provides Medicaid-related information to providers and the interested public. Information can be accessed through the Mississippi Medicaid web portal at https://msmedicaid.acs-inc.com. The web portal provides another alternative to using the Provider and Beneficiary Call Center or the Automated Voice Response System (AVRS). It is available free of charge, 24 hours a day, 7 days a week, 365 days a year.

For Health Care Providers

The web portal has two areas that can be accessed from the initial home page. One area is non-secure and allows access to the general public without registration. No confidential provider- or patient-related data is disclosed on the portal's public pages. The second area is a secure one that requires registration and provides additional functionality that is associated with the Call Center and the AVRS. Details on how to enroll can be found on the home page under the link titled Web Registration. The main page of the web portal has links to the Division of Medicaid (DOM), HealthSystems of Mississippi (HSM), and Health Information Designs (HID) websites.

The secure area of the web portal is available to providers with a login and password. Providers will have access to the secure features of the web portal with greater enhancements, such as direct data entry and adjudication of claims. Through the claim inquiry feature, providers are able to access claims status information and reason for denial of a claim. Additionally the web portal offers provider type FAQs, access to training materials, provider bulletins, fee schedules, and enrollment options. Providers are able to submit prior authorization requests and report insurance changes to the third party liability (TPL) beneficiary file via the web portal. When providers check beneficiary eligibility through either the Automated Voice Response System (AVRS) or through the Mississippi Envision web portal, they are able to obtain a more detailed response tailored specifically to the beneficiary's Category of Eligibility (COE). A brief description of the COE for the beneficiary and their Medicaid benefits and/or exclusions is provided. Be advised that the web portal is a mechanism for providers to check eligibility prior to treatment; however, the successful verification is not a guarantee of payment.

1.3 Electronic Data Interchange

Mississippi Medicaid strongly encourages providers to use the fiscal agent's Electronic Data Interchange (EDI) environment, which is a free service. The EDI Gateway Division offers a variety of options for Mississippi Medicaid providers.

Electronic Claim Submission. The fiscal agent offers a variety of options including data entry software as well as connectivity for vendor software, billing agents, and clearinghouses submitting the ANSI X12N format.

Reject and Electronic Remittance Advice (ERA) Retrieval. The fiscal agent offers electronic Reject notification and ERA retrieval.

Web Site dedicated to EDI. The EDI web site, which offers valuable information on the submission of electronic claims, including claims submission software, is available at www.acs-gcro.com. This site has a page dedicated to Mississippi Medicaid that offers EDI Enrollment forms, agreements, companion guides and software downloads.

The fiscal agent's EDI Support Unit is available to assist with any EDI questions by calling 1-800-884-3222, Monday through Friday, 7:00 AM – 5:00 PM EST.

Important Website Addresses
Mississippi Envision web portal – https:/ / msmedicaid.acs-inc.com DOM website – http://www.medicaid.ms.gov ACS EDI website – www.acs-gcro.com

1.4 HealthSystems of Mississippi

The Division of Medicaid has contracted with HealthSystems of Mississippi (HSM) to serve as the Utilization Management/Quality Improvement Organization (UM/QIO) for the State of Mississippi. The purpose of the UM/QIO is to evaluate medical necessity for the Medicaid services listed below.

The UM/QIO provides pre-certification and concurrent review for:

- Inpatient Medical/Surgical
- Acute Psychiatric
- Swing Bed
- Psychiatric Residential Treatment Facilities
- Private Duty Nursing
- Home Health Visits beginning with visit 26 for beneficiaries under age 21
- Durable Medical Equipment, Prosthetics, Orthotics, and Diapers/Underpads **(Other Medical Supplies Are Excluded)**
- Outpatient Hospital Mental Health Services
- Outpatient Physical, Occupational, and Speech Therapy
- Transplant Services
- Mississippi Youth Programs Around the Clock Waiver (MYPAC)

For each of the type reviews listed above, the UM/QIO conducts quality review in all established review settings and offers due process for any confirmed quality issues. In addition, the scope of work for the UM/QIO includes medical necessity reviews for transplants and management of the maternity reporting requirements.

HealthSystems of Mississippi may be contacted through the internet, by telephone, or by written correspondence. Telephone lines are staffed from 8:00 a.m. to 5:00 p.m., Monday through Friday, except holidays. The Inpatient and Swing-bed telephone lines have extended staffing hours from 7:00 a.m. to 5:30 p.m. Providers may use the contact information below to reach the office during regular business hours.

GENERAL CONTACT INFORMATION

HSM Address
175 E. Capitol Street Suite 250, Lockbox 13 Jackson, MS 39201
Telephone and FAX Numbers
Telephone: (601) 352-6353 Facsimile: (601) 352-6358
Website Address
www.hsom.org

CERTIFICATION CONTACT INFORMATION

Certifications may be submitted using the following contact information:

Type of Certification	Fax Number	Phone Number	Web Address
Inpatient Hospital	1-888-204-0504	1-888-204-0502	www.hsom.org
Swing-bed	1-888-204-0504	1-888-204-0502	
Psychiatric Residential Treatment	1-888-204-0504		
Private Duty Nursing	1-888-204-0504		
Home Health	1-888-204-0377		www.hsom.org
Durable Medical Equipment	1-888-204-0159		
Outpatient Therapy	1-888-557-1920		
Acute Psychiatric Inpatient Care	1-888-204-0504	1-888-204-0502	www.hsom.org
Transplant Services	1-888-204-0504	1-888-204-0502	www.hsom.org

HELPLINE AND HOTLINE TELEPHONE NUMBERS

Type of Line	Purpose	Phone Number
Helpline	Provide assistance to providers	Local - (601) 360-4949 Toll Free - 1-866-740-2221
Hotline	Report quality concerns	1-888-204-0221

1.5 Health Information Designs

The Mississippi Division of Medicaid requires prior authorization for reimbursement of pharmacy claims under certain circumstances. The prior authorization process is designed to encourage appropriate use of cost-effective pharmaceuticals for Medicaid beneficiaries.

DOM contracts with Health Information Designs, Inc. (HID) to provide prior authorization services. HID operates a call center in the Jackson area, and employs a clinical staff of pharmacists and nurses to review and process prior authorization requests from Mississippi Medicaid providers.

HID's website, www.hidmsmedicaid.com, provides access to prior authorization criteria and forms, as well as the current Mississippi Medicaid preferred drug list (PDL).

Health Information Designs may be contacted through the internet, by telephone, or by written correspondence. Telephone lines are staffed from 8:00 a.m. to 6:00 p.m., Monday through Friday, except holidays. Providers may use the contact information below to reach the office during regular business hours.

GENERAL CONTACT INFORMATION

HID Mailing Address
Health Information Designs, Inc. P. O. Box 320506 Flowood, MS 39232
Telephone and FAX Numbers
Telephone: 1-800-355-0486 Facsimile: 1-800-459-2135
Website Address
www.hidmsmedicaid.com
Email Address
pa_ms@hdinfo.com

1.6 DOM Prior Authorization

Prior authorizations (PAs) can also be obtained from select bureaus within the Division of Medicaid. These program areas verify medical necessity for a particular procedure or service, prior to the delivery of that procedure or service. They conduct reviews and make determinations. The table below provides the DOM program area contact information, special requirements that are applicable to that service, the appropriate paper form for submitting the request, and reference to the relevant sections in the Provider Policy Manual pertaining to that service. Instructions for completing the forms are also provided in the Provider Policy Manual under the appropriate section.

Prior to submitting ANY prior authorization request, the provider of service must verify the beneficiary's eligibility. Be aware that the submission of a prior authorization (PA) is not a guarantee of Medicaid coverage or DOM's approval. All requests for authorization must be reviewed and approved by the appropriate bureau **before** the procedure/service is performed.

A Medicaid provider may request prior authorization for services/procedures through the web portal or by submitting the appropriate form(s), plus supporting documentation to the Bureau. Submitting prior authorization requests via the web portal is preferred. Forms for paper submissions are available through the fiscal agent by calling 1-800-884-3222.

Once the form(s), along with any supporting documentation, are completed, they must be submitted, to the responsible bureau. The form(s) will be reviewed and a determination made by DOM or DOM consultant. For paper prior authorization, a copy of the form(s), with the determination noted and a Medicaid-authorized signature affixed, will be returned to the provider. Providers utilizing web portal prior authorization will receive a weekly report giving the status (approved/denied) via the web portal through the manage messages inbox. Providers may also use the PA Inquiry function on the web portal to check the status of a prior authorization request at any time.

It is the provider's responsibility to secure authorization from DOM before providing any service which requires PA. In case of an emergent situation, the provider should fax a copy of the request form to the appropriate DOM fax number. Tentative approval for service delivery may be granted depending on the circumstances, but the final approval upon which reimbursement depends cannot be given until the original copy of the PA request is received. Providers may also enter PA requests via the web portal and notify the appropriate bureau at the Division of Medicaid immediately after submission of the PA of the emergent situation for more prompt response to the PA request.

If additional information is needed, it is the provider's responsibility to resubmit the PA request, along with the requested information. It is possible for a request to be only partially approved. In the case of partial approval, the approval or denial will be clearly stated on the form. Please note that there may be specific working days/timeframes for information to be received or the PA request will be denied. Providers must send an invoice along with the PA request when billing codes that require manual pricing. The invoices must be itemized. Refer to the Mississippi Medicaid Provider Policy Manual if there are questions regarding the service or procedure that may require additional information.

Contact Information for Issuance of Division of Medicaid Prior Authorizations

DOM SERVICE	Responsible Bureau Telephone Number FAX Number	Requirements/ Special Instructions	Paper Prior Authorization Form Number(s)	DOM Policy Manual Section
Mental Health Services	Mental Health 601-359-9545 601-576-4163 (FAX)	Limited to beneficiaries under 21 years of age Approved evaluations have a three-month authorization	MA-1148 MA-1148A	See Section 21.16 for complete details
Dental Services	Medical Services 601-359-5683 601-359-5252 (FAX)	The items listed must be included with orthodontics PA request: •Diagnostic models •Radiographs (cephalogram, phanorex, or full mouth) •Photos •Treatment Plan •Letter from dentist. Prior Authorization is only valid for 180 days based on beneficiary eligibility.	MA-1097 (orthodontics) MA-1098 (all other dental services)	See Section 11 for complete details
Vision	Medical Services 601-359-5683 601-359-5252 (FAX)	An itemized invoice must be included for manually-priced procedure codes. Contact Lenses must meet diagnosis criteria in Medicaid policy.	DOM-210	See Section 29 for complete details

DOM SERVICE	Responsible Bureau Telephone Number FAX Number	Requirements/ Special Instructions	Paper Prior Authorization Form Number(s)	DOM Policy Manual Section
Air Ambulance Fixed Wing Transports	Medical Services 601-359-5683 601-359-5252 (FAX)	The prior authorization (PA) must be requested by telephone or fax; there is no electronic PA process. If PA request is received on a holiday or weekend and provider chooses to transport, a retrospective review will be conducted.	Request for Urgent Air Ambulance Approval	See Section 8.04 for complete details
Mississippi Cool Kids (Expanded EPSDT Services)	Maternal Child Health 601-359-6150 601-359-6147 (FAX)	Limited to beneficiaries under 21 years of age	MA-1148 MA-1148A	See Section 73.09 for complete details
Hearing Services	Medical Services 601-359-5683 601-359-5252 (FAX)	Limited to beneficiaries under 21 years of age The following must be included with PA request: •Invoices for manually-priced procedure codes and miscellaneous procedure codes •Documentation that explains the need for repair/modification	DOM-210	See Section 30 for complete details

1.7 National Provider Identifier (NPI)

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans will use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty.

If you are a health care provider who bills for services, you must have an NPI. Obtaining an NPI is free and easy. The first step is to get your NPI. **If you delay applying for your NPI, you risk your cash flow and that of your health care partners as well. Your Medicaid claims will deny if your NPI is not on file with Medicaid.**

You may obtain your NPI through the National Plan and Provider Enumeration System (NPPES) as listed below:

By Telephone
1-800-465-3203 (NPI Toll-Free) 1-800-692-2326 (NPI TTY)
By E-mail
customerservice@npienumerator.com
By Mail
NPI Enumerator PO Box 6059 Fargo, ND 58108-6059

Once you obtain your NPI from NPPES, report it to Mississippi Medicaid/ACS. Prepare a facsimile cover page and include the following information in transmitting your NPI information to the ACS Provider Enrollment fax number, 601-206-3015:

1. Provider Name
2. The name of a representative in your organization to be contacted
3. A direct telephone number
4. A fax number
5. An email address
6. NPI – Please indicate whether the NPI is for an individual, group, or facility
7. 8-digit MS Medicaid provider number that corresponds to the NPI listed
8. A servicing address which corresponds to the NPI and 8-digit Medicaid provider number
9. A copy of the NPI CMS certification form

You may also use the NPI Submission Form to submit your NPI to Mississippi Medicaid. The form is located at https://msmedicaid.acs-inc.com/NPI%20Submission%20Form.pdf . It is recommended that you print the completed form and fax it, along with the NPI Certification Form, to ACS Provider Enrollment at 601-206-3015. If the NPI Certification Form is not included with your NPI information, the NPI will **NOT** be entered on your Medicaid provider file and the incomplete NPI information will be returned. You may contact ACS Provider and Beneficiary Services at 1-800-884-3222 if you have additional questions or to verify your NPI has been added to your provider file.

1.8 Mississippi Division of Medicaid Benefits and Limitations

The following services are covered under the Mississippi Medicaid Program. The definition, scope, duration, and policies are located in the appropriate sections of the Provider Policy Manual. Be reminded that service limits may change, so always refer to the Policy Manual or information provided through the web portal. Where items of service are limited to a fiscal year, reference is to the annual period of July 1 through June 30. For waiver benefits, refer to the appropriate waiver section.

Benefit	Limitation	Prior Authorization
Ambulatory Surgical Center services		No
Chiropractic services	$700 maximum per fiscal year	No
Christian Science Sanatoria services		
Therapeutic and Evaluative Mental Health Services for Children	Refer to section 21.15 in the Provider Policy Manual	Yes, for evaluations or to exceed the Service standard
Community Mental Health Center (CMHC) Services	Refer to section 15.30 in the Provider Policy Manual	No
Dental services Children • Preventive • Diagnostic • Restorative • Orthodontia Adults • Emergency pain relief • Palliative care	Dental $2,500 maximum per fiscal year- adults and children; additional benefits if prior authorized Orthodontia $4,200 maximum per lifetime per child.	If applicable -See Dental Policy
Dialysis (freestanding or hospital-based) Center services		No
Durable Medical Equipment	Refer to section 10 in the Provider Policy Manual	Yes
Emergency Ambulance services	Prior authorization required for Urgent Air Ambulance (Fixed Wing) only.	Yes
EPSDT Expanded EPSDT services	Limited to beneficiaries less than 21 years of age. Prior authorization required for services not covered, or any service that exceeds service limits.	No Yes

Benefit	Limitation	Prior Authorization
Eyeglasses (Vision)	2 pair per fiscal year for children 1 pair every 5 years for adults	Yes for children after 2nd pair per FY
Family Planning services	Applies to physician office visit limit	No
Federally Qualified Health Center services	Applies to physician office visit limit	No
Health Department services	Applies to physician office visit limit	No
Hearing services	Limited to beneficiaries under 21 years of age	Yes, for hearing aids
Home Health services	25 visits per fiscal year	*Yes *After the 25th visit for beneficiaries under 21*
Hospice	Limited to a diagnosis of 6 months or less life expectancy as certified by physician.	No
Hospital services • Inpatient days • Outpatient ER visits • Swing Bed services	30 days per fiscal year 6 visits per fiscal year	Yes No Yes
ICF/ MR services	Therapeutic Leave days limited to 90 days per fiscal year	No
Inpatient psychiatric services	Limited to beneficiaries under 21 years of age	Yes
Laboratory and X-Ray services		No
Medical Supplies	Refer to section 10 in the Provider Policy Manual	*Yes *Diapers/Underpads Only*
Non-emergency transportation services	Limited to Medicaid covered services only. Excluded if services limits have been exceeded. Excluded if beneficiary has transportation resources.	Yes
Nurse Practitioner services	Applies to physician office visit limit	No
Nursing facility services	Therapeutic Leave days limited to 58 days per fiscal year.	
Orthotics & Prosthetics	Limited to beneficiaries under 21 years of age	Yes
Outpatient PT, OT, ST		Yes
Pediatric skilled nursing (Private Duty Nursing) services	Limited to beneficiaries under 21 years of age	Yes
Perinatal High Risk Management services		
Pharmacy Disease Management Services	12 visits per fiscal year	No

Benefit	Limitation	Prior Authorization
Physician Assistant services	Applies to physician office visit limit	No
Physician services • Office & ER visits • Psychiatry • Hospital inpatient visits • Long-term care visits	 12 per fiscal year 12 per fiscal year 30 per fiscal year 36 per fiscal year	 No No No No
Podiatrist services	Applies to physician office visit limit	No
Prescription drugs	5 per month with no more than 2 of the 5 being brand name drugs; beneficiaries under 21 can receive more than the monthly limits with a medical necessity PA.	Yes – for beneficiaries under 21 that require more than 5 prescriptions per month
Psychiatric Residential Treatment Facility (PRTF) services	Limited to beneficiaries under 21	Yes
Psychiatry services	12 per fiscal year; can be exceeded for beneficiaries under 21 with PA	Yes – for beneficiaries under 21 who require more than 12 visits
Rural Health Clinic services	Applies to physician office visit limit	No
Targeted Case Management services for children with special needs		

Refer to Section 1.10 in the Provider Policy Manual for information on obtaining prior authorizations from the UM/QIO.

1.9 Co-payments and Exception Codes

Certain services require a co-payment from the beneficiary. It is the provider's responsibility to collect this co-payment from the beneficiary. The co-payment will be withheld when the claim is processed. Do not reduce your submitted charge or enter the co-payment amount on the claim form. The co-payment amount will be automatically deducted on all applicable services. Services that are subject to co-payment are shown below.

Federal law prohibits the collection of co-payments in certain instances. When the beneficiary is exempt from the co-payment, one of the exception codes listed below must be indicated on the claim in the Medicaid beneficiary ID field as a suffix to the Medicaid number or the co-payment will be deducted from the claim's payment amount. To comply with federal regulations regarding co-payments, any prescription written for a pregnant woman should have a bold letter "P" on its face. This will help the pharmacist identify exempt beneficiaries.

Service	Co-pay Amount
Ambulance	$3.00 per trip
Ambulatory Surgical Center	$3.00 per visit
Dental	$3.00 per visit
Durable Medical Equipment Orthotics, Prosthetics (excludes Medical Supplies)	Up to $3.00 per item (Co-payment amounts vary, and are listed in the Provider Policy Manual – DME section)
Federally Qualified Health Centers	$3.00 per visit
Home Health	$3.00 per visit
Hospital Inpatient	$10.00 per day up to one-half the hospital's first day per diem per admission
Hospital Outpatient	$3.00 per visit
MS State Department of Health	$3.00 per visit
Physician (any setting)	$3.00 per visit
Prescription Drugs	$3.00 per prescription, including refills
Rural Health Clinic	$3.00 per visit
Vision	$3.00 per pair of eyeglasses

Groups and Services	Exception Code
Infant (newborn)	K
Children under age 18	C
Pregnant women	P
Nursing facility, ICF/ MR, and PRTF residents	N
Family planning services	F
Chemotherapy (Drug therapy for Cancer)	O
Laboratory/ Laboratory Pathology	L
Radiation Therapy	T
Emergency room services*	E
*The documentation in the medical records must justify the service as a true emergency.	

2.0 CMS-1500 Claim Form Instructions

This section explains the procedures for obtaining reimbursement for services submitted to Medicaid on the CMS-1500 billing form, and must be used in conjunction with the MS Medicaid Provider Policy Manual. The policy manual and fee schedules should be used as a reference for issues concerning policy and the specific procedures for which Medicaid reimburses. If you have questions, contact the fiscal agent's Provider and Beneficiary Services Call Center toll-free at 1-800-884-3222 for assistance.

Provider Types

The instructions for the CMS-1500 claim form are to assist the following categories of provider types:

- Ambulance
- Ambulatory Surgical Centers
- Certified Registered Nurse Anesthetists
- Chiropractic Care
- Community Mental Health
- Durable Medical Equipment (DME)
- Federally Qualified Health Centers
- Hearing Aid Providers
- Independent Laboratory
- Independent Radiology
- Mental Health Services
- MS Cool Kids (EPSDT)/ Screening/ Diagnostic Providers
- Nurse Practitioners
- Optical/ Vision Providers
- Perinatal High Risk Management
- Pharmacy Disease Management
- Physicians
- Physician Assistants
- Podiatrists
- Private Duty Nursing
- Rural Health Clinics
- Therapy Services
- Waiver Services

Web Portal Reminder

Providers are encouraged to use the Mississippi Envision Web Portal for easy access to up-to-date information. The web portal provides rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The web portal is available 24 hours a day, 7 days a week, 365 days a year via the Internet at https://msmedicaid.acs-inc.com.

Paper Claim Reminders

Claims should be completed accurately to ensure proper claim adjudication. Remember the following:

- Complete an original CMS-1500 claim form.
- No photocopied claims will be accepted.
- Use blue or black ink.
- Be sure the information on the form is legible.
- Do not use highlighters.
- Do not use correction fluid or correction tape.
- Ensure that names, codes, numbers, etc. print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable.
- No multiple page claims may be submitted.
- The six service lines in Locator 24 have been divided horizontally to accommodate submission of supplemental information along with NPI and other identifiers such as taxonomy codes or legacy identifiers. The top, shaded portion of each service line is for reporting supplemental information (i.e., NDC code). It is **not** intended to allow the billing of twelve service lines. Each procedure, service, drug, or supply must be listed on its own claim line in the bottom, un-shaded portion of the claim line.

Paper Claims with Attachments

When submitting attachments with the CMS-1500 claim form, please follow these guidelines:

- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.
- For claims with more than one third- party payor source, include all EOBs that relate to the claim.
- For third party payments less than 20% of charges, indicate on the face of the claim, LESS THAN 20%, PROOF ATTACHED.
- For Medicare denials, indicate on the claim, MEDICARE DENIAL, SEE ATTACHED.
- For other insurance denials, indicate on the claim, TPL DENIAL, SEE ATTACHED.

Electronic CMS-1500 Claims

Electronic CMS-1500 claims may be submitted to Mississippi Medicaid by these methods:

- Using the Web Portal Claims Entry feature
- Using WINASAP (free software available from the fiscal agent)
- Using other proprietary software purchased by the provider
- Using a clearinghouse to forward claims to Mississippi Medicaid.

Electronic CMS-1500 claims must be submitted in a format that is HIPAA compliant with the ANSI X12 CMS-1500 claim standards.

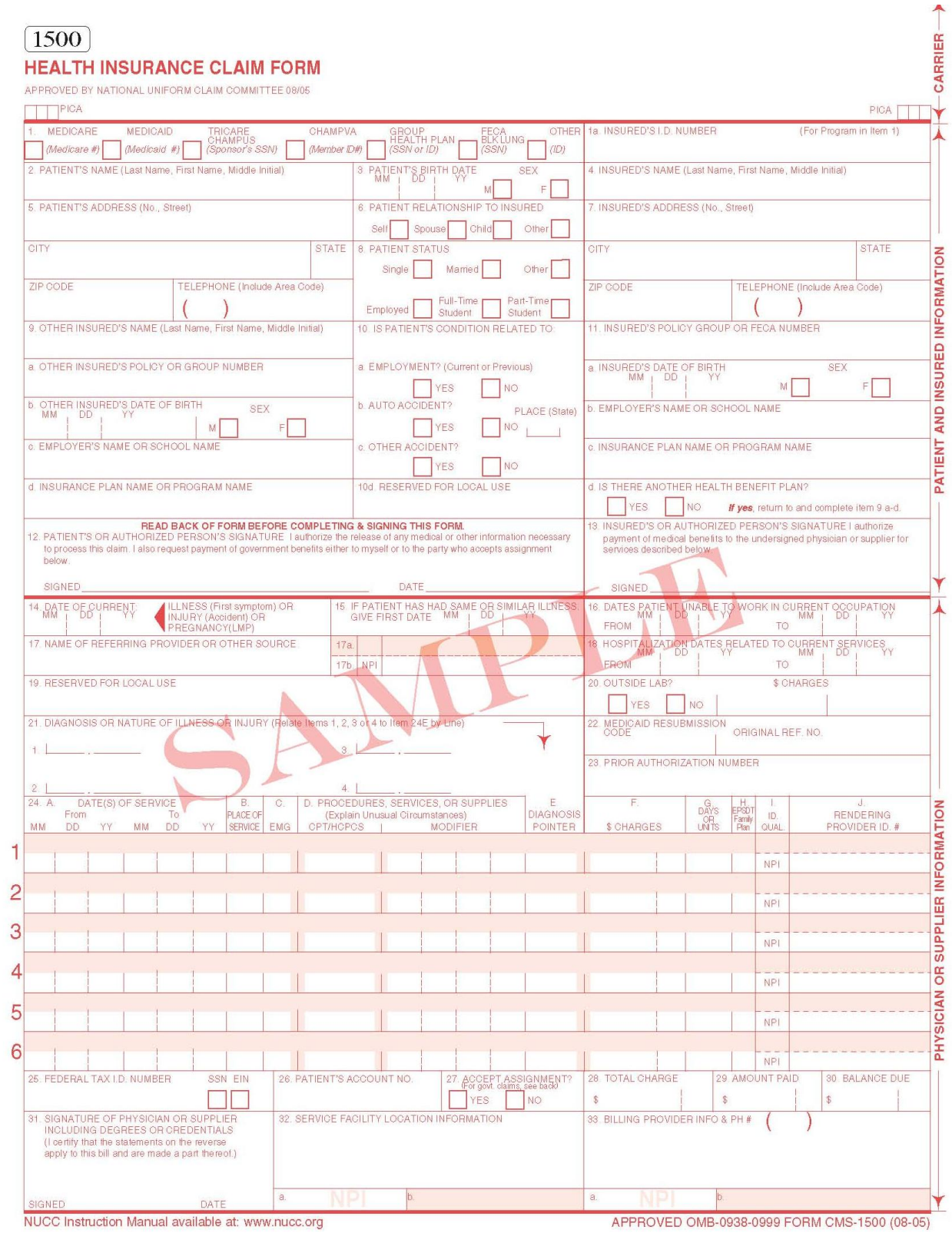
Billing Tip 

Be sure to include prior authorization number, timely filing TCN, proper procedure codes, modifiers, units, etc., to prevent your claim from denying inappropriately.

Claim Mailing Address

Once the claim form has been completed and checked for accuracy, please mail the completed claim form to:

Mississippi Medicaid Program
P. O. Box 23076
Jackson, MS 39225-3076



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1											NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

CMS-1500 Claim Form Instructions for Mississippi Medicaid

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
1	**Required**	**Medicare, Medicaid, TRICARE CHAMPUS, CHAMPVA, Group Health Plan, FECA, Black Lung, Other:** For Primary Medicaid claims, enter an X in the box marked Medicaid. For Medicare crossover claims, enter X in both the Medicare and Medicaid boxes.
1a	**Required**	**Insured's ID Number:** Enter the patient's 9-digit Beneficiary ID Number (Enrollee ID) as shown on their Medicaid card.
2	**Required**	**Patient's Name:** Enter patient's full last name, first name and middle initial (Enrollee Name) as printed on their Medicaid card. If the patient uses a last name suffix (e.g., Jr, Sr) enter it after the last name, and before the first name. Titles (e.g., Sister, Capt, Dr) and professional suffixes (e.g., PhD, MD, Esq.) should not be included with the name. Use commas to separate the last name, first name, and middle initial. A hyphen can be used for hyphenated names. Do not use periods within the name.
3	**Required**	**Patient's Birth Date, Sex:** Enter the patient's birth date in MM DD CCYY format. Enter an X in the correct box to indicate the sex of the patient.
4	Not Required	Insured's Name
5	**Required**	Patient's Address, City, State, Zip Code, Telephone
6	Not Required	Patient Relationship To Insured
7	Not Required	Insured's Address, City, State, Zip Code, Telephone
8	Not Required	Patient Status
9	**Required if Applicable**	**Other Insured's Name**
9a	**Required if Applicable**	**Other Insured's Policy Or Group Number:** If the patient has TPL, enter the policy number with their primary carrier.
9b	**Required if Applicable**	**Other Insured's Date Of Birth, Sex:** Enter the birth date of the patient in the MM/DD/CCYY format.
9c	**Required if Applicable**	**Employer's Name Or School Name**
9d	**Required if Applicable**	**Insurance Plan Name Or Program Name:** enter the name of the primary carrier.
10a–c	**Required if Applicable**	**Is Patient's Condition Related To:** If the patient's condition is a result of a work-related circumstance/occurrence, an automobile accident or other type of accident, check "YES" on the appropriate line.
10d	**Required if Applicable**	**Reserved for Local Use: If billing laboratory services, the CLIA number must be entered.**
11	**Required if Applicable**	**Insured's Policy Group or FECA Number:** If the beneficiary has two forms of TPL other than Medicaid, enter the policy number of the secondary carrier.
11a	**Required if Applicable**	**Insured's Date Of Birth, Sex:** Enter policy holder's birth date in the MM/DD/CCYY format and sex.
11b	**Required if Applicable**	**Employer's Name or School Name**
11c	**Required if Applicable**	**Insurance Plan Name or Program Name:** If the beneficiary has two forms of TPL other than Medicaid, enter the name of the beneficiary's secondary carrier.

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
11d	**Required if Applicable**	**Is There Another Health Benefit Plan?**
12	**Required if Applicable**	**Patient's or Authorized Person's Signature:** Enter Signature on File or legal signature with the date in MM/DD/YY format.
13	Not Required	Insured's or Authorized Person's Signature
14	Not Required	Date Of Current: Illness, Injury, Pregnancy
15	Not Required	If Patient has had Same or Similar Illness
16	Not Required	Dates Patient Unable to Work in Current Occupation
17	**Required if Applicable**	**Name of Referring Provider or Other Source: E**nter the name of the referring provider.
17a	**Optional**	**Other ID#:** Enter the eight-digit Mississippi Medicaid provider number of the referring provider.
17b	**Required if Applicable**	**NPI #:** Enter the NPI of the referring provider.
18	**Required if Applicable**	**Hospitalization Dates Related to Current Services:** Enter the admission/discharge dates in MM/DD/YY
19	Not Required	Reserved for Local Use
20	Not Required	Outside Lab Charges
21	**Required**	**Diagnosis or Nature of Illness or Injury:** Enter the beneficiary's ICD-9-CM Codes in priority order. Up to four diagnoses may be entered.
22	**Required if Applicable**	**Medicaid Resubmission:** Complete this field to show proof of timely filing on a resubmission of a claim twelve months past the original date of service. • In the "ORIGINAL REF. NO" area enter the first Transaction Control Number (TCN) assigned to the claim.
23	**Required if Applicable**	**Prior Authorization Number:** If you obtained authorization for an item on this claim, enter your Authorization Number in this field without hyphens, dashes, spaces, etc.  **Enter only one Authorization Number per claim form. Complete additional forms if needed.**
24A	**Required**	**Physician -Administered Drugs - NDC REQUIRED:** Enter the 11-digit NDC code in the top, shaded portion of the detail line of Locator 24 A. The corresponding HCPCS code should be entered in the bottom, un-shaded portion of Locator 24D. Other required information, including the number of units administered to the patient and the actual cost of the drug should be entered in the appropriate fields in Locator 24. **Date(s) of Service:** Enter the begin ("From") and end ("To") dates of service in the bottom, un-shaded portion of Locator 24A. Enter the date in the MM/DD/YY format. If a service was provided on one day only, enter the same date twice.
24B	**Required**	**Place of Service:** Enter the code indicating where the service was rendered. See **Figure 3-2** for place of service codes.

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
24C	**Required if Applicable**	**EMG:** Enter "P" (Positive) or "N" (Negative) in the appropriate box to indicate the PHRM/ISS Medical Risk Screening Code T1023-TH (maternal) or T1023-EP (Infant).
24D	**Required** **Required if Applicable** **Required if Applicable**	**Procedures, Services, Or Supplies CPT/HCPCS Modifier:** • **Procedure Code** – Enter the appropriate CPT-4/HCPCS code that identifies the service provided. • **Procedure Modifier** – Enter the appropriate procedure modifier that further qualifies the service provided. • **Explain Unusual Circumstances**- Attach a written description of any unusual circumstances/services.
24E	**Required**	**Diagnosis Pointer:** Enter only one diagnosis indicator (1, 2, 3, or 4) that identifies appropriate diagnosis for the procedures. These indicators should correspond to the line numbers of the diagnosis codes listed in field 21.
24F	**Required**	**Charges:** Enter your usual and customary charge for each listed service. For injections, the actual cost of the drug should be entered in this field.
24G	**Required**	**Days Or Units:** Enter the number of days or the number of units being billed per procedure.
24H	**Required if Applicable**	**EPSDT/Family Plan:** Enter an "E" if the service is a result of a MS Cool Kids (EPSDT) screening. Enter an "F" if the service is related to Family Planning.
24I	Not Required	ID Qualifier
24J	**Required if Applicable**	**Rendering Provider ID #:** Enter the rendering provider's individual 10-digit National Provider Identifier (NPI) in the bottom, un-shaded half of the claim line.
25	Not Required	**Federal Tax ID Number:**
26	**Optional**	**Patient's Account No.** Enter your internal patient account number here. The patient account number will be printed on your Remittance Advice (RA) to further identify the beneficiary.
27	Not Required	Accept Assignment
28	**Required**	**Total Charge:** Enter the total of all the line item charges. Each claim form must be totaled in this field. Do not submit claims that are continued on the second page.
29	**Required if Applicable**	**Amount Paid:** Enter the total amount paid by all other insurance carriers (other than Medicare and Medicaid).  **Entering prior payments from Medicare and/or Medicaid in this field will result in a reduced or zero payment.**
30	Not Required	Balance Due:
31	**Required**	**Signature of Physician or Supplier:** The claim form must be signed and dated by the healthcare provider or authorized representative. Original rubber stamp and automated signatures are acceptable.

Field	Requirement	Field Name and Instructions for CMS-1500 (08/05) Form
32	**Required if Applicable**	**Service Facility Location Information:** Enter the name, address, city, state, and zip code of the location where services were rendered if other than patient's home or physician's office.
32a	Not Required	NPI#
32b	Not Required	Other ID#
33	**Required**	**Billing Provider Info & Phone #:** Enter the billing provider's name, address, zip code, and telephone number as shown on your Medicaid remittance advice and provider file.  **For individual providers, enter the name in the last name, first name format. For physician billing groups, enter the group's name as it appears on the Remittance Advice (RA) or the Medicaid file.**
33a	**Required**	**NPI #:** Enter the NPI number of the billing provider if the provider is considered a health-care services provider.
33b	**Optional**	**Other ID #:**  **EXCEPTION: Required For Atypical Providers - Enter the 8-digit Medicaid provider number.** ***The 8-digit MS Medicaid provider ID may be entered for health-care services providers.***

Figure 2.1 Checklist of Required Fields for CMS-1500 Claim Form

CMS-1500 Checklist for Required Fields		Required	Required, if Applicable	Optional	Not Required
1	Health Insurance Box	✓			
1a	Insured's I.D Number	✓			
2	Patient's Name	✓			
3	Patient's Birth Date and Sex	✓			
4	Insured's Name		✓		
5	Patient's Address	✓			
6	Patient's Relationship To Insured		✓		
7	Insured's Address		✓		
8	Patient Status				✓
9	Other Insured's Name		✓		
9a	Policyholder's number		✓		
9b	Policy holder's birth date and sex		✓		
9c	Employer's/school name		✓		
9d	Insurance plan name or program name		✓		
10 a-c	Is Patient's Condition Related To Employment, Auto/Other Accident		✓		
10d	Reserved For Local Use		✓		
11	Insured's Policy Group Or FECA Number		✓		
11a	Insured's Date Of Birth And Sex		✓		
11b	Employer's Name Or School Name		✓		
11c	Insured Plan Name Or Program Name		✓		
11d	Is There Another Health Benefit Plan?		✓		
12	Patient's Signature	✓			
13	Authorization				✓
14	Date Of Current				✓
15	If Patient Has Had Same Or Similar Illness				✓
16	Dates Patient Unable To Work In Current Occupation				✓
17	Name Of Referring Physician Or Other Source		✓		

CMS-1500 Checklist for Required Fields		Required	Required, if Applicable	Optional	Not Required
17a	I.D. Number Of Referring Physician			✓	
17b	Referring Provider NPI		✓		
18	Hospitalization Dates Related To Current Services		✓		
19	Reserved For Local Use				✓
20	Outside Lab Charges				✓
21	Diagnosis	✓			
22	Medicaid Resubmission Or Original Ref. No.		✓		
23	Prior Authorization No.		✓		
24a	Dates Of Service	✓			
24b	Place Of Service	✓			
24c	EMG				✓
24d	Procedure Code	✓			
	Explain Unusual Services/Circumstances		✓		
	Procedure Modifier		✓		
24e	Diagnosis Code	✓			
24f	Charges	✓			
24g	Days Or Units	✓			
24h	ESPDT Family Plan		✓		
24i	ID Qualifier				✓
24j	Rendering Provider ID #		✓		
25	Federal Tax I.D. No.				✓
26	Patient Account No.			✓	
27	Accept Assignment?				✓
28	Total Charges	✓			
29	Amount Paid		✓		
30	Balance Due				✓
31	Signature Of Physician Or Supplier	✓			
32	Service Facility Location		✓		
32a	Service Facility NPI				✓
32b	Service Facility Other ID#				✓
33	Billing Provider Info & Ph#	✓			
33a	Billing Provider NPI	✓			
33b	Billing Provider Other ID #			✓	

Figure 2-2. Place of Service Codes

Code	Description
03	School
04	Homeless Shelter
05	Indian Health Service Freestanding Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Freestanding Facility
08	Tribal 638 Provider-Based Facility
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room – Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Facility
57	Non-residential Substance Abuse Treatment Facility
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
65	End Stage Renal Disease Treatment Facility
71	Public Health Clinic
72	Rural Health Clinic
81	Independent Laboratory
99	Other Place of Service

2.1 CMS-1500 Billing Modifiers

The Mississippi Medicaid program uses modifiers to enhance a code narrative and to describe the circumstances of some procedures or services and how they individually apply to the patient. Some modifiers impact reimbursement, while others are informational.

A complete listing and description of modifiers can be found in the Provider Policy Manual, General Coding Information, Section 81.02.

2.2 Filing Medicare Part B Crossover Claims on the CMS-1500

Beneficiaries that are both Medicare and Medicaid eligible require a slightly different approach to claims submission. This section includes detailed instructions on how to use the CMS-1500 form to file crossover claims. Complying with these instructions will expedite claims adjudication.

- Submit a legible copy of the CMS-1500 claim form that was submitted to Medicare. If there is no copy of the Medicare claim or Medicare was billed electronically, prepare a CMS-1500 claim form according to Medicare guidelines.
- In field 1, enter Xs in the boxes labeled "Medicare" and "Medicaid."
- Ensure that the beneficiary's nine-digit Medicaid number is in field 1a.
- Enter the NPI number of the billing provider who is the one to which Medicaid payment will be made in field 33. If field 33 contains a group NPI provider number, enter the 10-digit NPI of the servicing/ rendering provider in field 24j.
- Circle the corresponding claim information on the Explanation of Medicare Benefits (EOMB). Attach the EOMB to the back of the claim.

The Medicare Explanation of Medicare Benefits (EOMB) must be completely legible and copied in its entirety. The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider may line out patient data not applicable to the claim submitted.
- The provider may line out any claim line that has been previously paid by Medicaid that the provider chooses not to bill Medicaid, or that has been paid in full by Medicare.
- If the claim lines on the EOMB have been lined out, the "claim totals" line on the EOMB must be changed to reflect the deleted line(s).

The claim lines or "recipient section" on the EOMB that are being submitted for reimbursement must be circled and never highlighted.

2.3 Medicare Part C Only - Mississippi Medicaid Part B Claim Form Instructions

The Mississippi Medicaid Part B Crossover Claim form located in this section is a state specific form, and must be used when billing for Medicare Part C Advantage Plans only. Medicare Advantage Plans claims are for dually eligible beneficiaries enrolled in Medicare and eligible for Medicaid coverage. The following are instructions for completing the Medicare Part B crossover billing form when billing Medicare Part C Advantage Plan claims. An additional requirement is that a copy of the Medicare EOMB for the billed services **must** be attached for all paper Crossovers. This claim form and instructions are available on the Division of Medicaid's website at http:/ / www.medicaid.ms.gov. Select the Provider link then choose the Forms link.

Paper Claim Reminders

Claims should be completed accurately to ensure proper claim adjudication. Remember the following:

- Use blue or black ink.
- Be sure the information on the form is legible.
- Do not use highlighters.
- Do not use correction fluid or correction tape.
- Ensure that names, codes, numbers, etc., print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable.
- Claims received on an incorrect claim form or without the appropriate EOMB can not be processed for payment.
- Indicate that the claim is a Medicare Part C Advantage Plan claim by writing the words **Advantage Plan** on the bottom of the claim form.

Paper Claims with Attachments

When submitting attachments with the Mississippi Medicaid Part B Crossover claim form, please follow these guidelines:

- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.
- For claims with more than one third- party payor source, include all EOBs that relate to the claim.
- For third party payments less than 20% of charges, indicate on the face of the claim, LESS THAN 20%, PROOF ATTACHED.
- For Medicare denials, indicate on the claim, MEDICARE DENIAL, SEE ATTACHED.
- For other insurance denials, indicate on the claim, TPL DENIAL, SEE ATTACHED.

Billing Tip 

Some Medicare Part C Advantage Plans have a co-pay/co-insurance field or a co-pay/deductible field on their Explanation of Medicare Benefits (EOMB). The Division of Medicaid will only pay co-insurance and/or deductible. Claims submitted with these types of EOMBs will be returned to the provider and may be resubmitted with written documentation from the health plan verifying the coinsurance or deductible amount(s). Medicaid does not pay co-pay for these claim types.

Claim Mailing Address

Once the claim form has been completed and checked for accuracy, please mail the completed claim form to:

Mississippi Medicaid Program
P. O. Box 23076
Jackson, MS 39225-3076

Instructions for Mississippi Medicaid Part B Crossover Claim Form (08/08) For Part C Claims ONLY

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part B Crossover Claim Form (08/08)
1	Required	**Provider Name and Address**: Enter the full name and address of the provider/facility submitting the claim.
2a	Optional	**Medicaid Provider Number:** Enter the 8 digit Medicaid number of the health care provider.
2b	Required	**National Provider Identifier (NPI):** Enter the 10 digit NPI number of the health care provider who is to receive payment for the service(s).
3	Required	**Beneficiary Name and Address:** Enter the full name (last name, first name) and the address of the beneficiary receiving services.
4	Required	**Beneficiary Medicaid ID Number:** Enter the 9 digit Medicaid ID number assigned to the beneficiary receiving the service.
5	Optional	**Patient Account/Medical Record Number:** Enter the internal account number or medical record number of the beneficiary.
6	Required	**Diagnosis Code:** Enter up to 4 (ICD-9) diagnosis codes (beginning with primary) related to the billing period.
7	Required	**Service Dates:** Enter the from and thru date of service for this billing in MM/DD/CCYY format.
8	Required	**Procedure Code:** **Outpatient Services:** Enter the HCPCS code for laboratory, radiology and dialysis services provided. **Professional services**: Enter the appropriate CPT code for the services provided.
9	Required	**Procedure Modifier**: Enter the applicable modifier for the procedure rendered.
10	Required	**Service Units:** Enter the number of units provided on each detail line.
11	Required	**Medicare Billed Charges:** Enter the total charges (dollars.cents) billed to Medicare for each detail line.
12	Required	**Medicare Allowed Amount:** Enter the amount payable for each service (dollars.cents) as determined by Medicare.
13	Required	**Medicare Non-covered Amount:** Enter the charge (dollars.cents) for any non-covered service, such as take-home drugs.
14	Required	**Blood Deductible Amount:** Enter the total Medicare deductible amount (dollars.cents) for blood which is to be paid by Medicaid.
15	Required	**Medicare Paid Amount:** Enter the total amount (dollars.cents) Medicare paid on the claim for each detail line.
16	Required	**Medicare Deductible:** Enter the total Medicare deductible (dollars.cents) amount which is to be paid by Medicaid.

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part B Crossover Claim Form (08/08)
17	**Required**	**Medicare Coinsurance:** Enter the total Medicare coinsurance amount (dollars.cents) to be paid by Medicaid.
18	**Required**	**Medicare Paid Date:** Enter the date of Medicare payment in MM/DD/CCYY format.
19	**Required if Applicable**	**Third Party Payment Amount:** Enter the amount (dollars.cents) of payment made by any third party source applied toward the claim for each detail.
20	**Required**	**Provider Signature:** The provider or an authorized representative must sign the claim form. Rubber stamp signatures are acceptable.
21	**Required**	**Billing Date:** Enter the date the claim was submitted to the Medicaid fiscal agent for processing in MM/DD/CCYY format.

Medicare Part **B**

MISSISSIPPI CROSSOVER CLAIM FORM

State of Mississippi Medicaid Program

For Medicare Part C ONLY

1. Provider Name and Address	2a. Medicaid Provider Number	3. Recipient Name & Address	4. Recipient Medicaid ID
	2b. NPI Number		

5. Patient Account / Medical Record Number

6. Diagnosis	
Primary	Secondary
3rd	4th

	7. Service Dates From	Thru	8. Procedure Code	9. Modifier	10. Service Units	11. Medicare Billed Charges	12. Medicare Allowed Amount
	13. Medicare Non-covered Amt.	14. Medicare Blood Deductible	15. Medicare Paid Amount	16. Medicare Deductible	17. Medicare Co-insurance	18. Medicare Paid Date	19. Third Party Amount
1						.	.
2						.	.
3							
4						.	.
5						.	.
6						.	.

Part C Claims ONLY

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized copayment.

20. Provider Signature	21. Billing Date

Revised 08/25/08

3.0 UB-04 Claim Form

This section explains the procedures for obtaining reimbursement for services submitted to Medicaid on the UB-04 billing form, and must be used in conjunction with the MS Medicaid Provider Policy Manual. You may refer to the policy manual and fee schedules for issues concerning policy and the specific procedures for which Medicaid reimburses. If you have questions, please contact the fiscal agent's Provider Services Call Center toll-free at 1-800-884-3222.

Provider Types

The following provider types should bill using the UB-04 claim form

- Dialysis Centers
- Home Health Agencies
- Hospice Providers
- Hospitals
- Intermediate Care Facility for the Mentally Retarded (**ICF/MR**)
- Nursing Facilities
- Psychiatric Residential Treatment Facilities (**PRTF**)
- Swing-Bed

Web Portal Reminder

Providers are encouraged to use the Mississippi Envision Web Portal for easy access to up-to-date information. The web portal provides rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The web portal is available 24 hours a day, 7 days a week, 365 days a year via the Internet at http:// msmedicaid.acs-inc.com.

Paper Claim Reminders

Claims should be completed accurately to ensure proper claim adjudication. Remember the following:

- Complete an original UB-04 claim form.
- No photocopied claims will be accepted.
- Use blue or black ink.
- Be sure the information on the form is legible.
- Do not use highlighters.
- Do not use correction fluid or correction tape.
- Ensure that names, codes, numbers, etc., print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable.

Multi-Page Paper Claims

When submitting UB-04 claims with multiple pages, please follow these guidelines:

- Multi-page claims are **limited to 2 pages** with a maximum of **44 claim lines**.
- Do not total the first form.
- Staple or clip the 2 pages together, but do not staple more than once.
- Indicate **Page X of 2** in **line 23** of **Field 42**.
- Revenue **code 001** (total charges) must be on the **second page**.
- If reporting TPL payment, indicate in **field 54** on the **first page**.
- Only one copy of an attachment (e.g. EOB, EOMB, and Consent Form) is required per claim.

Paper Claims with Attachments

When submitting attachments with the UB-04 claim form, please follow these guidelines:

- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.
- For claims with more than one third- party payor source, include all EOBs that relate to the claim.
- For third party payments less than 20% of charges, indicate on the face of the claim, LESS THAN 20%, PROOF ATTACHED.
- For Medicare denials, indicate on the claim, MEDICARE DENIAL, SEE ATTACHED.
- For other insurance denials, indicate on the claim, TPL DENIAL, SEE ATTACHED.

Electronic UB-04 Claims

Electronic UB-04claims may be submitted to Mississippi Medicaid by these methods:

- Using the Web Portal Claims Entry feature
- Using WINASAP (free software available from the fiscal agent)
- Using other proprietary software purchased by the provider
- Using a clearinghouse to forward claims to Mississippi Medicaid.

Electronic UB-04 claims must be submitted in a format that is HIPAA compliant with the ANSI X 12 UB-04 claim standards.

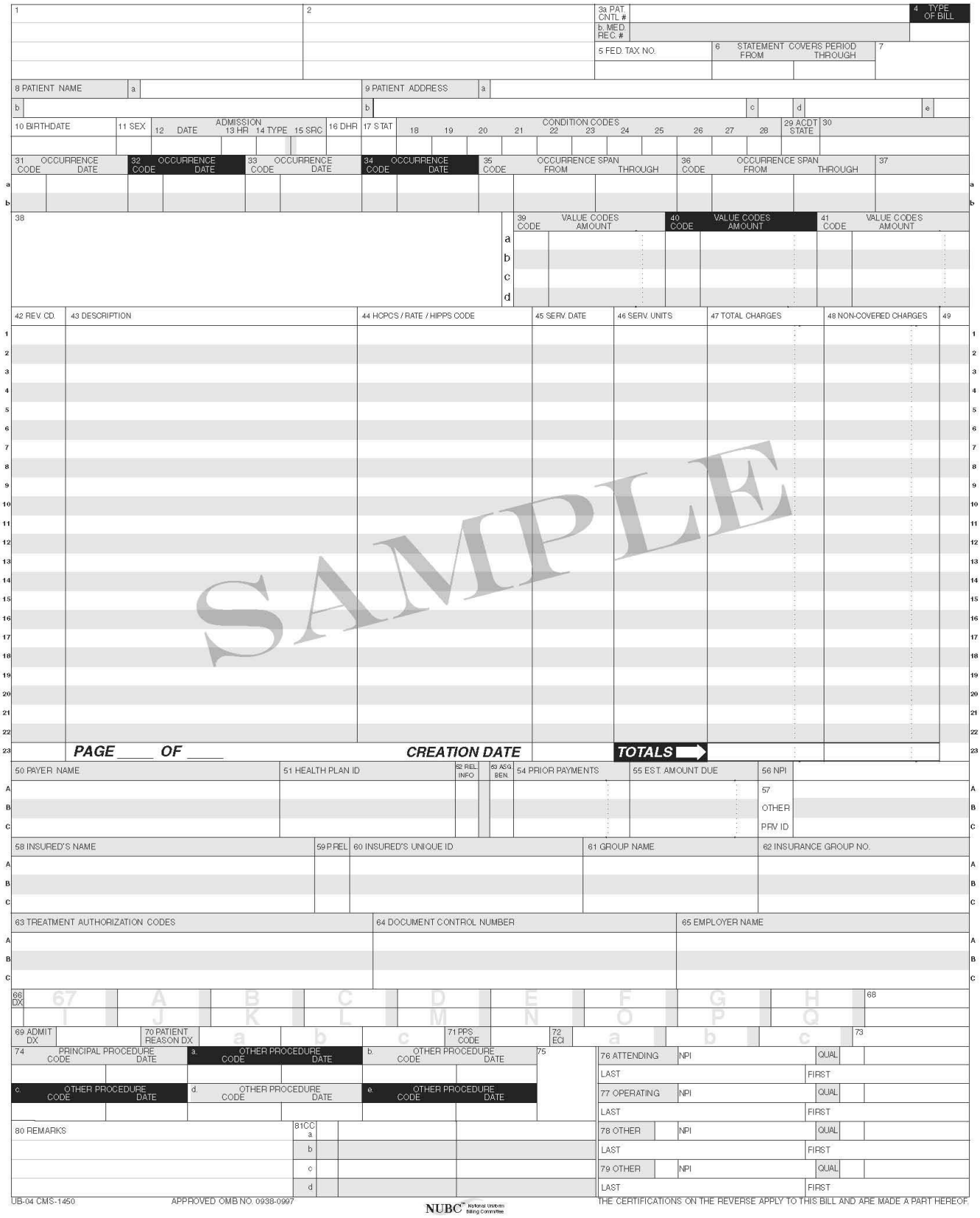
Billing Tip 

Be sure to include prior authorization number, timely filing TCN, proper procedure codes, modifiers, units, etc., to prevent your claim from denying inappropriately.

Claim Mailing Address

Once the claim form has been completed and checked for accuracy, please mail the completed claim form to:

Mississippi Medicaid Program
P. O. Box 23076
Jackson, MS 39225-3076


1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 ADMISSION DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
18 19 20 21 22 23 24 25 26 27 28 CONDITION CODES
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO
53 ASG. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67
67 A B C D E F G H I J K L M N O P Q
68
69 ADMIT DX
70 PATIENT REASON DX a b c
71 PPS CODE
72 ECI a b c
73
74 PRINCIPAL PROCEDURE CODE DATE
a. OTHER PROCEDURE CODE DATE
b. OTHER PROCEDURE CODE DATE
75
c. OTHER PROCEDURE CODE DATE
d. OTHER PROCEDURE CODE DATE
e. OTHER PROCEDURE CODE DATE
80 REMARKS
81CC a b c d
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
UB-04 CMS-1450
APPROVED OMB NO. 0938-0997
NUBC National Uniform Billing Committee
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-04 Claim Form Instructions for Mississippi Medicaid

Field	Requirement	Field Name and Instructions for UB-04 Form
1	**Required**	**Billing Provider Name, Address and Telephone Number:** Enter the name, address and telephone number of the billing provider exactly as it appears in the upper left corner of the remittance advice. Enter the provider's mailing address, city, state, ZIP code and telephone. Line 1 – Provider Name Line 2 – Provider Street Address Line 3 – Provider City, State, Zip Line 4 – Provider Telephone, FAX, Country
2	Not Required	Pay-to Name and Address (Unlabeled on Form)
3a	**Optional**	**Patient Control Number:** You may enter the patient's unique account number assigned by the provider account number. If the patient's account number is listed on the claim, it will be appear on the remittance advice.
3b	**Required if Applicable**	**Medical/Health Record Number**: Enter the provider taxonomy of the billing provider if the provider is a subpart of the facility.
4	**Required**	**Type of Bill:** Enter the appropriate type of bill code. This code indicates the specific type of bill being submitted and is critical to ensure accurate payment. See **Figure 3-2** at the end of this section.  **Types of bill xx7 or xx8 are reserved for electronic adjustment/void only.**
5	Not Required	Federal Tax Number: Not required.
6	**Required**	**Statement Covers Period:** Enter the beginning service date in the "From" area and the last service date in the "Through" area of this field. Use MMDDYY format for each date. For services received on a single day, use the same "From" and "Through" dates. For **outpatient services**, enter the first visit in the "From" block and the date of the last visit in the "Through" block. For **inpatient services**, the "From" date must always equal the date of admission with the following three exceptions: • The second half of a split bill • The patient's Medicaid eligibility begins after the admission date • The baby remains hospitalized after the mother is discharged. For **Psychiatric Residential Treatment Facility (PRTF)** claims, the "From" date must always equal the date of admission with the following exceptions: • The second half of a split bill, or • The patient's Medicaid eligibility begins after the admission date.
7	Not Required	Reserved for Assignment by the NUBC
8a	Not Required	Patient Name/ Identifier
8b	**Required**	**Patient Name:** Enter the beneficiary's name as it appears on the Medicaid ID card in the last name, first name, and middle initial format.
9a-e	Not Required	Patient Address

Field	Requirement	Field Name and Instructions for UB-04 Form
10	**Required**	**Patient Birth Date:** Enter the beneficiary's birth date in MM/ DD/ YYYY format.
11	**Required**	**Patient Sex:** Enter the sex of the patient. M – Male, F – Female, U - Unknown
12	**Required if Applicable**	**Admission Date:** Enter the month, day, and year of the admission of the beneficiary in the MM/ DD/ YY format. • This field is not required for Dialysis Center claims. • For Nursing Facility claims, use the original admission date that the patient entered the facility.
13	**Required if Applicable**	**Admission Hour:** Enter the time of admission in military time (24 hour clock). See **Figure 3-3** at the end of this section.
14	**Required if Applicable**	**Type of Admission/Visit:** Enter the appropriate admission code. See **Figure 3-4** for a list of admission types.
15	**Required if Applicable**	**Source of Referral for Admission or Visit**: Enter the source of referral for this admission or visit. See **Figure 3-5** at the end of this section for a list of admission source codes.
16	Not Required	Discharge Hour
17	**Required**	**Patient Discharge Status:** Indicate the beneficiary's disposition or discharge status at the end of service for the period covered on this bill, as reported in Field 6, Statement Covers Period. See **Figure 3-6** at the end of this section for a list of status codes.
18-28	**Required if Applicable**	**Condition Codes**: If applicable, indicate conditions or events relating to this claim. Enter the appropriate condition code taken from the Uniform Billing Manual.
29	Not Required	Accident State
30	Not Required	Reserved for Assignment by the NUBC
31-34	**Required if Applicable**	**Occurrence Codes and Dates:** Enter the appropriate occurrence code and date MM/ DD/ YYYY format. See the Uniform Billing Manual.  **For <u>inpatient claims</u>, use occurrence code C3 along with the date of discharge to bill a one-day stay for a claim with the same "From" and "Through" service date.** **For <u>inpatient claims</u>, to show that benefits are exhausted, use occurrence code C3 with the date that benefits ended along with code 42 to show the actual date of discharge from the facility.**
35-36	Not Required	Occurrence Span Codes and Dates
37	Not Required	Reserved for Assignment by the NUBC
38	Not Required	Responsible Party Name and Address

Field	Requirement	Field Name and Instructions for UB-04 Form
39-41	**Required if Applicable**	**Value Codes and Amounts:** Enter the appropriate value code and amount. See the Uniform Billing Manual for Value Code structure. The following value codes should be entered on the form in these fields:  To show **covered days,** use **value code 80.** For non-amount related value codes, include decimals. For example, to report 5 covered days on a claim, enter Value Code 80 and enter it as 5 in the amount field and 00 in the decimal place.
42	**Required**	**Revenue Code:** Enter the revenue code that identifies a specific service or item. The specific revenue codes can be taken from the revenue code section of the Uniform Billing Manual. See **Figure 3-7** at the end of this section for a partial list of revenue codes. **Figure 3-7** contains the only revenue codes billable to Mississippi Medicaid for the specific provider types listed. For an all-inclusive list of revenue codes see the Uniform Billing Manual.
43	**Required**	**Revenue Code Description:** Enter the standard abbreviation of the narrative description for revenue code. Revenue descriptions are listed in the revenue code section of the Uniform Billing Manual. • **For Dialysis Providers: Enter the 11-digit NDC code number for physician-administered drugs in the Revenue Code description field.**
44	**Required if Applicable**	**HCPCS/Accommodation Rates/HIPPS Rate Codes:** For **inpatient services**, **Nursing Facility/ICFMR services**, **Swing-Bed services** or **PRTF services** enter the **accommodations rate.** For **outpatient services** or **Dialysis Center services**, enter the appropriate **CPT or HCPCS procedure code** for services including but not limited to lab and radiology procedures, diagnostic tests, and injectable drugs.
45	**Required if Applicable**	**Service Date:** Enter the month, day, and year in MM/ DD/ YY format for **Dialysis Center claims** and **hospital outpatient services only**.
46	**Required**	**Service Units**: Enter the total number of covered accommodation days, ancillary units of service, or visits being billed per procedure or revenue code.
47	**Required**	**Total Charges:** Enter the total charges pertaining to the related revenue codes for the billing period as entered in Field 6 Statement Covers Period. Enter the grand total charges at the bottom of this field with revenue code 001 in form locator 42.
48	**Required if Applicable**	**Non-covered Charges:** Enter the charge for any non-covered services such as take-home drugs or services by private duty nurses.
49	Not Required	Reserved for Assignment by the NUBC

Field	Requirement	Field Name and Instructions for UB-04 Form
50A-C	**Required**	**Payer Name:** As applicable, enter the name of the beneficiary's primary, secondary, and tertiary insurance on Lines A, B and C, respectively. **On claims with no TPL, Medicaid information is entered on Line A.**
51A-C	Not Required	Health Plan ID
52A-C	Not Required	Release of Information
53A-C	Not Required	Assignment of Benefits
54A-C	**Required if Applicable**	**Prior Payments:** Enter payment received from any other insurance carriers. **Do not include contractual adjustments when no payment from the third party source is made. Do not enter prior payments from Medicare or Medicaid as it may cause your claim to pay at zero dollars or a reduced rate.**
55A-C	Not Required	Estimated Amount Due
56	**Required**	**National Provider Identifier (NPI)** – Enter the National Provider Identifier for the billing provider.
57A-C	**Optional**	**Other Provider Identifier:** Enter the eight-digit MS Medicaid ID number.
58A-C	**Required**	**Insured's Name:** As applicable, enter the insured's name for the primary, secondary and tertiary insurance on Lines A, B and C, according to proper billing order. On the line that shows payor, "Medicaid," enter the beneficiary's name exactly as shown on the Medicaid card.
59A-C	**Required**	**Patient's Relationship to Insured:** Enter the code indicating the relationship of the patient to the identified insured. The following codes are acceptable to report the required information: Code – Title 01 – Spouse 18 – Self 19 – Child 20 – Employee 21 – Unknown 39 – Organ Donor 40 – Cadaver Donor 53 – Life Partner G8 – Other Relationship
60A-C	**Required**	**Insured's Unique Identifier:** As applicable, enter the insured's unique identifier for the primary, secondary and tertiary insurance on Lines A, B and C, according to proper billing order. On the line that shows payor, "Medicaid," enter the 9-digit Medicaid beneficiary ID Number as shown on the beneficiary's Medicaid card. Do not include spaces or hyphens. If the beneficiary is exempt from co-payment, enter the applicable exception code immediately following the Medicaid ID number.

Field	Requirement	Field Name and Instructions for UB-04 Form
61A-C	**Required if Applicable**	**Insured's Group Name:** As applicable, enter the group name of the beneficiary's primary, secondary and tertiary insurance on Lines A, B and C, according to proper billing order. Do not enter a group name on the line that shows payor, "Medicaid."
62A-C	**Required if Applicable**	**Insured's Group Number:** As applicable, enter the group number of the beneficiary's primary, secondary and tertiary insurance on Lines A, B and C, according to proper billing order. Do not enter a group number on the line that shows payor, "Medicaid."
63A-C	**Required if Applicable**	**Treatment Authorization Code:** Enter the TAN authorization number in this field. Only one authorization number may be entered per claim.
64	**Required if Applicable**	**Document Control Number:** Enter the transaction control number (TCN) of the original claim for proof of timely filing on a resubmission of a claim twelve months past the original date of service.
65A-C	**Required if Applicable**	**Employer Name:** Enter the name of the employer that could provide a source of third party insurance payment.
66	Not Required	Diagnosis Version Qualifier
67	**Required**	**Principal Diagnosis Code:** Enter the ICD-9-CM code for the principal diagnosis codes that relate to the billing period.
67A-Q	**Required if Applicable**	**Other Diagnosis Codes:** Enter an ICD-9-CM diagnosis code for each condition that coexists at the time of admission, that develops subsequently, or that affects the treatment received and/ or the length of stay.
68	Not Required	Reserved for Assignment by the NUBC
69	**Required**	**Admitting Diagnosis Code**: Enter the ICD-9-CM diagnosis code describing the beneficiary's reason for admission as stated by the physician.
70a-c	Not Required	Patient's Reason for Visit
71	Not Required	Prospective Payment System (PPS) Code
72a-c	Not Required	External Cause of Injury (ECI) Code
73	Not Required	Reserved for Assignment by the NUBC
74	**Required if Applicable**	**Principal Procedure Code and Date:** Enter the appropriate ICD-9-CM procedure code. Record the date in the MM/ DD/ YY format.  **For family planning outpatient services, indicate the appropriate ICD-9-CM code in fields 74 and 74a - e.**
74a-e	**Required if Applicable**	**Other Procedure Codes and Dates:** Enter procedure codes to identify all significant procedures (other than the principal) and the dates on which each procedure was performed (MMDDYY format).
75	Not Required	Reserved for Assignment by the NUBC
76	**Required if Applicable**	**Attending Provider Name and Identifiers:** Enter the attending provider's last and first name. Enter the NPI for the attending provider. Qualifier Code- Not Required.
77	Not Required	Operating Physician Name and Identifiers

Field	Requirement	Field Name and Instructions for UB-04 Form
78	**Required if Applicable**	**Other Provider (Individual) Names and Identifiers:** Enter the NPI ~~and ID~~ for the other provider. Qualifier Codes are not required.
79	Not Required	Other Provider (Individual) Names and Identifiers
80	**Required if Applicable**	**Remarks Field:** Use this area for notations, providing additional information necessary to adjudicate the claim.
81A-D	Not Required	Code-Code Field: Use this field to report additional value codes and taxonomy codes.

Figure 3-1. Checklist of Required UB-04 Fields.

UB-04 Checklist for Required Fields	Required	Required if Applicable	Optional	Not Required
1 Provider Name	✓			
2 Pay-to Name				✓
3a Patient Control No.			✓	
3b Medical Record Number		✓		
4 Type of Bill	✓			
5 Fed. Tax. No.				✓
6 Statement Covers Period	✓			
7 Reserved for Assignment				✓
8a Patient Name - ID				✓
8b Patient Name	✓			
9a Patient Address-Street				✓
9b Patient Address-City				✓
9c Patient Address-State				✓
9d Patient Address - Zip				✓
9e Patient Add.-Country Code				✓
10 Patient Birth Date	✓			
11 Patient Sex	✓			
12 Admission Date	✓			
13 Admission Hour		✓		
14 Admission Type		✓		
15 Source of Referral		✓		
16 Discharge Hour				✓
17 Patient Discharge Status	✓			
18 – 28 Condition Codes		✓		
29 Accident State				✓
30 Reserved for Assignment				✓
31 – 34 Occurrence Codes and Dates		✓		
35 – 36 Occurrence Span and Dates				✓
37 Reserved for Assignment				✓
38 Responsible Party				✓
39-41 Value Codes/Amounts		✓		
42 Revenue Code	✓			
43 Rev. Code Description	✓			
44 HCPCS/Rates/HIPPS Codes		✓		
45 Service Date		✓		
46 Units of Service	✓			
47 Total Charges	✓			

UB-04 Checklist for Required Fields	Required	Required if Applicable	Optional	Not Required
48 Non-Covered Charges		✓		
49 Reserved for Assignment				✓
50A-C Payer Name	✓			
51A-C Health Plan ID				✓
52A-C Release of Information				✓
53A-C Assignment of Benefits				✓
54A-C Prior Payments		✓		
55A-C Est. Amount Due				✓
56 NPI	✓			
57A-C Other Provider ID			✓	
58 A-C Insured's Name	✓			
59 A-C Patient's Relationship	✓			
60A-C Insured's Unique ID	✓			
61A-C Group Name		✓		
62A-C Insurance Group No.		✓		
63 Treatment Authorization Code		✓		
64 Document Control No.		✓		
65A-C Employer Name		✓		
66 Diagnosis Version Qual.				✓
67 Principal Diagnosis Code	✓			
67 a-q Other Diag. Codes		✓		
68 Reserved for Assignment				✓
69 Admitting Diagnosis Code	✓			
70 -73 Fields				✓
74 Principal Procedure Code and Date		✓		
74 a - e Other Procedure Codes and Dates		✓		
75 Reserved for Assignment				✓
76 Attending Physician Info		✓		
77 Operating Physician Info				✓
78 Other Provider Name/ID		✓		
79 Other Provider Name/ID				✓
80 Remarks		✓		
81 a - d Code-Code Field				✓

Figure 3-2. Examples of Type of Bill (Field 4)

Bill Type	Definition
111	Hospital Inpatient—complete stay, admission through discharge
112	Hospital Inpatient—patient is admitted and is still a patient, first half of a split bill
113	Hospital Inpatient—patient is a patient for the full month, interim bill
114	Hospital Inpatient—patient is discharged in a different month from admission, second half of a split bill
131	Outpatient
181	Swing bed – used when the claim is for a complete stay, admission through discharge
182	Swing bed – used when the patient is admitted and is still a patient through the date noted in Form Locator 6. This claim is the first part of a split bill.
183	Swing bed – used when the beneficiary is a patient for the full month of billing, having been admitted in a previous month. This claim is an interim bill.
184	Swing bed - used when a patient is discharged in a different month from admission. This claim is the final bill.
331	Home Health – Admit through discharge
332	Home Health – Interim Billing (First claim)
333	Home Health – Interim Billing (Continuing Claim)
334	Home Health – Interim Billing (Last Claim)
721	Freestanding renal dialysis centers or hospital based dialysis units
811	Hospice (non-hospital based)
821	Hospice (hospital-based)
891	PRTF and Nursing Facility-complete stay, admission through discharge.
892	PRTF and Nursing Facility – patient is admitted and is still a resident, first half of a split bill
893	PRTF and Nursing Facility – patient is a resident for the full month, interim bill
894	PRTF and Nursing Facility – patient is discharged in a different month from admission, second half of a split bill

Figure 3-3. Admission Hour Code Structure (Field 13)

AM TIMES		PM TIMES	
Code	Time	Code	Time
00	12:00 Midnight – 12:59am	12	12:00 Noon – 12:59pm
01	01:00 – 01:59	13	01:00 – 01:59
02	02:00 – 02:59	14	02:00 – 02:59
03	03:00 – 03:59	15	03:00 – 03:59
04	04:00 – 04:59	16	04:00 – 04:59
05	05:00 – 05:59	17	05:00 – 05:59
06	06:00 – 06:59	18	06:00 – 06:59
07	07:00 – 07:59	19	07:00 – 07:59
08	08:00 – 08:59	20	08:00 – 08:59
09	09:00 – 09:59	21	09:00 – 09:59
10	10:00 – 10:59	22	10:00 – 10:59
11	11:00 – 11:59	23	11:00 – 11:59

Figure 3-4. Admission Types (Field 14)

Code	Definition
1	**Emergency**: The patient requires immediate intervention as a result of severe, life-threatening, or potentially disabling conditions.
2	**Urgent**: The patient requires immediate attention for the care and treatment of a physical or mental disorder.
3	**Elective**: The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
4	**Newborn**: Any newborn infant born within a hospital setting.
5	**Trauma Center:** The patient visits a trauma center/ hospital (as licensed or designated by the state or local government entity authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.
9	**Use this code only if admission type is "not available/NA":** The provider is unable to clarify the type of admission; rarely used.

Figure 3-5. Admission Source (Field 15)

Code	Newborn Admission Sources/Definition
1-3	Discontinued
4	Born inside hospital
5	Born outside hospital
Code	**Admission Sources/Definition**
1	Non-healthcare Facility Point of Origin
2	Clinic Referral
3	Discontinued
4	Transfer from a Hospital (different facility)
5	Transfer from a Skilled Nursing Facility
6	Transfer from another Health Care Facility
7	Emergency Room
8	Court/ Law Enforcement
9	Information not available
A	Reserved for Assignment by NUBC
B	Transfer from another home health agency
C	Readmission to same home health agency
D	Transfer from one distinct unit of hospital to another distinct unit of hospital
E	Transfer from Ambulatory Surgical Center
F	Transfer from Hospice

Figure 3-6. Patient Status (Field 17)

Code	Definition
01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital for inpatient care
03	Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skill care
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to another type of health care institution not defined elsewhere in this code list
06	Discharged/transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
09	Admitted as an inpatient to this hospital
20	Expired
30	Still Patient
40	Expired at home (Medicare hospice claims only)
41	Expired in a medical facility (e.g., hospital, SNF, ICF, or freestanding hospice) (Medicare hospice claims only)
42	Expired, place unknown
43	Discharged/transferred to federal healthcare facility
50	Discharged to Hospice-Home
51	Discharged to Hospice-Medical Facility (certified) providing hospice level of care
61	Discharged/transferred within this institution to a hospital-based, Medicare-approved swing bed
62	Discharged/transferred to inpatient rehabilitation facility, including rehabilitation-distinct part units of a hospital
63	Discharged/transferred to a Medicare-certified long-term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid, but not under Medicare
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
66	Discharges/transfers to a Critical Access hospital
70	Discharged/transferred to another type of health care institution not defined elsewhere in this code list

Figure 3-7. Revenue Codes (Field 42)

Code	Definition
Hospice	
651	Routine home care
652	Continuous home care
655	Inpatient respite care
656	General inpatient care (non-respite)
659	Other hospice (nursing facility hospice)
Psychiatric Residential Treatment Facilities	
101	All inclusive room and board
181	Hospital leave*
183	Therapeutic leave
Nursing Facilities and ICF/MR	
101	All inclusive room and board
181	Hospital leave*
183	Therapeutic leave
Dialysis Centers	
250	Pharmacy General Classification
636	Drugs Requiring Detailed Coding
821	Outpatient or Home Dialysis – Hemodialysis/Composite or Other Rate
831	Outpatient or Home Dialysis – Peritoneal/Composite or Other Rate
841	Continuous Ambulatory Peritoneal Dialysis (CAPD) – Outpatient or Home CAPD/Composite or Other Rate
851	Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient or Home CCPD/Composite or Other Rate
Home Health	
270	Medical/Surgical Supplies and Devices - General
421	Physical Therapy Visit
441	Speech Therapy Visit
551	Skilled Nurse Visit
571	Home Health Aide Visit

****Note**: For Mississippi Medicaid billing purposes, please use the above-mentioned revenue code to bill hospital leave until further notice.**

3.1 Filing Medicare Part A Crossover Claims on the UB-04

Beneficiaries that are both Medicare and Medicaid eligible require a slightly different approach to claims submission. This section includes detailed instructions on how to use the UB-04 form to file crossover claims. Complying with these instructions will expedite claims adjudication.

- Submit a legible copy of the UB-04 claim form that was submitted to Medicare. If there is no copy of the Medicare claim or Medicare was billed electronically, prepare a UB-04 claim form according to Medicare guidelines.
- Enter the word "CROSSOVER" in field 2.
- Enter the beneficiary's Medicare number in field 50A.
- Enter the beneficiary's 9-digit Medicaid number is in field 50B.
- Enter the 10-digit NPI number in field 56.
- **Optional**: Enter the 8-digit Medicaid provider number in field 57A.
- Circle the corresponding claim information on the Explanation of Medicare Benefits (EOMB). Attach the EOMB to the back of the claim.
- Only TPL (**carriers other than Medicare and Medicaid**) payments should be reported in field 54 of the UB-04. Entering prior payments from Medicare and/or Medicaid will result in a reduced or zero payment.

The Medicare Explanation of Medicare Benefits (EOMB) must be completely legible and copied in its entirety. The only acceptable alterations or entries on a Medicare EOMB are as follows:

- The provider may line out patient data not applicable to the claim submitted.
- The provider may line out any claim line that has been previously paid by Medicaid that the provider chooses not to bill Medicaid, or that has been paid in full by Medicare.
- If the claim lines on the EOMB have been lined out, the "claim totals" line on the EOMB must be changed to reflect the deleted line(s).

The claim lines or "recipient section" on the EOMB that are being submitted for reimbursement must be circled and never highlighted.

****REMINDER****
Medicaid policy requires crossover claims be submitted within 180 days of the Medicare paid date. Claims submitted in excess of 180 days from the Medicare paid date will be denied for timely filing.

3.2 Medicare Part C Only - Mississippi Medicaid Part A Claim Form Instructions

The Mississippi Medicaid Part A Crossover Claim form located in this section is a state specific form and must be used when billing for Medicare Part C Advantage Plans only. Medicare Advantage Plans claims are for dually eligible beneficiaries enrolled in Medicare and eligible for Medicaid coverage. The following are instructions for completing the Medicare Part A crossover billing form when billing services for Medicare Part C Advantage Plans. An additional requirement is that a copy of the Medicare EOMB for the billed services **must** be attached for all paper Crossovers. This claim form and instructions are available on the Division of Medicaid's website at http://www.medicaid.ms.gov. Select the Provider link then choose the Forms link.

Paper Claim Reminders

Claims should be completed accurately to ensure proper claim adjudication. Remember the following:

- Use blue or black ink.
- Be sure the information on the form is legible.
- Do not use highlighters.
- Do not use correction fluid or correction tape.
- Ensure that names, codes, numbers, etc. print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable.
- Claims received on an incorrect claim form or without the appropriate EOMB can not be processed for payment.
- Indicate that the claim is a Medicare Part C Advantage Plan claim by writing the words **Advantage Plan** on the bottom of the claim form.
-

Paper Claims with Attachments

When submitting attachments with the Mississippi Crossover Part A claim form, please follow these guidelines:

- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.
- For claims with more than one third- party payor source, include all EOBs that relate to the claim.
- For third party payments less than 20% of charges, indicate on the face of the claim, LESS THAN 20%, PROOF ATTACHED.
- For Medicare denials, indicate on the claim, MEDICARE DENIAL, SEE ATTACHED.
- For other insurance denials, indicate on the claim, TPL DENIAL, SEE ATTACHED.

Billing Tip 

Some Medicare Part C Advantage Plans have a co-pay/co-insurance field or a co-pay/deductible field on their Explanation of Medicare Benefits (EOMB). The Division of Medicaid will only pay co-insurance and/or deductible. Claims submitted with these types of EOMBs will be returned to the provider and may be resubmitted with written documentation from the health plan verifying the coinsurance or deductible amount(s). Medicaid does not pay co-pay for these claim types.

Claim Mailing Address

Once the claim form has been completed and checked for accuracy, please mail the completed claim form to:

Mississippi Medicaid Program
P. O. Box 23076
Jackson, MS 39225-3076

Instructions for Mississippi Medicaid Part A Crossover Claim Form For Part C Claims ONLY

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part A Crossover Claim Form (08/08)
1	Required	**Type of Bill:** Enter a valid code for the type of claim being submitted – (inpatient, interim billing, hospice, etc.)
2	Required	**Provider Name and Address**: Enter the full name and address of the provider/facility submitting the claim.
3	Optional	**Medicaid Provider Number:** Enter the 8 digit Medicaid number of the health care.
3a	Required	**National Provider Identifier (NPI):** Enter the 10 digit NPI number of the health care provider who is to receive payment for the service(s).
4	Required	**Beneficiary Name and Address:** Enter the full name (last name, first name) and the address of the beneficiary receiving services.
5	Required	**Beneficiary Medicaid ID Number:** Enter the 9 digit Medicaid ID number assigned to the beneficiary receiving the service.
6	Optional	**Patient Account/Medical Record Number:** Enter the internal account number or medical record number of the beneficiary.
7	Required	**Admission Date:** Enter the date of beneficiary's admission in MM/DD/CCYY format.
8	Required	**Admission Hour:** Enter the hour of beneficiary's admission to the facility (00-23) per the UB-04 Uniform Billing Instructions.
9	Required	**Admission Type**: Enter the nature of the admission using the applicable codes (0-9) per the UB-04 Uniform Billing Instructions.
10	Required	**Dates of Service:** Enter the from and thru date of service for this billing in MM/DD/CCYY format.
11	Required	**Covered Days:** Enter the number of covered days for this billing. Note: date of death and date of discharge are not counted as covered days.
12	Required	**Diagnosis Code:** Enter up to 4 (ICD-9) diagnosis codes (beginning with primary) related to the billing period.
13	Required	**Total Medicare Billed Charges:** Enter the total charges (dollars.cents) billed to Medicare for all services.
14	Required	**Total Medicare Allowed Amount:** Enter the total amount payable for the claim (dollars.cents) as determined by Medicare.

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part A Crossover Claim Form (08/08)
15	Required	**Total Medicare Paid Amount:** Enter the total amount (dollars.cents) Medicare paid on the claim.
16	Required	**Total Medicare Deductible Amount:** Enter the total Medicare deductible (dollars.cents) amount which is to be paid by Medicaid.
17	Required	**Total Medicare Coinsurance Amount:** Enter the total Medicare coinsurance amount (dollars.cents) to be paid by Medicaid.
18	Required	**Total Medicare Blood Deductible Amount:** Enter the total Medicare deductible amount (dollars.cents) for blood which is to be paid by Medicaid.
19	Required	**Medicare Paid Date:** Enter the date of Medicare payment in MM/DD/CCYY format.
20	Required if applicable	**Total Third Party Payment Amount:** Enter the amount (dollars.cents) of payment made by any third party source which applies toward the claim.
21	Required Required if applicable	**Revenue Code:** Enter the appropriate 3-digit revenue code from the Uniform Billing Manual. **Procedure Code:** Enter the HCPCS code for laboratory, radiology, and dialysis services provided.
22	Required	**Units:** Enter the number of days or units of service provided for each detail line.
23	Required	**Medicare Billed Amount:** Enter the total charges (dollars.cents) billed to Medicare for each detail service.
24	Required if applicable	**Medicare Non-covered Amount:** Enter the charge (dollars.cents) for any non-covered service such as take-home drugs.
25	Required	**Provider Signature:** The provider or an authorized representative must sign the claim form. Original rubber stamp signatures are acceptable.
26	Required	**Billing Date:** Enter the date the claim was submitted to the Medicaid fiscal agent for processing in MM/DD/CCYY format.

Part C Claims ONLY

Medicare Part **A**

MISSISSIPPI CROSSOVER CLAIM FORM

State of Mississippi Medicaid Program

For Medicare Part C ONLY

1. Type of Bill

2. Provider Name and Address	3. Medicaid Provider Number	4. Recipient Name & Address	5. Recipient Medicaid ID
	3a. NPI Number		

6. Patient Acct/Medical Record No.	Admission 7. Date	8. Hour	9. Type	10. Dates of Service From / Thru	11. Cov. Days

12. Diagnosis Primary	Secondary
3rd	4th

13. Total Medicare Billed Charges	14. Total Medicare Allowed Amount	15. Total Medicare Paid Amount

16. Total Medicare Deductible Amount	17. Total Medicare Co-insurance Amount	18. Total Medicare Blood Deductible Amount	19. Medicare Paid Date	20. Total Third Party Payment Amount

	21. Revenue Code	Procedure Code	22. Units	23. Medicare Billed Amount	24. Medicare Non-Covered Amount	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept. as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized copayment.

25. Provider Signature	26. Billing Date

Revised 8/25/08

4.0 Dental Claim Form Instructions

This section explains the procedures for obtaining reimbursement for dental services submitted to Medicaid. Mississippi Medicaid accepts both electronic and paper dental claims. **Dentists are strongly encouraged to bill electronic claims to reduce the potential for error and speed reimbursement.** This section only addresses billing procedures and must be used in conjunction with the MS Medicaid Provider Policy Manual, especially Section 11 Dental. The Dental Fee Schedule is available on the Medicaid web site at http://www.medicaid.ms.gov or on the Web Portal at https:/ / msmedicaid.acs-inc.com/ msenvision/ index.do. If you have questions, please contact the fiscal agent's Provider and Beneficiary Services Call Center toll-free at 1-800-884-3222.

Provider Types

The following provider types should bill using the Dental claim form:

- Dentists
- Federally Qualified Health Centers (FQHC) dentists
- Rural Health Clinic (RHC) dentists

Before You Bill Medicaid

- Check the beneficiary's eligibility for Medicaid.
- Check the beneficiary's eligibility for dental services.
- Check the beneficiary's service limits.
- Check the procedure code on the dental fee schedule to determine if prior authorization is needed.
- Check for other dental insurance coverage.
- Check the procedure code on the fee schedule to see if Mississippi Medicaid covers that code.
- Check the current version of the ADA's Current Dental Terminology code book for correct procedure codes.
- Check to see if the procedure code requires tooth, surface, or quadrant indicators.
- Check to see if co-payment is required.

Electronic Dental Claims

Electronic dental claims may be submitted to Mississippi Medicaid by these methods:

- Using the Web Portal Claims Entry feature
- Using WINASAP (free software available from the fiscal agent)
- Using other proprietary software purchased by the dental provider.

Electronic dental claims must be submitted in a format that is HIPAA compliant with the ANSI X12 Dental claim standard.

Paper Dental Claims

Claims should be completed accurately to ensure proper claim adjudication. Remember the following:

- Complete an original 2006 ADA Dental Claim form. Mississippi Medicaid will only accept the 2006 ADA Dental Claim form; no other versions will be accepted.
- No photocopied claims will be accepted.
- Use blue or black type or ink.
- Be sure the information on the form is legible.
- Do not use highlighters.
- Do not use correction fluid or correction tape.
- Ensure that names, codes, numbers, etc., print in the designated fields for proper alignment.
- Claim must be signed. Rubber signature stamps are acceptable.

Multi-Page Paper Claims

When submitting ADA Dental claims with multiple pages, please follow these guidelines:

- If the number of procedures reported exceeds the number of lines available on one claim (10 lines per claim), the remaining procedures must be listed on a separate, fully completed claim form.
- Do not total the first form.
- Staple or clip the 2 pages together.
- If reporting TPL payment, indicate in field #35 on the **first claim**.
- Only one copy of an attachment (e.g. EOB, EOMB, Consent Form) is required.

Paper Claims with Attachments

When submitting attachments with the ADA Dental claim form, please follow these guidelines:

- Do not staple attachments more than once.
- Any attachment should be marked with the beneficiary's name and Medicaid ID number.
- For different claims that refer to the same attachment, a copy of the attachment must accompany each claim.

Billing Tip

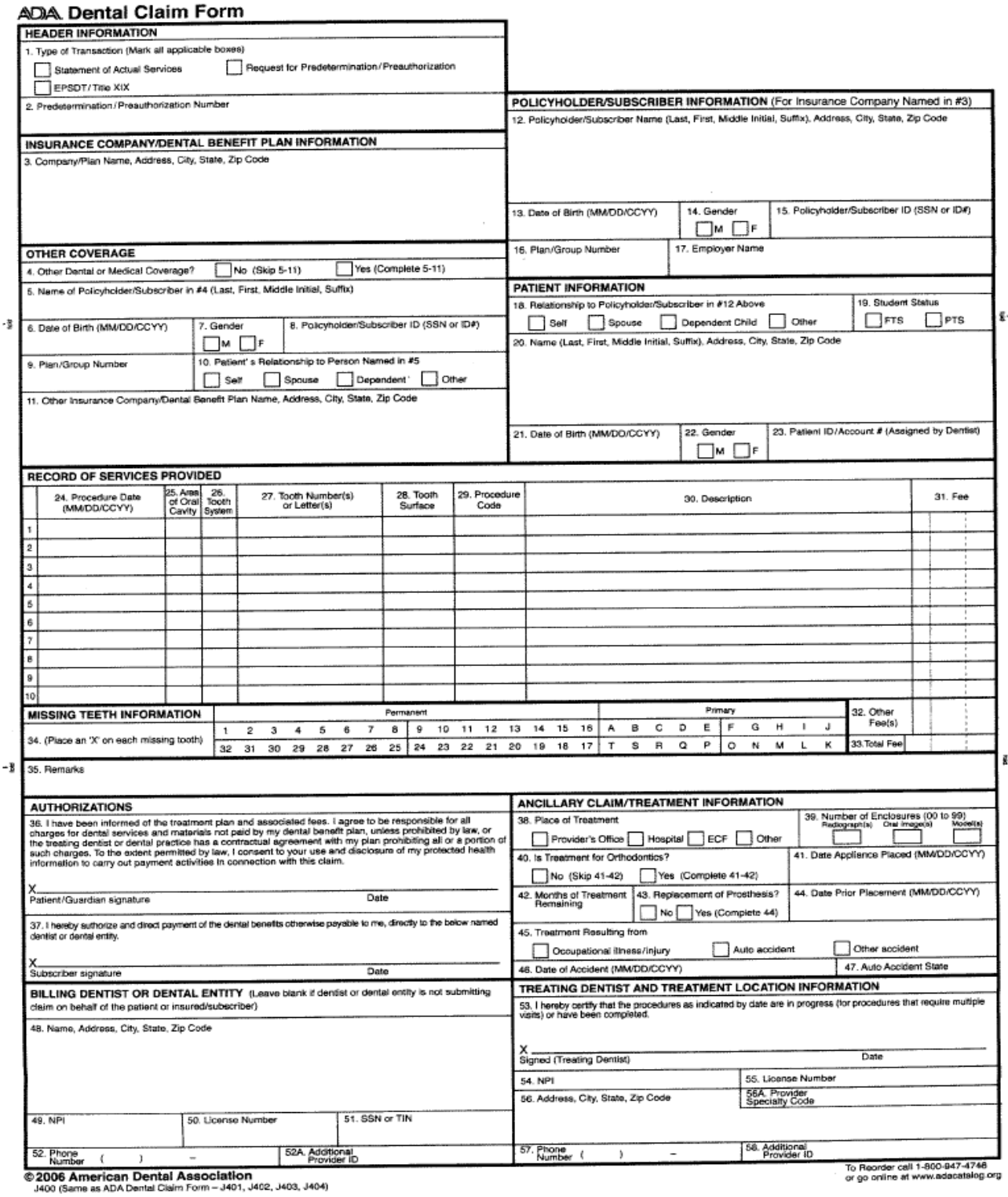
Be sure to include prior authorization number, timely filing TCN, proper procedure codes, modifiers, units, etc. to prevent your claim from denying inappropriately.

Claim Mailing Address

Once the claim form has been completed and checked for accuracy, please mail the completed claim form to:

Mississippi Medicaid Program
P. O. Box 23076
Jackson, MS 39225-3076

2006 ADA Dental Claim Form



ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT/Title XIX

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) | 7. Gender ☐M ☐F | 8. Policyholder/Subscriber ID (SSN or ID#)

9. Plan/Group Number | 10. Patient's Relationship to Person Named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) | 14. Gender ☐M ☐F | 15. Policyholder/Subscriber ID (SSN or ID#)

16. Plan/Group Number | 17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other | 19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) | 22. Gender ☐M ☐F | 23. Patient ID/Account # (Assigned by Dentist)

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary										32. Other Fee(s)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J		
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K	33. Total Fee	

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI | 50. License Number | 51. SSN or TIN

52. Phone Number ( ) – | 52A. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment ☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other | 39. Number of Enclosures (00 to 99) Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics? ☐ No (Skip 41-42) ☐ Yes (Complete 41-42) | 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining | 43. Replacement of Prosthesis? ☐ No ☐ Yes (Complete 44) | 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) | 47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X _____
Signed (Treating Dentist) Date

54. NPI | 55. License Number

56. Address, City, State, Zip Code | 56A. Provider Specialty Code

57. Phone Number ( ) – | 58. Additional Provider ID

J400 (Same as ADA Dental Claim Form – J401, J402, J403, J404)

To Reorder call 1-800-947-4746 or go online at www.adacatalog.org

2006 ADA Dental Claim Form Instructions for Mississippi Medicaid

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
1	Not Required	Type of Transaction: Not Required.
2	**Required if Applicable**	**Predetermination/Preauthorization Number**: Enter the prior authorization (PA) number for services that require PA and approval by DOM. Refer to the Medicaid Provider Policy Manual and Dental Fee Schedule at http:/ / www.medicaid.ms.gov for specific instructions about services that require PA.
3	**Required**	**Company/Plan Name, Address, City, State, and Zip Code**: Enter the name and address for the insurance company that is the third party payer receiving the claim. For Mississippi Medicaid, enter Mississippi Medicaid Program, P. O. Box 23076, Ridgeland, MS 39225-3076. If the beneficiary has more than one dental insurance plan and Medicaid is the secondary payer, enter the Medicaid address in this field and complete fields 4 through 11 and field 17.
4	**Required**	**Other Dental or Medical Coverage?** Check "NO" if the patient does not have dental coverage under any other dental or medical benefit plan and do not complete fields 5-11. Check "YES" if the patient has dental coverage under any other dental or medical plan.
5	**Required if Applicable**	**Name of Policyholder/Subscriber with Other Coverage Indicated in #4 (Last, First, Middle Initial, Suffix)**: If "yes" is checked in field #4, enter the name of the policyholder for the other dental or medical plan. If the patient has other coverage through a spouse, domestic partner or, if a child, through a parent, the name of the person who has other coverage is reported here.
6	**Required if Applicable**	**Date of Birth (MM/DD/CCYY):** If "yes" is checked in field #4, enter the date of birth of the person listed in field #5. The date must be entered with two digits for the month and day, and four digits for the year of birth.
7	**Required if Applicable**	**Gender:** If "yes" is checked in field #4, mark the gender of the person who is listed in field #5. Mark "**M" for male** or "**F" for female** as applicable.
8	**Required if Applicable**	**Policyholder/Subscriber Identifier (SSN or ID#):** If "yes" is checked in field #4, enter the Social Security Number or the identifier for the person listed in field #5. The identifier number is a number assigned by the payer/ insurance company to this individual.
9	**Required if Applicable**	**Plan/Group Number:** If "yes" is checked in field #4, enter the group plan or policy number for the person identified in field #5.
10	**Required if Applicable**	**Patient's Relationship to Person Named in Field #5:** If "yes" is checked in field #4, check the box corresponding to the patient's relationship to the other insured named in field #5.
11	**Required if Applicable**	**Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code**: If "yes" is checked in field #4, enter the complete information of the additional payer, benefit plan or entity for the insured named in field #5.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
12	**Required**	**Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, and Zip Code:** Enter the complete name, address and zip code of the Medicaid beneficiary receiving treatment.
13	**Required**	**Date of Birth (MM/DD/CCYY)**: Enter the Medicaid beneficiary's date of birth with two digits for the month and day and four digits for the year.
14	**Required**	**Gender:** Mark "**M" for male** or "**F" for female** as applicable for the beneficiary's gender.
15	**Required**	**Policyholder/Subscriber Identifier (SSN or ID#)**: Enter the full 9-digit Medicaid ID number for the beneficiary as indicated on the beneficiary's Medicaid ID card.
16	Not Required	Plan/ Group Number: Not required.
17	**Required if Applicable**	**Employer Name:** Required if the beneficiary has other dental insurance in addition to Medicaid. Enter the name of the policyholder/ subscriber's employer.
18	**Required**	**Relationship to Policyholder/Subscriber in #12 Above:** Mark the relationship of the patient to the person identified in field #12 who has the primary insurance coverage. For Medicaid beneficiaries, mark the box titled "Self" and skip to field #24.
19	Not Required	Student Status: Not required.
20	Not Required	Name (Last, First, Middle Initial, Suffix), Address, City, State, and Zip Code: Not required.
21	Not Required	Date of Birth (MM/ DD/ CCYY): Not required.
22	Not Required	Gender: Not required.
23	Not Required	Patient ID/ Account# (Assigned by Dentist): Not required.
24	**Required**	**Procedure Date (MM/DD/CCYY)**: Enter the procedure date for actual services performed. The date must have two digits for the month, two for the day, and four for the year.
25	**Required if Applicable**	**Area of Oral Cavity:** Enter the area of the oral cavity designated by a two-digit code as follows: 00 Entire oral cavity 01 Maxillary arch 02 Mandibular arch 10 Upper right quadrant 20 Upper left quadrant 30 Lower left quadrant 40 Lower right quadrant
26	Not Required	Tooth System: Not required.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
27	**Required if Applicable**	**Tooth Number(s) or Letter(s):** Enter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise, leave blank. If the same procedure is performed on more than a single tooth on the same date of service, report each procedure code and tooth involved on separate lines on the claim form. When a procedure involves a range of teeth, the range is reported in this field. This is done either with a hyphen "-"to separate the first and last tooth in the range (e.g., 1-4; 7-10; 22-27), or by the use of commas to separate individual tooth numbers or ranges (e.g., 1, 2, 4, 7-10, 3-5, 22-27). Supernumerary teeth in the permanent dentition are identified by tooth numbers 51 through 82; for primary dentition, supernumerary is identified by placement of the letter "S" following the letter identifying the adjacent primary tooth. See **Figure 4-2** for a list of procedure codes that require either a tooth number or a quadrant code.
28	**Required if Applicable**	**Tooth Surface:** Enter a tooth surface code when the procedure performed by tooth involves one or more tooth surfaces. See **Figure 4-2** for a list of procedure codes that require a surface code.
29	**Required**	**Procedure Code:** Enter the appropriate procedure code from the current version of the American Dental Association (ADA) Current Dental Terminology Manual.
30	**Required**	**Description:** Enter a brief description of the service provided (e.g., abbreviation of the procedure code's nomenclature).
31	**Required**	**Fee:** Report the dentist's full fee or usual and customary charge. Do not deduct co-payment from your usual and customary charge.
32	Not Required	Other Fee(s): Not required.
33	**Required**	**Total Fee:** Enter the sum of all fees from lines in field #31.
34	**Required if Applicable**	**Missing Teeth Information:** Report a missing tooth/ teeth when pertinent to periodontal, prosthodontic (fixed and removable), or implant procedures.
35	**Required if Applicable**	**Remarks**: If submitting a claim that was originally submitted within twelve (12) months from the date of service, but is now over twelve (12) months old, enter the 17-digit transaction control number (TCN). If the beneficiary has dental insurance other than Medicaid, and Medicaid is the secondary payer, enter the payment amount received from the primary dental insurance in this field.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
36	**Required**	**Patient Consent:** The beneficiary must sign his/ her name indicating he/ she has agreed that he/ she has been informed of the treatment plan, the costs of treatment and the release of any information necessary to carry out payment activities related to the claim. If the beneficiary cannot write his/ her name, he/ she should sign by a mark and have a witness sign his/ her name and indicate by whom the name was entered. If the beneficiary is a minor or is otherwise unable to sign, any responsible person such as a parent or guardian must enter the beneficiary's name and write "By," sign his/ her own name in the space, show his/ her relationship to the beneficiary, and explain briefly why the beneficiary cannot sign. In lieu of having the beneficiary sign a claim form on each visit, the provider may retain a copy of a statement of release signed by the beneficiary or his/ her guardian. Medicaid will allow a beneficiary signature for a lifetime when the provider has a signature authorization on file. On the claim form, the provider would enter "Signature on file" to satisfy the signature guidelines. If the beneficiary is unable to sign, the billing clerk may sign the beneficiary's name and indicate "By: (name of office person signing)." In addition, the reason the beneficiary is not available must be specified.
37	Not Required	Insured's Signature**:** Not required.
38	**Required**	**Place of Treatment:** Check the appropriate box to indicate the place where services were provided. **Provider's Office** Service provided in the dentist office **Hospital** Service provided in the inpatient or outpatient hospital **ECF** Service provided in an extended care facility, e.g., nursing home, PRTF, ICF/ MR **Other** Service provided in a location other than those listed.
39	Not Required	Number of Enclosures (00 to 99): Not required.
40	Not Required	Is Treatment for Orthodontics?: Not required.
41	Not required	Date Appliance Placed (MM/ DD/ CCYY): Not required.
42	Not Required	Months of Treatment Remaining: Not required.
43	Not Required	Replacement of Prosthesis? Not required.
44	Not Required	Date of Prior Placement (MM/ DD/ CCYY): Not required.
45	Not Required	Treatment Resulting From: Not required.
46	Not Required	Date of Accident (MM/ DD/ CCYY): Not required.
47	Not Required	Auto Accident State: Not required.
48	**Required**	**Billing Dentist Name, Address, City, State, and Zip Code:** Enter the name and complete address of the billing dentist, dental group, FQHC, or RHC.
49	**Required**	**Billing Dentist NPI (National Provider Identifier):** Enter the appropriate NPI number for the billing dentist, dental group, FQHC, or RHC. The NPI is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. An NPI is required for payment of Medicaid claims.

Field	Requirement	Field Name and Instructions for 2006 ADA Dental Claim Form
50	Not Required	License Number: Not required.
51	Not Required	SSN or TIN: Not required.
52	Not Required	Phone Number: Not required.
52A	**Optional**	**Additional Provider ID:** Enter the Medicaid provider number for the billing provider, i.e., dentist, dental group, FQHC, or RHC.
53	**Required**	**Certification:** Enter the signature of the treating or rendering dentist and the date the form was signed. The provider must sign and date the claim form; a rubber stamp signature is not acceptable. If anyone other than the provider is designated to sign the provider's name, a power of attorney must be on file and available on request. The provider is certifying that it is understood that payment and satisfaction of the claim will be from federal or state funds, and that any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable federal and state laws.
54	**Required**	**Treating Dentist NPI:** (National Provider Identifier): Enter the appropriate NPI number for the treating dentist. The NPI is an identifier assigned by the federal government to all providers considered to be HIPAA covered entities. An NPI is required for payment of Medicaid claims.
55	Not Required	License Number: Not required.
56	Not Required	Address, City, State, Zip Code: Not required.
56A	**Required**	**Provider Specialty Code:** Enter the code that indicates the type of dental professional who delivered the treatment. Provider specialty codes, also known as "provider taxonomy" codes, come from the Dental Service Providers section of the Healthcare Providers Taxonomy code list, which is used in HIPAA transactions. The current full list of provider taxonomy codes is posted at www.wpc-edi.com/ codes/ codes.asp.
57	Not Required	Phone Number: Not required.
58	**Optional**	**Additional Provider ID:** Enter the Medicaid provider number for the treating or rendering dentist.

Figure 4-1. Checklist of Required ADA Dental Claim Form Fields

Dental Claim Checklist for Required Fields	Required	Required if Applicable	Optional	Not Required
1 Type of Transaction				✓
2 Predetermination/ Preauthorization Number		✓		
3 Company/Plan Name, Address, City, State, Zip Code	✓			
4 Other Dental or Medical Coverage?	✓			
5 Name of Policyholder/Subscriber with Other Coverage Indicated in Field #4		✓		
6 Date of Birth		✓		
7 Gender		✓		
8 Policyholder/Subscriber Identifier (SSN or ID#)		✓		
9 Plan/Group Number		✓		
10 Patient's Relationship to Person Named in Field #5		✓		
11 Other Insurance Company/ Dental Benefit Plan Name, Address, City, State, Zip Code		✓		
12 Policyholder/Subscriber Name, Address, City, State, Zip Code	✓			
13 Date of Birth	✓			
14 Gender	✓			
15 Policyholder/ Subscriber Identifier (SSN or ID#)	✓			
16 Plan/Group Number				✓
17 Employer Name		✓		
18 Relationship to Policyholder/Subscriber in #12 Above	✓			
19 Student Status				✓
20 Name, Address, City, State, Zip Code				✓
21 Date of Birth				✓
22 Gender				✓
23 Patient ID/Account#				✓
24 Procedure Date	✓			
25 Area of Oral Cavity		✓		
26 Tooth System				✓
27 Tooth Number(s) or Letter(s)		✓		
28 Tooth Surface		✓		

Dental Claim Checklist for Required Fields	Required	Required if Applicable	Optional	Not Required
29 Procedure Code	✓			
30 Description	✓			
31 Fee	✓			
32 Other Fee(s)				✓
33 Total Fee	✓			
34 Missing Teeth Information		✓		
35 Remarks		✓		
36 Patient Consent	✓			
37 Insured's Signature				✓
38 Place of Treatment	✓			
39 Number of Enclosures				✓
40 Is Treatment for Orthodontics?				✓
41 Date Appliance Placed				✓
42 Months of Treatment Remaining				✓
43 Replacement of Prosthesis?				✓
44 Date of Prior Placement				✓
45 Treatment Resulting From				✓
46 Date of Accident				✓
47 Auto Accident State				✓
48 Billing Dentist Name, Address, City, State, Zip Code	✓			
49 Billing Dentist NPI	✓			
50 License Number				✓
51 SSN or TIN				✓
52 Phone Number				✓
52A Additional Provider ID	✓		✓	
53 Certification	✓			
54 Treating Dentist NPI	✓			
55 License Number				✓
56 Address, City, State, Zip Code				✓
56A Provider Specialty Code	✓			
57 Phone Number				✓
58 Additional Provider ID	✓		✓	

Figure 4-2. Required Fields for Certain Dental Procedure Codes

Code	Surface	Tooth Number	Quadrant
D1351		X	
D2140	X	X	
D2150	X	X	
D2160	X	X	
D2161	X	X	
D2330	X	X	
D2331	X	X	
D2332	X	X	
D2335	X	X	
D2390	X		
D2391	X	X	
D2392	X	X	
D2393	X	X	
D2394	X	X	
D2750		X	
D2751		X	
D2752		X	
D2930		X	
D2931		X	
D2933		X	
D2934		X	
D2940		X	
D3220		X	

Code	Surface	Tooth Number	Quadrant
D3310		X	
D3320		X	
D3330		X	
D4210			X
D4211			X
D4240			X
D4241			X
D4260			X
D4261			X
D4341			X
D4342			X
D7140		X	
D7210		X	
D7220		X	
D7230		X	
D7240		X	
D7241		X	
D7250		X	
D7280		X	
D7310			X
D7311			X
D7320			X
D7321			X

5.0 Pharmacy

This section contains contact information, to include telephone numbers, mailing addresses, and website addresses, which will provide a point of contact for almost any question that requires a response, and provides a quick reference and definitions for essential Pharmacy billing information. Providers must utilize this section in conjunction with the Mississippi Medicaid Provider Policy Manual. You may refer to the policy manual and fee schedules for issues concerning policy and the specific procedures for which Medicaid reimburses. Fee schedules can be found on the DOM web site at http://www.medicaid.ms.gov.

Contact Information for Pharmacy Providers			
		Telephone #	**Fax #**
Affiliated Computer Services (ACS)	Fiscal Agent	800-844-3222 or 601-206-3000	601-206-3059
Automated Voice Response System (AVRS)	Eligibility	866-597-2675 or 601-206-3090	
Division of Medicaid (DOM)	Pharmacy Services	800-421-2408 or 601-359-5253	601-359-9555
Health Information Designs (HID)	Prior Authorizations	800-355-0486	800-459-2135
Pharmacy Helpdesk		866-759-4108	866-209-4502

Beneficiary Eligibility

A beneficiary's MS Medicaid (green) card should be checked at every pharmacy visit to validate current identification number. Eligibility status can be verified through the AVRS system at 866-597-2675 or 601-206-3090. Pharmacists should use professional discretion to verify patient identity.

Retroactive Eligibility

Retroactive Pharmacy Claims can be processed electronically through the POS system for up to one calendar year from the original date of service on a Medicaid beneficiary. Retroactive Pharmacy Claims older than 12 months may be processed via paper submission on a MS Medicaid Pharmacy Claim Form or via the web portal, as long as the claim submission date is not more than 24 months from the original date of service. See **Web Portal Pharmacy Claims** submission for detailed instructions for submitting Retro Pharmacy Claims.

Claim Payments to Providers

Providers who wish to inquire about their check amount are referred to AVRS at 866-597-2675 or 601-206-3090.

Co-Payments

Co-pays for all drugs (Brand, Generic or OTC) are $3.00 per prescription.

Use the following Exemption Codes
Infants (newborns only)-**K**; See K-baby section
Children under age 18-**C**
Pregnant women – a '**P**' must be written on the prescription
Long Term Care Beneficiaries-**N**
Family Planning Beneficiaries-**F** (yellow card holders)

Cycle Billing- Automatic Refill

DOM does not allow prescriptions to be automatically refilled for MS Medicaid beneficiaries. The refill of a prescription must be initiated by the beneficiary.

Days Supply

Beneficiaries are limited to a maximum of a 31-day supply based on the daily dosage for all prescriptions. MS Medicaid allows a 90 day supply on a limited number of maintenance medications. For the current 90 day maintenance list, go to:
http://www.medicaid.ms.gov/Documents/Pharmacy/90DayMaintenanceList.pdf click on 90 day maintenance list.

Dispense as Written (DAW) Codes

(See Narrow Therapeutic Index Drugs – DAW 7 located in this section)

Dispensing Fee

The dispensing fee is $3.91 for branded products and $4.91 for generic products. Dispensing fee for beneficiaries residing in a Long Term Care facility is $3.91 for all drugs.

Drug Limits

Beneficiaries are entitled to five prescriptions per month, of which, two may be brand products. *Long term care residents are exempt from this limit.*

Beneficiaries under the age of 21 may receive more than the prescription limit, if medically necessary, through expanded EPSDT services when prior authorization is requested by the prescriber from HID.

Dual Eligibles

Dual eligibles are those beneficiaries who are eligible under both Medicare and Medicaid and receive primary drug coverage under Medicare Part D**.** Medicare Part D payment is considered payment in full and should not be submitted to Medicaid.

For drugs not covered by Medicare Part D, Medicaid offers limited coverage of some drugs.

Durable Medical Equipment (DME)/Medical Supplies

DOM does not process any DME/medical supply claims via POS. Pharmacies may be DME providers; however, in order for DOM to reimburse for DME/medical supplies, the pharmacy must enroll as a MS Medicaid DME provider. All DME items and/or medical supplies must be filed on a CMS-1500 claim form. See the CMS 1500 section of this manual for further instructions.

Fraud

If you suspect a case of fraud, please call MS Medicaid Program of Integrity 1-800-880-5920 or 601-576-4162 or via the web at http://www.medicaid.ms.gov/PI/FraudAbuse/WebFormFraudAbuse.aspx.

Health Information Designs (HID)

DOM contracts with Health Information Designs, Inc. (HID) to provide prior authorization services. Through its offices in the Jackson area, HID operates a call center and employs a clinical staff of pharmacists and nurses to review and process prior authorization requests from Mississippi Medicaid providers. For a listing of drugs requiring prior authorization, refer to www.hidmsmedicaid.com .

Health Information Portability and Accountability Act (HIPAA)

All POS transactions submitted to MS Division of Medicaid must be HIPAA compliant. Data must now be encoded to comply with NCPDP 5.1 format.

Hospice Drug Coverage

Medicaid beneficiaries enrolled in Hospice Services are covered under a per diem rate which covers all services for that beneficiary. For those beneficiaries receiving Medicaid Hospice Services, all palliative therapy, or drugs used to treat beneficiary's terminal illness, is to be billed to the Hospice provider. Medicaid will only pay for drugs used for an indication not directly related to the beneficiary's terminal illness that are within the applicable Medicaid prescription service limits. Since plans of care are specific for beneficiaries, it is the responsibility of the dispensing pharmacy to bill the Hospice Provider or Medicaid appropriately. The dispensing pharmacy must retain documentation regarding Hospice Service drug coverage for beneficiaries which is easily retrievable for auditing purposes.

All Medicaid policies and procedures such as prior authorization requirements and limits are still applicable. Pharmacy providers must maintain the explanation of benefits (EOB) from other insurance companies (or payers, i.e., Hospice). These records must be available to Medicaid upon request.

How to Bill a Non-Covered Hospice Drug

Pharmacy may override electronically by entering a '3' in the 'Other Coverage Code" field. It is the responsibility of the pharmacy to have documentation and proof that Hospice was billed first and that they received a denial of 'drug not covered' in case of an audit.

When Hospice Is No Longer In Effect

Hospice Providers must submit a disenrollment form (DOM-1166) to ACS, Medicaid's Fiscal Agent, for Medicaid beneficiaries who are no longer receiving care by that Hospice Provider. Disenrollment forms may be found at http://www.medicaid.ms.gov, Provider Manual under Hospice, and should be mailed to the Fiscal Agent at the address noted on top of the form. Forms may also be faxed to ACS's Provider Beneficiary Relations at 601-206-3015.

For additional information regarding Hospice, refer to the Hospice Provider Manual, at

http://www.medicaid.ms.gov, Provider Manuals, and select Hospice.

K-Baby

K-babies are newborns born to a Medicaid beneficiary without an assigned Medicaid ID. When billing for prescription drugs for a K-baby, use the mother's Medicaid ID number followed by the letter 'K' with the baby's name, date of birth and gender.

Lock-In

Beneficiaries can be locked into a specific pharmacy provider and/or prescriber(s) which means they can only receive their prescriptions from an assigned provider. If they attempt to have their prescriptions written or filled at a provider other than the one assigned, their claims will deny. MS Bureau of Program Integrity administers this program and can be reached at 1-800-880-5920 or 601-576-4162.

Long-Term Care (LTC)

Long-term care beneficiaries are exempt from the prescription drug limits. The dispensing fee for all drugs dispensed to a patient in LTC is $3.91. Drugs in tamper-resistant packaging that were prescribed for a resident in a LTC facility, but never administered, can be returned to the pharmacy and should not be billed to Medicaid in accordance with Mississippi State Board of Pharmacy laws.

Lost/Stolen Medications

If a beneficiary's medication is lost or stolen, DOM allows the beneficiary to have a prescription refilled in some situations with an override from HID if service limits have not been exhausted. If you have questions, contact HID.

Max Daily Dose

The max daily dose sets a DUR edit for High Dose, if the daily dose exceeds the max daily dose on the drug file. If a beneficiary's medical condition requires a higher dose, DOM allows the beneficiary to have the higher unit dose with prior approval, which is handled by HID.

Medicare Part B

Beneficiaries with Medicare Part B services are allowed minimal prescription drug coverage. DME pharmacy providers may submit Medicare crossover claims to Medicaid using a CMS-1500 claim form. Refer to the CMS-1500 section of the Billing Manual for further instructions.

DOM does not process any Medicare Part B claims via POS.

Medicare Part D

Medicare Part D is the portion of Medicare that covers prescription drugs. Any Medicaid beneficiary eligible for Medicare Part A and B is eligible for Medicare Part D and **MUST** enroll for coverage. Medicare Part D must be billed before Medicaid in all circumstances. Medicare Part D payment is considered payment in full and should not be submitted to Medicaid for additional payment. Remember Medicaid is always the payor of last resort.

For drugs not covered by Medicare Part D, Medicaid offers limited coverage of some drugs.

Narrow Therapeutic Index Drugs – DAW 7

DOM recognizes some drugs as narrow therapeutic index (NTI) drugs in which the generic mandate does not apply. Claims must be submitted with a DAW equal to "7". MS Medicaid considers the following five drugs as NTI drugs:

- Coumadin
- Dilantin
- Lanoxin
- Synthroid
- Tegretol

The prescriber must indicate one of the following on a written or faxed prescription in order for the pharmacist to submit the DAW 7:

- Brand name medically necessary **or**
- Dispense as written **or**
- Do not substitute.

Over the Counter (OTC) Drug Coverage

Medicaid covers certain over-the-counter (OTC) drugs pursuant to a written, faxed or verbal order prescription. Covered OTC products must be manufactured by pharmaceutical companies who are participating in the Federal Drug Rebate Program. OTC drug prescriptions are included in the monthly drug benefit limit. DOM may not cover ALL available package sizes.
A current listing of the covered OTC products can be found at http://www.medicaid.ms.gov/Documents/Pharmacy/OtcListEff01012009.pdf click on the "OTC List".

**List Subject to Revision

Paper Claims

All paper claims are processed by ACS. Pharmacists should submit paper claims to the following address:

Mississippi Medicaid Program
P. O. Box 23076
Jackson, Mississippi 39225

Refer paper claim questions to ACS at 800-884-3222. See the billing forms section of this manual for a copy of the Pharmacy Paper Claim and instructions.

Payor Sheet

A separate NCPDP Payor sheet is included in the appendix section of this manual for specific NCPDP 5.1 DOM POS requirements.

Pharmacy Disease Management

Pharmacy Disease Management services are those provided by specially credentialed pharmacists for Medicaid beneficiaries with specific chronic disease states of diabetes, asthma, hyperlipidemia, anticoagulation therapy, or other disease states as defined by the Mississippi State Board of Pharmacy. The pharmacist providing DM services must have an individual MS Medicaid Provider Number and

NPI. Claims filed for these services must be submitted on a CMS 1500 form and not billed through POS.

For more information go to:
http://www.medicaid.ms.gov/Manuals/Section%2031%20-%20Pharmacy/Section%2031.19%20-%20Pharmacy%20Disease%20Management.pdf.

Pharmacy Providers

All providers dispensing medications for the Division of Medicaid (DOM) must be a Mississippi Medicaid provider. Pharmacists must use their National Provider Identifier (NPI) to bill POS pharmacy claims to Mississippi Medicaid.

Providers who have questions about remittance advice statements, check inquiries, billing medical supplies, publications, and beneficiary eligibility can call the Provider Inquiry Unit: 800-884-3222 or 601-206-3000.

Providers can also utilize the Mississippi Medicaid Web Portal for the most current information. Providers can enroll online, check claim status, check eligibility, and check policy through the web portal. Once registered as a provider, pharmacies can also submit claims (CMS 1500 claims, 72 Hour Emergency, Retroeligibility and TPN claims) online, through the Envision web portal. The web portal is a one-stop shop for Medicaid providers. The Web Portal address is: https://msmedicaid.acs-inc.com.

Prescription Benefits

Description	Prescription Benefits
Regular Beneficiaries	Full Prescription Benefits
Long-Term Care Beneficiaries	Full Prescription Benefits
Dually Eligible – Qualified Medicare Beneficiary (QMB)	Medicare Part D
Early Periodic Screening, Diagnosis and Treatment (EPSDT) Children under 21	Full Prescription Benefits
Family Planning Beneficiaries	Limited Prescription Benefits
Dually Eligible – Specified Low Income Medicare Beneficiary (SLMB)	Medicare Part D
K- Baby (newborns without a Medicaid ID number)	Full Prescription Benefits

Preferred Drug List (PDL)

The mandatory Preferred Drug List for Mississippi Medicaid was implemented March 1, 2005. The PDL is updated every January 1st and July 1st. To view the current PDL, go to http://www.medicaid.ms.gov/Pharmacy.aspx. The PDL is maintained by First Health Services Corporation, and can be found at http://www.providersynergies.com/services/medicaid/default.asp?content=Mississippi .

Prescriber's NPI

Beginning January 2, 2008, pharmacies should submit claims using the prescriber's National Provider Identifier. For a list of prescriber NPIs, go to:

https://msmedicaid.acs-inc.com/msenvision/prescribingProviderList.do or https://nppes.cms.hhs.gov/NPPES/Welcome.do .

Prior Authorizations

The Mississippi Division of Medicaid requires prior authorization for reimbursement of pharmacy claims under certain circumstances. The prior authorization process is designed to encourage appropriate use of cost-effective pharmaceuticals for Medicaid beneficiaries. HID's website, www.hidmsmedicaid.com, provides access to prior authorization criteria and forms, as well as the current Mississippi Medicaid preferred drug list (PDL).

The staff is available to providers through the following contact information:

HID Mailing Address
Health Information Designs, Inc. P O Box 320506 Flowood, MS 39232
Telephone and FAX Numbers
Telephone: 1-800-355-0486 Facsimile: 1-800-459-2135
Website Address
www.hidmsmedicaid.com
Email Address
pa_ms@hdinfo.com

Refill- too-Soon (Early Refill)

The refill-too-soon or early refill logic is set up to allow a beneficiary the opportunity to get their prescriptions filled no more than 25% early for regular legend drugs and no more than 15% early for controlled drugs.

- DUR overrides do not stop the early refill edits from posting.
- Early refill requests are handled by HID.

Reimbursement

For the current DOM reimbursement methodology, visit the DOM website at: http://www.medicaid.ms.gov/Manuals/Section%2031%20-%20Pharmacy/Section%2031.04%20-%20Reimbursement.pdf.

Suspended Claims

Mississippi Medicaid does not suspend any pharmacy POS claims. Claims pay or deny. Exceptions are some claims entered through the web portal. See **Web Portal Section** for specific information.

Third Party Liability (TPL)

Mississippi Medicaid Pharmacy Point of Sale- How to bill other insurance (cost avoidance)

Pharmacy providers are required to bill prescription claims to private third party insurance carriers for those beneficiaries covered by both Medicaid and other third party insurance.

Mississippi Medicaid Electronic Procedure for Billing Other Insurance

A. Beneficiaries whose data on file with Medicaid indicates other third party coverage:

1. Pharmacy sends electronic claim to fiscal agent and it is rejected with NCPDP Reject Code "41" which will display the message, "Submit Bill to Other Processor or Primary Payer". The text of the rejection message (NCPDP Field # 504-F4) will also state the Third Party payer information including name, address and telephone number.
2. Pharmacy sends claim to Third Party Payer.
   a. Third Party Payer *pays 100%* of the Medicaid allowable charge- Claim may be resubmitted to Medicaid but no payment will result.
   b. Third Party Payer *pays less than 100%* of the Medicaid allowable- Claim should be resubmitted to Medicaid.
      i. Enter the total amount paid by Third Party Payer in the "TPL Amount Paid" field (NCPDP Field # 431-DV -'Other Payer Amount Paid').
      ii. Enter '02' in 'Other Coverage Code' Field (#308-C8- Other Coverage Exists-Payment Collected).
      iii. Submit claim to Medicaid fiscal agent for the full usual and customary amount. DO NOT SUBMIT COPAY AMOUNT ONLY.
      iv. Resulting payment will be Medicaid allowable minus TPL Amount Paid.
   c. Third Party Payer sends back a *$0.00 Paid* Amount* (Rejection or Denial) *Valid Values for 'Other Payer Reject Codes' (Field # 472-6E) received from other insurance are:
      40= Pharmacy Not Contracted with Plan on Date of Service
      65= Patient is Not Covered
      67= Filled Before Coverage Effective
      68= Filled After Coverage Expired
      69= Filled After Coverage Terminated
      70= Product/Service Not Covered
      73= Refills are Not Covered
      76= Plan Limitations Exceeded
      i. **Enter $0.00 in the 'TPL Amount Paid'** Field 431-DV
      ii. In Field #'**308-C8,'Other Coverage Code' one of the following** applicable values **should** be entered:
         a. **01= No Other Coverage Exists** (Ex: Claim denies due to coverage expired)
         b. **03= Other Coverage Exists**-Claim Not Covered (Ex: Claim denies due to non-coverage of drug by insurance and drug is covered by Medicaid)
         c. **04= Other Coverage Exists**-Payment Not Collected
         d. **06= Other Coverage Denied**- Not Participating Provider (Ex: Beneficiary has insurance coverage but the pharmacy and/or prescriber are out of the insurance company's network.
         e. **07= Other Coverage Exists**- Not in Effect on Date of Service

iii. Submit claim to Medicaid fiscal agent.
iv. Claim will pay Medicaid Allowable

B. Beneficiaries whose data on file indicates no other coverage but provider is aware of other insurance coverage.
1. Follow steps under "A" above.
2. Provider must report the beneficiary's other insurance to Medicaid: Call Bureau of Recovery- Division of Medicaid- 601-359-6095, 601-359-6082, 601-359-6831 Or (preferably) FAX information to: 1-601-359-6632

Notes:
Pharmacy providers must keep explanation of benefits (EOB) from other insurance companies. These records must be available to Medicaid upon request. Remember, Medicaid is always the payer of last resort. If a beneficiary tells the provider that his/her insurance policy is no longer in effect, that the policy never existed, or that the policy is for something other than medical insurance, the provider should obtain a signed statement from the beneficiary which includes the name of the insurance company, the policy number, and the ending date of coverage. The signed statement should be forwarded to the DOM Bureau of Recovery. Upon receipt of this information, the patient's statement will be researched and, if necessary, the third party resource file will be updated.

Timely Filing Limits
Providers must submit claims within 365 days.

Total Parenteral Nutrition (TPN)
Claims for TPN (hyper-alimentation, IDPN, and IPN) solutions must be submitted as follows:

- Claims are to be billed via the web portal or on a paper Mississippi Medicaid Pharmacy Claim form and sent to DOM. **See Web Portal Section of this document and Section 5.2 of this handbook for specific instructions.**
- Claims are to be billed monthly for no more than a max 31-day supply.
- Claims should list the actual NDC number(s) with the quantity of each ingredient used beginning with the most costly ingredient.
- The provider should bill for the number of milliliters of TPN that were dispensed to the beneficiary during the billing period.
- The maximum dispensing fee shall not exceed $30.00 per liter.
- The quantity for those non-covered NDCs will not be included in the total liter quantity to determine the dispensing fee.
- For dually eligible beneficiaries, Mississippi Medicaid will not cover TPNs. Such claims should not be submitted to DOM.
-

Vacation Supply
DOM does not allow for a vacation supply.

Web Addresses

ACS	https://msmedicaid.acs-inc.com
Division of Medicaid (DOM)	http://www.medicaid.ms.gov
First Health Services Corporation	http://www.providersynergies.com/services/medicaid/default.asp?content=Mississippi
Health Information Designs (HID)	www.hidmsmedicaid.com

Web Portal Claims Entry

DOM allows certain claims to be submitted for reimbursement through the web portal at https://msmedicaid.acs-inc.com/msenvision/index.do .

- 72 hour emergency fill claims
- Disputed Reimbursement pharmacy claims
- Regular POS pharmacy claims in emergency situations
- Retroactive eligibility claims older than 12 months
- TPN- Total Parenteral Nutrition claims

Please refer to the Web Portal Pharmacy Claim section of this manual for explicit instructions for submitting these claims.

5.1 Pharmacy Claim Form Instructions

Medicaid Title XIX Pharmacy Invoice

☐ 72 Hour Emergency Supply
☐ Dispute Reimbursement
☐ Retro Eligibility
☐ TPN/ Special Pricing Claim

State of Mississippi
Division of Medicaid
P.O. Box 23076
Jackson, MS 39225

PROVIDER INFORMATION			
[1]Provider Name	[2]NPI _ _ _ _ _ _ _ _ _ _	[3]Medicaid Number _ _ _ _ _ _ _ _	[4]Phone # Fax #
[5]Street Address	[6]City	[7]State	[8]Zip Code
BENEFICIARY INFORMATION	[9]Medicaid ID _ _ _ _ _ _ _ _ _ Medicare # _ _ _ _ _ _ _		
[10]Last Name	[11]First Initial	[12]DOB _ _/_ _/_ _ _ _	

1	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price
2	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price
3	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price
4	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price
5	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under that state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency request. I further agree to accept as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized co-payment.

26. Pharmacist's Signature: _____ 27. Date: _____

28. Pharmacist's Name Printed: _____

CLAIM FORM INSTRUCTIONS FOR PHARMACY SERVICES

Field	Requirement	Field Name and Instructions for Pharmacy Claim Form
1	Required	**Provider's Name:** Enter the Billing Provider's Name
2	Required	**NPI:** Enter the Billing Provider's10 digit National Provider Identifier
3	Optional	**Medicaid Number:** Enter the Billing Provider's 8- digit Medicaid Provider Number.
4	Required	**Phone #, Fax #:** Enter the Billing Provider's 10 digit phone and fax numbers
5	Required	**Street Address:** Enter the Billing Provider's **Mailing** Street Address
6	Required	**City:** Enter the Billing Provider's City
7	Required	**State:** Enter the Billing Provider's State
8	Required	**Zip Code:** Enter the Billing Provider's **Mailing** Zip Code
9	Required if Applicable	**Medicaid ID, Medicare #:** Enter the Beneficiary's 9 digit Medicaid Identification Number (include Medicare number, if applicable)
10	Required	**Last Name:** Enter the Beneficiary's Last Name as it appears on Medicaid Card
11	Required	**First Initial:** Enter the Beneficiary's First Name Initial
12	Required	**Date of Birth:** Enter the Beneficiary's Date of Birth (MM/DD/YYYY)
13	Required	**Rx Number:** Enter the pharmacy prescription number
14	Required	**Prescriber NPI:** Enter the Prescriber's 10 digit National Provider Identifier
15	Required if applicable	**Prescriber Medicaid #:** Enter the Prescriber's 9 digit Medicaid Provider Number
16	Required	**Date of Service:** Enter the date the prescription was filled (MM/DD/YYYY)
17	Required	**New or Refill:** Check appropriate box to indicate if prescription is New or a Refill
18	Required	**Drug Name:** Enter the Name of the Drug
19	Required	**Days Supply:** Enter the estimated number of days supply for the drug billed
20	Required	**Quantity:** Enter the quantity of the drug dispensed
21	Required	**Dispensing Fee:** Enter the appropriate dispensing fee code. A= IV drugs C= hyperalimentation
22	Required	**NDC:** Enter the 11 digit National Drug Code for the drug dispensed
23	Not Required	Blank: Do NOT write in this field
24	Required	**TPL Amount:** Enter the total third party insurance payment received
25	Required	**U&C Price:** Enter the usual and customary charge for the drug dispensed
26	Required	**Pharmacist's Signature:** The pharmacy claim form must be signed by the pharmacist.
27	Required	**Date:** Enter the date that the claim form was completed (MM/DD/YYYY)
28	Required	**Pharmacist's Name Printed:** Print the submitting pharmacist's name.

5.2 Pharmacy Payor Sheet

NCPDP VERSION 5.1 PAYER SHEET – B1/B3 Transactions

GENERAL INFORMATION

Payor Name: Mississippi- Division of Medicaid	Date: August 21,2008
Plan Name/Group Name: Mississippi Division of Medicaid	
Processor: ACS	Switch:
Effective as of: October 2003 Revised: January 1, 2008	Version/Release #: 5.1
Provider Relations Help Desk Info: 1-866-759-4108	

*** OTHER TRANSACTIONS SUPPORTED ***

Payer: Please list each transaction supported with the segments, fields, and pertinent information on each transaction.

Transaction Code	Transaction Name
B1	**Billing**
B3	**Rebill**

BILLING TRANSACTION:

Transaction Header Segment: *Mandatory in all cases*

Field	NCPDP Field Name	Value	M/R/RW	Comment
1Ø1-A1	BIN Number	610084	M	
1Ø2-A2	Version/Release Number	5.1	M	
1Ø3-A3	Transaction Code	B1 = Billing B2 = Reversals B3 = Rebill	M	
1Ø4-A4	Processor Control Number	DRMSPROD	M	
1Ø9-A9	Transaction Count	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	
2Ø2-B2	Service Provider ID Qualifier	01- National Provider Identifier	M	
2Ø1-B1	Service Provider ID	National Provider Identifier	M	
4Ø1-D1	Date of Service	CCYYMMDD	M	
11Ø-AK	Software Vendor/Certification ID	This will be supplied by the provider's software vendor	M	If no number is supplied, populate with zeros

Patient Segment: *Optional*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø1	M	Patient Segment
331-CX	Patient ID Qualifier	Blank = Not Specified 01=Social Security Number 02=Driver's License Number 03=U.S. Military ID 99=Other	NA	Not used by DOM
332-CY	Patient ID		NA	Not used by DOM
304-C4	Date of Birth	CCYYMMDD	R	
305-C5	Patient Gender Code	0=Not specified 1=Male 2=Female	R	
310 –CA	Patient First Name	Up to 12 characters	NA	Not used by DOM
311 – CB	Patient Last Name	Up to 15 characters	NA	Not used by DOM
322-CM	Patient Street Address	Up to 30 characters	NA	Not used by DOM
323-CN	Patient City Address	Up to 20 Characters	NA	Not used by DOM
324-CO	Patient State/Province Address	2 characters	NA	Not used by DOM
325-CP	Patient Zip/POSTAL Zone	Up to 15 characters	NA	Not used by DOM
326-CQ	Patient Phone Number	Up to 10 characters	NA	Not used by DOM
307-C7	Patient Location	**0=Not specified** **01=Home** 02=Inter-Care **03=Nursing Home** 04=Long Term/Extended Care 05=Rest Home **06=Boarding Home** 07=Skilled Care Facility 08=Sub-Acute care Facility 09=Acute Care Facility 10=Outpatient 11=Hospice	NA	Not required by DOM
333-CZ	Employer ID		NS	Not Supported
334-1C	Smoker/Non-Smoker Code		NS	Not Supported
335-2C	Pregnancy Indicator	Blank=Not Specified 1=Not pregnant 2=Pregnant	RW	Required when submitting a claim for a pregnant member

Insurance Segment: *Mandatory*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID	9 digit Medicaid ID number	M	
312-CC	Cardholder First Name	12 characters	R	
313-CD	Cardholder Last Name	20 Characters	R	
314-CE	Home Plan		NS	Not Supported
524-FO	Plan ID	3 characters	NA	Auto Populated when claim is processed
309-C9	Eligibility Clarification Code	0=Not specified 1=No Override 2=Override 3=Full Time Student 4=Disabled Dependent 5=Dependent Parent 6=Significant Other	NA	Not used by DOM
336-8C	Facility ID		NS	Not Supported
301-C1	Group ID	SIPPI	R	
306-C6	Patient Relationship Code	**1 = Cardholder** 2 = Spouse 3=Child 4=Other	RW	Not required by DOM

Claim Segment: *Mandatory*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	1 = Rx Billing	M	
4Ø2-D2	Prescription/Service Reference Number	Number assigned by the pharmacy	M	
436-E1	Product/Service ID Qualifier	03 = National Drug Code	M	
4Ø7-D7	Product/Service ID	NDC Number	M	
456-EN	Associated Prescription/ Service Reference #		NA	Not used by DOM
457-EP	Associated Prescription/Service Date		NA	Not used by DOM
458-SE	Procedure Modifier Count		NA	Not used by DOM
459-ER	Procedure Modifier Code Count		NA	Not used by DOM
442-E7	Quantity Dispensed	Metric Decimal Quantity	R	
403-D3	Fill Number	0 = Original Dispensing 1-99 = Number of refills	R	
405-D5	Days Supply		R	
406-D6	Compound Code	0 = Not specified 1= Not a compound **2 = Compound**	RW	Required when submitting a claim for a compound
408-D8	Dispense as Written (DAW)	0=Default, no product selection indicated 1=Physician request 2=patient request 3=pharmacist request 4=generic out of stock (temp) 5=brand used as generic 6=override **7=brand mandated by law** 8=generic not available in marketplace 9=not used	RW	Required when submitting a claim for Narrow Therapeutic Index Drugs.
414-DE	Date Prescription Written	CCYYMMDD	R	
415-DF	Number of Refills Authorized	0=Not Specified 1-99=number of refill	NA	Not used by DOM
419-DJ	Prescription Origin Code	0=Not specified 1=Written 2=Telephone 3=Electronic 4=Facsimile	NA	Not used by DOM

Field	NCPDP Field Name	Value	M/R/RW	Comment
420-DK	Submission Clarification Code	0=Not specified, default 1=No override 2=Other override 3=Vacation Supply 4=Lost Prescription 5=Therapy Change 6=Starter Dose 7=Medically Necessary 8=Process compound for Approved Ingredients 9=Encounters 99=Other	RW	Required when submitting a claim for a compound that has non-approved or ingredients without an NDC number
460-ET	Quantity Prescribed		NS	Not used, use 442-E7
308-C8	Other Coverage Code	**0=Not Specified** 1=No other Coverage Identified **2=Other coverage exists-payment collected** **3=Other coverage exists-this claim not covered** **4=Other coverage exists-payment not collected** 5=Managed care plan denial 6=Other coverage exists, not a participating provider 7=Other Coverage exists-not in effect at time of service 8=Claim is a billing for a co-pay	RW	Required when submitting a claim for a recipient who has other coverage
429-DT	Unit Dose Indicator	0=Not specified 1=Not Unit Dose 2=Manufacturer Unit Dose 3=Pharmacy Unit Dose	NA	Not used by DOM
453-EJ	Orig Prescribed Product/Service ID Qual	01=Universal Product Code (UPC) 03=National Drug Code (NDC)	NA	Not used by DOM

Field	NCPDP Field Name	Value	M/R/RW	Comment
445-EA	Originally Prescribed Product/Service Code		NA	Not used by DOM
446-EB	Originally Prescribed Quantity		NA	Not used by DOM
330-CW	Alternate ID		NS	Not Supported
454-EK	Scheduled prescription ID Number		NS	Not Supported
600-28	Unit of Measure		NS	Not Supported
343-HD	Dispensing Status		NA	Not used by DOM
344-HF	Quantity Intended to be Dispensed		NA	Not used by DOM
345-HG	Days Supply Intended to be Dispensed		NA	Not used by DOM

Pharmacy Provider Segment: *Optional*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø2	M	Pharmacy Provider Segment
465-EY	Provider ID Qualifier	Blank=Not specified 01=Drug Enforcement Administration (DEA) 02=State License 03=Social Security Number (SSN) 04=Name 05=National Provider Identifier (NPI) 06=Health Industry Number (HIN) 07=State Issued 99=Other	NA	Not used by DOM
444-E9	Provider ID		NA	Not used by DOM

Prescriber Segment: *Optional*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø3	M	Prescriber Segment
466-EZ	Prescriber ID Qualifier	01-National Provider Identifier 05=Medicaid ID 12=DEA#	R	
411-DB	Prescriber ID	National Provider Identifier	R	
467-1E	Prescriber Location Code		NS	Not Supported
427-DR	Prescriber Last Name	15 characters	NA	Not used by DOM
498-PM	Prescriber Phone Number	10 characters	NA	Not used by DOM
468-2E	Primary Care Provider ID Qualifier	Blank=Not Specified 01=National Provider ID (NPI) 02=Blue Cross 03=Blue Shield 04=Medicare 05=Medical Assistance Program 06=UPIN 07=NCPDP Provider ID 08=State License 09=Champus 10=Health Industry Number (HIN) 11=Federal Tax ID 12=Drug Enforcement Administration (DEA) 13=State Issued 14=Plan Specific 99=Other	NA	Not used by DOM
421-DL	Primary Care Provider ID	15 characters	NA	Not used by DOM
469-H5	Primary care Provider Location Code		NS	Not Supported
470-4E	Primary Care Provider Last Name		NS	Not Supported

COB/Other Payments Segment: *Optional*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø5	M	COB/Other Payments Segment
337-4C	Coordination of Benefits/Other Payments Count		M	
338-5C	Other Payer Coverage Type		M (Repeating)	
339-6C	Other Payer Id Qualifier	Blank=Not Specified 01=National Payer ID 02=Health Industry Number 03=Bank Information Number (BIN) 04=National Association of Insurance Commissioners (NAIC) 09=Coupon 99-Other	NA	Not used by DOM
340-7C	Other Payer ID	10 characters	NA	Not used by DOM
443-E8	Other Payer Date	CCYYMMDD	RW (Repeating)	Required when there is payment from another source
341-HB	Other Payer Amount Paid Count		NA	Not used by DOM
342-HC	Other Payer Amount Paid Qualifier	Blank=Not specified 01=Delivery 02=Shipping 03=Postage 04=Administrative 05=Incentive 06=Cognitive Service 07=Drug Benefit 08=Sum of all Reimbursement 98=Coupon 99=Other	RW (Repeating)	Required when there is payment from another source
431-DV	Other Payer Amount Paid	S$$$$$$cc	RW	Required when there is payment from another source
471-5E	Other Payer Reject Count	2 Characters	NA	Not used by DOM
472-6E	Other Payer Reject Code		NA	Not used by DOM

***Workers' Compensation Segment:* Not** *used by Mississippi Division of Medicaid*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø6	NA	Workers' Compensation Segment
434-DY	Date of Injury		NA	
315-CF	Employer Name		NS	Not Supported
316-CG	Employer Street Address		NS	Not Supported
317-CH	Employer City Address		NS	Not Supported
318-CI	Employer State/Province ID		NS	Not Supported
319-CJ	Employer Zip/Postal Zone		NS	Not Supported
320-CK	Employer Phone Number		NS	Not Supported
321-CL	Employer Contact Name		NS	Not Supported
327-CR	Carrier ID		NS	Not Supported
435-DZ	Claim/Reference ID		NS	Not Supported

DUR/PPS Segment: *Optional*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø8	M	DUR/PPS Segment
473-7E	DUR/PPS Code counter		NA	Not used by DOM
439-E4	Reason For Service Code	See Attached list of valid values	RW (Repeating)	Required when there is a conflict to resolve or reason for service to be explained
440-E5	Professional Service Code	See Attached list of valid values	RW	Required when there is a professional service to be identified
441-E6	Result of Service Code	See attached list of valid values	RW	Required when there is a result of service to be submitted
478-8E	DUR/PPS Level of Effort		NA	Not used by DOM
475-J9	DUR Co-Agent ID Qualifier		NA	Not used by DOM
476-H6	DUR Co-Agent ID		NA	Not used by DOM

Pricing Segment: *Mandatory*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	11	M	Pricing Segment
409-D9	Ingredient Cost Submitted		R	Required by ACS
412-DC	Dispensing Fee Submitted		NA	Not used by DOM
477-BE	Professional Service Fee Submitted		NA	Not used by DOM
433-DX	Patient Paid Amount		NA	Not used by DOM
481-HA	Flat Sales Tax Amount Submitted		NA	Not used by DOM
482-GE	Percentage Sales Tax Amount Submitted		NA	Not used by DOM
484-JE	Percentage Sales Tax Basis Submitted	Blank=Not specified 01=Gross Amount Due 02=Ingredient Cost 03=Ingredient Cost + Dispensing Fee	NA	Not used by DOM
426-DQ	Usual and Customary Charge		R	

Field	NCPDP Field Name	Value	M/R/RW	Comment
430–DU	Gross Amount Due		R	
423-DN	Basis of Cost Determination	Blank=Not specified 00=Not specified 01=AWP (Average Wholesale Price) 02=Local Wholesaler 03=Direct 04=EAC (Estimated Acquisition Cost) 05=Acquisition 06=MAC (Maximum Allowable Cost) 07=Usual & customary 09=Other	NA	Not used by DOM

Coupon Segment: *Segment is* ***not*** *supported*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø9	NS	Coupon Segment
485-KE	Coupon Type		NS	
486-ME	Coupon Number		NS	
487-NE	Coupon Value Amount		NS	

Compound Segment: *Segment is* ***not*** *used by Mississippi Division of Medicaid*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	1Ø	NA	Compound Segment
45Ø-EF	Compound Dosage Form Description Code		NA	Ø1=Capsule Ø2=Ointment Ø3=Cream Ø4=Suppository Ø5=Powder Ø6=Emulsion Ø7=Liquid 1Ø=Tablet 11=Solution 12=Suspension 13=Lotion 14=Shampoo 15=Elixir 16=Syrup 17=Lozenge 18=Enema
451-EG	Compound Dispensing Unit Form Indicator		NA	1=Each 2=Grams 3=Milliliters

Field	NCPDP Field Name	Value	M/R/RW	Comment
452-EH	Compound Route of Administration		NA	1=Buccal 2=Dental 3=Inhalation 4=Injection 5=Intraperitoneal 6=Irrigation 7=Mouth/Throat 8=Mucous Membrane 9=Nasal 1Ø=Ophthalmic 11=Oral 12=Other/Miscellaneous 13=Otic 14=Perfusion 15=Rectal 16=Sublingual 17=Topical 18=Transdermal 19=Translingual 2Ø=Urethral 21=Vaginal 22=Enteral
447-EC	Compound Ingredient Component (Count)		NA (Repeating)	
488-RE	Compound Product ID Qualifier		NA (Repeating)	Ø1=Universal Product Code (UPC) Ø3=National Drug Code (NDC)
489-TE	Compound Product ID		NA (Repeating)	
448-ED	Compound Ingredient Quantity		NA (Repeating)	
449-EE	Compound Ingredient Drug Cost		NA	Not used by DOM
490-UE	Compound ingredient basis of Cost Determination	Blank=Not specified 01=AWP 02=Local Wholesaler 03=Direct 04=EAC 05=Acquisition 06=MAC 07=Usual & customary 09=Other	NA	Not used By DOM

***Prior Authorization Segment:* Not** *Used by Mississippi Division of Medicaid*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	12	NA	Prior Authorization Segment
498-PA	Request Type		NA	
498-PB	Request Period Date –Begin		NA	
498-PC	Request Period Date- End		NA	
498-PD	Basis of Request		NA	

Field	NCPDP Field Name	Value	M/R/RW	Comment
498-PE	Authorized Representative First Name		NA	
498-PF	Authorized Representative Last Name		NA	
498-PG	Authorized Representative Street Address		NA	
498-PH	Authorized Representative City Address		NA	
498-PJ	Authorized Representative State/Province Address		NA	
498-PK	Authorized Representative Zip/Postal Code		NA	
498-PY	Prior Authorization Number Assigned		NA	
503-F3	Authorization Number		NA	
498-PP	Prior Authorization Supporting Documentation		NA	

***Clinical Segment:* Not** *Used by Mississippi Division of Medicaid*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	13	NA	Clinical Segment
491-VE	Diagnosis Code Count		NA	
492-WE	Diagnosis Code		NA	
424-DO	Diagnosis Code		NA	
493-XE	Clinical Information Counter		NA	
494-ZE	Measurement Date		NA	
495-H1	Measurement Time		NA	
496-H2	Measurement Dimension		NA	
497-H3	Measurement Unit		NA	
499-H4	Measurement Value		NA	

Additional Claim Information

DUR Codes

Reason for Service Codes (DUR Conflict Codes)

Code	Meaning	Code	Meaning
DD	Drug-Drug Interaction	PA	Drug Age Precaution
HD	High Dose Alert	PG	Drug Pregnancy alert
ID	Ingredient Duplication	SX	Drug gender alert
LD	Low Dose alert	TD	Therapeutic Duplication
MX	Excessive Duration Alert		

Professional Service Codes (Intervention Codes)

Code	Meaning	Code	Meaning
M0	MD Interface	R0	Pharmacist reviewed
P0	Patient Interaction		

Result of Service Codes (DUR Outcome Codes)

Code	Meaning	Code	Meaning
1A	Filled – False Positive	1F	Filled – Different quantity
1B	Filled as is	1G	Filled after prescriber approval
1C	Filled with different dose	2A	Not Filled
1D	Filled with different directions	2B	Not Filled – Directions Clarified

NCPDP VERSION 5.1 PAYER SHEET – B2 Transactions

GENERAL INFORMATION

Payer Name: Mississippi- Division of Medicaid	Date: August 21,2008
Plan Name/Group Name: Mississippi Division of Medicaid	
Processor: ACS, Inc	Switch:
Effective as of: October 2003	Version/Release #: 5.1
Provider Relations Help Desk Info: 1-866-759-4108	

Payer: Please list each transaction supported with the segments, fields, and pertinent information on each transaction.

Transaction Code	**Transaction Name**
B2	**Reversals**

Transaction Header Segment: *Mandatory in all cases*

Field	NCPDP Field Name	Value	M/R/RW	Comment
1Ø1-A1	BIN Number	610084	M	
1Ø2-A2	Version/Release Number	5.1	M	
1Ø3-A3	Transaction Code	B2	M	
1Ø4-A4	Processor Control Number	DRMSPROD	M	
1Ø9-A9	Transaction Count	1 = One Occurrence 2 = Two Occurrences 3 = Three Occurrences 4 = Four Occurrences	M	For B2 transactions, the transaction count must be a value of 1, 2,3 or 4
2Ø2-B2	Service Provider ID Qualifier	01-National Provider Identifier	M	
2Ø1-B1	Service Provider ID	National Provider ID	M	
4Ø1-D1	Date of Service	CCYYMMDD	M	
11Ø-AK	Software Vendor/Certification ID	This is the ID assigned by the processor to identify the software source. This ID verifies that the software is certified.	M	

Insurance Segment: *Mandatory*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø4	M	Insurance Segment
3Ø2-C2	Cardholder ID	9 Digit Medicaid ID	M	
312-CC	Cardholder First Name		NA	
313-CD	Cardholder Last Name		NA	
309-C9	Eligibility Clarification Code		NA	
301-C1	Group ID	SIPPI	R	
306-C6	Patient Relationship Code	1 = Cardholder	RW	

Patient Segment: ***Not*** *Supported for B2 Transactions*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø1	NS	Patient Segment

Claim Segment: Mandatory

Field	NCPDP Field Name	Value	M/R/RW	Comment
11-AM	Segment Identification	Ø7	M	Claim Segment
455-EM	Prescription/Service Reference Number Qualifier	1= RX Billing	M	
4Ø2-D2	Prescription/Service Reference Number		M	
436-E1	Product/Service ID Qualifier	03= NDC	M	
4Ø7-D7	Product/Service ID	NDC Number	M	
111-AM	Segment Identification	Ø7	M	Claim Segment
442-E7	Quantity Dispensed	Metric Decimal Quantity	R	
403-D3	Fill Number		R	
405-D5	Days Supply		R	
406-D6	Compound Code		RW	Required when submitting a claim for a compound
414-DE	Date Prescription Written		R	
308-C8	Other Coverage Code	0=Not Specified 1=No other Coverage Identified 2=Other coverage exists-payment collected 3=Other coverage exists-this claim not covered 4=Other coverage exists-payment not collected 5=Managed care plan denial 6=Other coverage exists, not a participating provider 7=Other Coverage exists-not in effect at time of service 8=Claim is a billing for a co-pay	R	
343-HD	Dispensing Status		NA	Not used by DOM
344-HF	Quantity Intended to be Dispensed		NA	Not used by DOM
345-HG	Days Supply Intended to be Dispensed		NA	Not used by DOM

Pharmacy Provider Segment: *Not Supported for B2 Transactions*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø2	NS	Pharmacy Provider Segment

Prescriber Segment: *Not Supported for B2 Transactions*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø3	NS	Prescriber Segment

COB/Other Payments Segment: *Not Supported for B2 Transactions*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø5	NS	COB/Other Payments Segment

Workers' Compensation Segment: *Not Supported for B2 Transactions*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø6	NS	Workers' Compensation Segment

DUR/PPS Segment: *Not Supported for B2 Transactions*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø8	NS	DUR/PPS Segment

Pricing Segment: *Not Supported for B2 Transactions*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	11	NS	Pricing Segment

Coupon Segment: *Not Supported for B2 Transactions*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	Ø9	NS	Coupon Segment

Compound Segment: *Not Supported for B2 Transactions*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	1Ø	NS	Compound Segment

Prior Authorization Segment: *Not Supported for B2 Transactions*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	12	NS	Prior Authorization Segment

Clinical Segment: *Not Supported for B2 Transactions*

Field	NCPDP Field Name	Value	M/R/RW	Comment
111-AM	Segment Identification	13	NS	Clinical Segment

LEGEND

M	Mandatory	Required by the NCPDP Version 5.1 Claim Format standards. If the provider does not use this field, it must be zero populated
NA	Not Applicable	Does not apply.
NS	Not Supported	Not supported by MS Medicaid.
R	Required	These fields are required per the payor and/or processor.
RW	Required When Applicable	Other data fields dictate whether or not these data elements are required.

6.0 Third Party Liability General Information

The Division of Medicaid (DOM) by law is intended to be the "payer of last resort"; that is, all other available third party sources must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. A list of "Third Party Sources" can be found in this section of the handbook.

In complying with Federal statute, a Medicaid provider may not refuse to furnish covered services to a beneficiary because of a third party's potential liability for the services. The law also protects the Medicaid beneficiary when a third party source is involved. The provider must accept either Medicaid's established reimbursement or the third party payment as payment in full. The beneficiary is not liable for any more than the co-payment that has been established by DOM.

As a condition of eligibility for Medicaid, the beneficiary is required by law to assign his/her rights to any third party benefits to the DOM. By law, DOM legally stands in place of the beneficiary to pursue recovery of Medicaid's payment from any liable third party. For detailed third party recovery policy, refer to your Medicaid Provider Policy Manual, Section 6.

State law requires the provider to identify to DOM any third party source, and to cooperate with DOM in the recovery of Medicaid's payment from the third party.

Any provider failing to cooperate with DOM in the protection and the recoupment of its payments from a legally liable third party or parties shall be liable to DOM to the extent of the payments made to the provider for services rendered to the beneficiary for which the third party or parties are or may be liable.

The exceptions to initially filing with the third party source prior to filing with Medicaid are found in this section under "Exceptions to Cost Avoidance and Casualty Cases".

For Point Of Sale (POS) pharmacy claims, see the Pharmacy Section 5.0 of the Provider Billing Handbook for detailed instructions on submitting claims with third party liability (TPL) payment.

6.1 Preferred Provider Organizations

In the event a Medicaid beneficiary is covered by a private insurance policy whose administrator has a preferred provider organization in which the Medicaid provider does not participate, the provider should choose one of the following methods of billing:

1. Submit the claim to the DOM Bureau of Recovery along with a statement indicating the provider is not a member of a particular preferred provider organization, the insurance company name and address, and specific third party filing data. The DOM Bureau of Recovery will research the claim and either instruct the fiscal agent to pay the claim or return the claim to the provider with further third party filing instructions, or
2. File the claim with the third party source and hold the patient liable for the amount the insurance company pays him/her for the service rendered. It must be noted, however, that if the provider files with the third party source and then decides to file with Medicaid via the DOM Bureau of Recovery, the patient cannot be held liable for payment.

When a Medicaid beneficiary is covered by a private insurance policy whose administrator of the policy has a preferred provider organization in which the Medicaid provider participates, the following applies:

> Pursuant to the State Medicaid Manual as written by the Centers for Medicare and Medicaid (CMS), "Medicaid is to make no payment when billed for the difference between the third party payment and the provider's charges. The provider's agreement as a member of the preferred provider organization to accept payment of less than his charges constitutes receipt of a full payment of his/her services; therefore, the Medicaid recipient who is insured has no further responsibility. Medicaid is intended to make payment only when there is a recipient legal obligation to pay."

To comply with this policy, the provider must enter the total of the contractual adjustment and the third party payment as the third party amount in the third party payment field of the appropriate Medicaid claim form. The table below provides the field location of TPL payment amount on the claim form. If no payment is received, enter zero in the third party fields.

FORM	FIELD
CMS – 1500	29
UB-04	54
ADA DENTAL	35
MS PHARMACY CLAIM	24
CROSSOVER A	20
CROSSOVER B	19

6.10 Billing Medicare

If a claim has been denied for "Bill Medicare for these services," the provider must file and obtain Medicare payment for the service or obtain a Medicare denial before Medicaid payment can be made. The denial can be in the form of a letter from the Social Security Administration or Supplemental Security Income Division, Form SSA-1600 or Form SSA-2458.

Upon receipt of the denial, resubmit the Medicaid claim to the Medicaid fiscal agent, indicating the transaction control number (TCN) of the denied original claim, and attach a copy of the Medicare denial. The claim is then paid according to Medicaid payment policies.

When the provider determines that a Medicaid beneficiary is eligible for Medicare in addition to being covered by private insurance, the provider must follow these guidelines:

Medicare Part A

The Medicare Part A intermediary will only crossover claims to Medicaid; therefore, submit separate claims to Medicare Part A (with no listing of Medicaid involvement) and the private third party source. When the third party payments or explanation of benefits (EOB) of denial are received from Medicare Part A and the private third party source, file the Medicaid claim as required.

Medicare Part B

The Medicare Part B intermediaries will crossover all claims to the appropriate third party source; therefore, the provider should complete the CMS-1500 listing the private third party source but with no mention of Medicaid. When the third party payments or EOBs of denial are received from Medicare Part B and the third party source, file the Medicaid claim as required.

If a beneficiary is found to have Medicare coverage after Medicaid claims have been paid, the fiscal agent may automatically recoup the payments from the provider and print a message on the payment register that explains the action to the provider with instructions to bill Medicare. The fiscal agent may perform this process monthly.

Medicare Part C

The Medicare Part C Advantage plans will not automatically crossover claims for payment to DOM for dually eligible beneficiaries. To submit these claims to DOM for payment, the provider must complete either Part A or Part B Mississippi Medicaid Crossover Claim Form. Please refer to sections 2.3 or 3.2 for specific instructions for completing these claim forms.

To access the form, visit the DOM website at http://www.medicaid.ms.gov, select the link Medicaid Provider Information. Then choose the link Forms for Providers. Complete the appropriate form per the instructions, and send the claim form along with the EOB attached to the fiscal agent for processing. These claims are subject to the 180 day time limit from the EOB payment date.

Medicare Part D

Medicaid considers Medicare Part D payments for prescription drugs to be considered payment in full.

6.11 Third Party Sources

Third party sources that must be used to reduce Medicaid program costs include, but are not limited to, the following:

- Medicare Parts A, B, C and D. Medicaid considers Medicare Part D payments for prescription drugs to be considered payment in full.
- Health insurance includes both reimbursement and indemnity policies that provide payment because medical care and/or service are rendered. Indemnity policies that restrict payment to periods of hospital confinement are considered a third party resource. Policies that provide income supplementation for lost income due to disability (without regard to hospital confinement), or policies that make payment for disability (without regard to hospital confinement), such as weekly disability policies, are not third party sources.
- Major medical, dental, drug, vision care or other supplements to basic health insurance contracts.
- CHAMPUS, which provides coverage for off-base medical services to dependents of uniformed services personnel, active or retired.
- Veterans Administration (CHAMP-VA), which provides coverage for medical services to dependents of living and deceased disabled veterans.
- Railroad Retirement.
- Automobile Medical Insurance.
- Workers' Compensation.
- Liability Insurance—includes automobile insurance and other public liability policies, such as home accident insurance, etc.
- Family health insurance carried by an absent parent.
- Black Lung Benefits.
- United Mine Workers of America Health and Retirement Fund.
- Donated funds.

6.2 Billing a Third Party Source

Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source and to file and collect all third party coverage prior to billing Medicaid. This includes those beneficiaries who are also Medicare/Medicaid eligible. The law further stipulates that providers will be held liable, to the extent of the Medicaid payment, for failure to cooperate with when they have knowledge of third party coverage.

Therefore, the Medicaid program requires that claims with third party coverage should not be submitted to the Medicaid fiscal agent until payment or denial notification is received from the third party source. However, in the event there is no response from the third party source in 60 days from the date of filing, the provider may file with Medicaid using the "No Response From The Third Party Source" form (DOM TPL 407) at the end of this section, and in the Appendix.

When a provider bills a third party insurer and does not receive a prompt response, the provider should:

- Submit a written inquiry to the insurance company if no response has been received within 30 to 40 days from the date of original claim submission.

- File the claim with DOM's fiscal agent if no response has been received in 60 days from the date of the original claim submission. You must attach a completed copy of form DOM TPL 407. This form must be signed and dated by the provider or the billing clerk. The claim is processed according to the Medicaid payment policies.

The fiscal agent forwards copies of the "No Response" attachments to the DOM Bureau of Recovery for research. If the research reveals that no claim had been filed with the third party source or that the delay was solely due to the provider's failure to supply adequate information, the Medicaid payment for the services are voided on the provider's next payment register with the message, "Bill Third Party Source."

TPL EDIT OVERRIDE ATTACHMENT:
NO RESPONSE

This is to certify that a claim has been filed with the third party source named below with follow-up as required and that no response has been received in at least 60 days.

Name of Medicaid beneficiary: _____

Medicaid ID number: _____

TPL Source Name: _____

Address: _____

_____

Telephone Number: _____

Policy Number: _____

Date of Original Billing: _____

Date of Follow-up: _____

I understand that the Division of Medicaid will research this matter. If no claim has been received by the TPL source, the Medicaid payment will be voided via the payment register with a message to bill the third party.

_____ _____

Signature of Provider or Billing Clerk Date

_____

Phone Number

6.3 Third Party Source for Maternity Claim

When filing claims for beneficiaries who have third party coverage and are approved for Medicaid either antepartum or postpartum, the provider has several options in billing Medicaid.

EXAMPLE: A patient, who delivered one month prior, notifies the provider that she has obtained Medicaid coverage - retroactive to the beginning of her pregnancy. However, the provider has already filed the prenatal care and delivery charges with the third party insurer.

The provider has two options that can be utilized to correct the problem:

1. The provider may void the TPL claim and bill Medicaid as the primary. Medicaid will pay the claim and seek reimbursement from the third party source; or

2. The provider can bill Medicaid and show the amount of the third party payment in the appropriate field on the claim form.

6.4 Assignment of Benefits

Any time a provider bills a third party insurer, it is the responsibility of the provider to obtain assignment of benefits. The provider is required both by state law and the Medicaid program to indicate the following information on the third party claim form whether or not the charges have been paid or will be paid by Medicaid:

- The person is a Medicaid beneficiary;
- The beneficiary's Medicaid ID number;
- The bill has been paid by Medicaid or will be submitted to Medicaid.

When Medicaid assignment is accepted and the third party is also billed, the following restrictions to beneficiary liability apply:

- If the third party payment is equal to or greater than Medicaid's established fee schedule, no collection from the beneficiary or a financially responsible person can be attempted.
- If the third party payment is less than the established Medicaid fee schedule, the provider may collect from the beneficiary the lesser of these two amounts - the Medicaid co-payment or the difference in Medicaid's fee schedule and the third party payment.

In situations where the beneficiary is, due to circumstances beyond his/her control, prevented from making assignment to the provider, the provider may submit a Medicaid claim through DOM Bureau of Recovery. The claim must contain the third party information as well as an attachment of the beneficiary's signed statement giving the reason he/she is unable to assign benefits. The Bureau of Recovery will research and either instruct the fiscal agent to pay the claim or return the claim to the provider for further contact with the beneficiary.

In the event the beneficiary fails to assign benefits to the provider when it is within his/her rights to do so, the provider may choose to pursue payment from the beneficiary rather than filing with Medicaid. However, if the provider files the claim with Medicaid, he/she must not violate beneficiary liability as protected by law.

When violation of the above beneficiary liability is revealed through third party provider audits, DOM may provide for a reduction of any payment amount otherwise due the provider up to three (3) times the amount incorrectly received from the patient.

6.5 When Beneficiary Denies Insurance Coverage

If a Medicaid beneficiary tells the provider that his/her insurance policy (recorded in the Medicaid claims payment system) is no longer in effect, that the policy never existed, or that the policy is for something other than medical insurance, the provider should obtain a signed statement from the beneficiary which includes the name of the insurance company, the policy number, and the ending date of coverage. The signed statement should be forwarded to the DOM Bureau of Recovery. Upon receipt of this information, the beneficiary's statement will be researched and, if necessary, the third party resource file will be updated.

6.6 Billing Medicaid after Receiving a Third Party Payment or Denial

After receiving payment or denial from all third party sources, the provider is required to file a claim with the Medicaid fiscal agent. The amount of third party payment must be indicated in the appropriate claim field, indicated in the table shown in Section 6.1 of this handbook. The claim is processed and Medicaid either pays the balance due on the claim (the total Medicaid payment amount less the third party payment amount) or makes no additional payment if the third party payment is equal to or greater than the total amount due from Medicaid. In either situation, the beneficiary's history of services is updated.

In the event the third party amount is less than 20 percent of the provider's charges, the provider must attach the Explanation of Benefits (EOB) from the third party source that lists the TPL amount. Even when it is necessary to attach the third party EOB that lists the third party payment, the third party amount must still be written in the appropriate field on the Medicaid claim form. If the third party amount is less than 20 percent of the billed charges and no attachment is included, the claim will be returned to the provider requesting verification of the third party amount. If no response is received within the 20 day allotted response period, the claim will be denied. After denial, the provider must resubmit the denied claim including the appropriate EOB.

If the third party denies the claim because: (1) the service is not covered by insurance, (2) insurance benefits have been exhausted, or (3) insurance coverage has expired; the provider must attach a copy of the denial EOB or denial letter to the Medicaid claim. The claim will be processed according to Medicaid payment policies. The third party resource file is updated appropriately.
All claims billed with third party denials may be billed either as a hardcopy or submitted electronically, with attachments, through the web portal.

If a claim is filed with the third party source as listed on the payment register and a denial is received as either service not covered, benefits exhausted, or coverage expired, submit the claim to the Medicaid fiscal agent with the denial EOB attached. The third party resource file is updated as appropriate. The claim is denied if a Medicaid claim is filed without a TPL amount, without the TPL insurer's denial EOB, without the NCPDP override code, and the Medicaid TPL file indicates that the beneficiary is covered for the services billed on the dates of service listed on the claim. The provider’s payment register will indicate the name, address, and policy number of the third party source of coverage. The provider should submit the claim to the third party source.

The exceptions to the requirement for filing with the third party source prior to filing with Medicaid are found in this section under “Exceptions to Cost Avoidance and Casualty Cases”.

The following are examples of reporting scenarios for TPL payment.

Scenario 1:
Often the contractual amount sometimes referred to as "provider write-off", "contractual adjustment", "Contractual write-off" or "PPO discount, will be indicated on the TPL EOB. However, if not specifically stated the amount can be calculated by subtracting the allowed charge from the total charge.

Example:

$56.00	Billed Charge
(54.09)	Allowed amount
$ 1.91	Contractual amount
$ 1.91	Contractual Amount
30.00	Payment Amount
$31.91	TPL amount to be shown on claim

Scenario 2:
If the contractual amount indicated is positive, the TPL amount shown on the claim should be the sum of the actual payment and the contractual discount.

Example:

$ 540.54	Contractual amount
$1,569.96	Payment amount
$2,110.50	TPL amount to be shown on claim

Scenario 3:
If the contractual amount indicated is negative or a zero payment, the TPL amount shown on the claim should be the stated payment amount.

Example A:

($1,065.99)	Contractual Amount
2,142.36	Payment amount
$2,142.36	**DO NOT SUM AMOUNTS**

Example B:

$ 65.99	Contractual amount
0.00	Payment Amount
$ 0.00	TPL amount to be shown on claim

6.7 Receipt of Duplicate Third Party Money and Medicaid Payment

If the provider receives third party payment(s) and Medicaid payment for the same services, the provider must accept either the third party payment(s) or the Medicaid payment as payment in full for the Medicaid covered services. The other payment(s) must be refunded to Medicaid. **The provider is required to make the refund to the Medicaid fiscal agent within 30 days from the receipt of the duplicate payment(s).**

The provider may choose to have the excess payment amount adjusted from a future payment register or may attach a refund check to the Adjustment/Void Request form to satisfy the duplicate payment. Refer to the section "Completing the Adjustment/Void Request Form" in the Medicaid Provider Billing Manual for specific instructions on how to file an Adjustment/Void Request.

The exception to a Medicaid provider being allowed to refund or adjust the receipt of third party monies is found in this section under “Exceptions to Cost Avoidance and Casualty Cases”.

6.8 Hospital Retroactive Settlements

When a hospital has a preferred provider organization (PPO) contract with an insurance company and payments are subject to retroactive adjustments, the amount to be reported as third party liability on the claim form must be as follows:

1. If the third party payor pays a final amount (i.e., per diem or per discharge 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 payor pays an interim payment, which may be adjusted or settled later based on contractual agreements with the provider, the maximum third party reimbursement (i.e., contractual benefit) should be reported as the third party liability amount.

    a. If future settlements with other third party payors result in the provider refunding amounts to the third party payor, DOM makes no additional payment because of such refunds.

    b. If future settlements with third party payors result in the third party payor making an additional payment to the provider, the following should be adhered to:
        - Third party liability amounts have been reported as benefits as required in item 2 above, therefore no amounts are due DOM.
        - Third party liability amounts have been reported at less than the maximum amount payable by the third party payor, the provider will be liable for the overpayment by DOM, plus interest and penalty.

6.9 Exceptions to Cost Avoidance and Casualty Cases

Federal law requires that in all instances, other than those outlined below, Medicaid must use the cost avoidance claims payment procedure. "Cost avoidance" means the Medicaid agency pays claims involving third party liability only to the extent Medicaid's established reimbursement exceeds the amount paid by the third party. To protect the rights of DOM, the provider must file with the third party source before filing with Medicaid.

DOM is required to reimburse the practitioner for certain covered services prior to billing the third party source, and then pursue recovery of Medicaid payment. Those services include:

1. pregnancy related services for women (prenatal, labor and delivery, and postpartum),

2. preventive pediatric services (including EPSDT services), and

3. covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program.

Claims submitted for pregnancy related services and/or preventive pediatric services must be submitted on separate claim forms.

Claims submitted for inpatient and outpatient hospital charges for labor and delivery and postpartum must be cost avoided. By law, all other hospital claims are excluded from the above exceptions. Hospital claims must be filed with the third party prior to billing Medicaid.

Claims submitted for individuals for whom child support services are enforced by the state's Title IV-D program will pay without any additional coding by the provider. The Medicaid third party record contains the necessary coding that allows these claims to bypass third party edits. The Title IV-D program for Mississippi is managed within the Department of Human Services (DHS).
Pharmacists must pursue any third party benefits to the extent of the paid drug claims except for covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program.

The exceptions to cost avoidance listed above do not relieve the provider from notifying the Division of Medicaid, Bureau of Recovery of possible third party liability as a result of casualty cases. In casualty cases involving the treatment of injuries arising out of vehicular collision, industrial accident, product liability, malpractice cases, etc. in which collection from the third party may be contingent upon legal action, the provider is authorized to submit claims immediately to the Medicaid fiscal agent. At the time the claim is submitted, the provider is obligated to notify the Bureau so that the collection of DOM's claim against the identified third party or parties can be pursued. The notice should contain the beneficiary's name and Medicaid ID number, the name and address of the potentially liable third party, the date and nature of the accident, and a copy of the claim submitted to the Medicaid fiscal agent. Once Medicaid has paid, the provider is not permitted to recoup from the beneficiary or the third party the differences between the provider's billed charges and the amount paid by the Medicaid agency.

If the provider elects not to bill the Medicaid agency in casualty cases, the provider may seek recovery of the full charges against the potentially liable third party. Should the provider elect to pursue the collection of the claim directly against the legally liable third party unsuccessfully and the Medicaid agency pursues the collection of all other claims against the legally liable third party, the provider is not then authorized to make claim against DOM or the beneficiary for the services rendered on behalf of the injured Medicaid beneficiary.

7.0 Remittance Advice (RA)

This section provides an overview of the weekly Remittance Advice (RA) and will assist you in properly understanding the format of the RA.

The remittance advice is a computer-generated document that displays the status of all claims submitted to the fiscal agent, along with a detailed explanation of adjudicated claims. This document is designed to permit accurate reconciliation of claim submissions. The remittance advice, which is available weekly, can be received electronically through the web portal. Data on the RA will consist of the following sections:

- Header Page
- Provider Messages
- Claim Detail Report will include the following when applicable:
  - Paid/Denied Claims
  - Suspended Claims
  - Provider Adjustments/Legends

7.1 Cover Page Information

Field	Field Name	Remittance Advice Field Description
1	**Pay to Provider Number**	The 8-digit number of the provider or group that is to receive payment. The pay to provider is not necessarily the same as the provider who performed the service. This provider number also appears in the top left of the header page.
2	**Provider Name**	The name of the provider entity receiving payment.
3	**Provider Address, City, State, Zip**	Address 1 and 2 – First and Second address line; City – Address city; State – Address state; Zip – Address zip code
4	**Please Send Inquiries To:**	Fiscal agent name, address, city, state, zip, contact telephone number and web portal address.
5	**Total Associated Payment**	Total amount of cycle check or electronic funds transfer (EFT).
6	**Payment Date**	Payment date of the check or EFT.
7	**Paid to Provider Tax ID**	The federal tax ID number of the provider or group that is to receive payment. This is not necessarily the same as the provider who performed the service.
8	**Method of Payment**	Indicates the form of payment. • CHK – Check • ACH – Automated Clearing House (EFT)
9	**ACH Format**	For ACH EFT payments
10	**Deposited To Bank**	Provider's bank routing number.
11	**Account No./Type**	Provider's bank account number and type.
12	**Check/EFT Payment Number**	System assigned check or EFT number
13	**For Claims Paid Through**	Cycle run date. Claims processed through this date are included in this RA.

00099999**********MISSISSIPPI MEDICAID REMITTANCE ADVICE**********PAGE 1

Cover Page Information

PAY TO PROVIDER NUMBER: 1 00099999 2

JOHN Q PROVIDER 3
1300 PHYSICIAN PARK DR
ANYTOWN, MS 38000

(FOR CHANGE OF ADDRESS, DOWNLOAD FORM FROM WEB PORTAL)

4 PLEASE SEND INQUIRIES TO: ACS, INC
PROVIDER SERVICES
P.O. BOX 23078
JACKSON, MS 39225-3078
TELEPHONE: (800) 884-3222
WEB PORTAL: HTTP://MSMEDICAID.ACS-INC.COM

REMITTANCE INFORMATION ONLY

TOTAL ASSOCIATED PAYMENT: $3,070.99 5 PAYMENT DATE: 01/07/2008 6

PAID TO PROVIDER TAX ID: 123456789 7

METHOD OF PAYMENT: ACH - ELECTRONIC FUNDS TRANSFER 8 ACH FORMAT: CCP - CCD PLUS ADDENDA 9

HECK/EFT PAYENT NUMBER: 001110043 12 DEPOSITED TO BANK: 123456778 10
ACCOUNT NO. /TYPE: 000111111 DA CHECKING 11

FOR CLAIMS PAID THROUGH: 01/07/2008 13

JOHN Q PROVIDER
1300 PHYSICIAN PARK DR
ANYTOWN, MS 38000

7.2 Message Page

The second page of the RA, as shown on the following page, is used to display messages to Medicaid providers from the Division of Medicaid and the fiscal agent. This page will provide information on any late breaking news, and will notify providers of changes in billing procedures or program area coverage. Do not be alarmed if your RA does not contain a message. However, pay special attention to this page, as any information listed here will be beneficial in facilitating the filing of Medicaid claims, as well as providing current information about the Mississippi Medicaid Program.

Message Page

DATE: 11/05/07 MISSISSIPPI ENVISION MMIS PAGE: 00000003
PROVIDER NO: 00099999 DIVISION OF MEDICAID RPT PAGE: 000000051
REMITTANCE: 00000001 REMITTANCE ADVICE REMIT SEQ: 00000073
NPI NUMBER:

****

All healthcare providers are mandated to have a National Provider Identifier (NPI). Your claims may deny if your NPI HAS NOT BEEN SENT TO THE DIVISION OF MEDICAID. It is imperative that your NPI be noted appropriately on your provider information on file at Medicaid. In order to pay claims correctly, you must submit your NPI number and MS Medicaid provider number on all Medicaid claims.

****

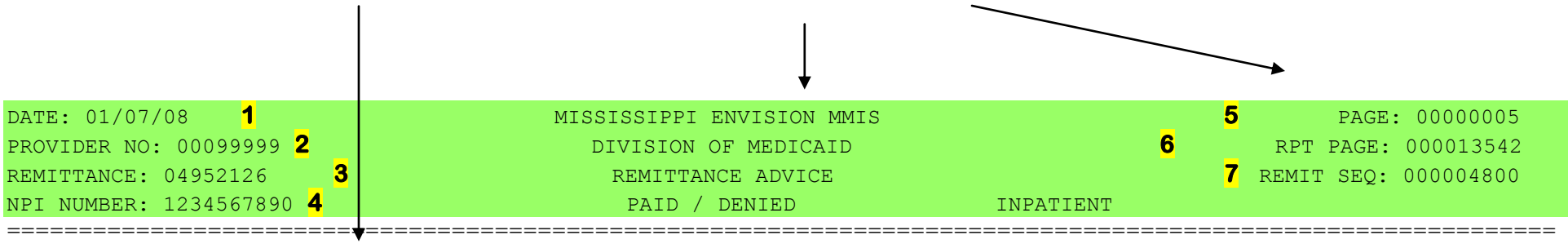
7.3 Page Header Information

The Mississippi Envision MMIS Remittance Advice consists of three different sections: paid/denied claims, suspended claims, and provider adjustments. The Page Header information will be similar throughout the remittance advice; however, the last line in the top middle section of the RA header will indicate the specific section of the RA (i.e. PAID/DENIED, ADJUSTMENTS, SUSPENDED etc.). The similar fields are as follows:

Field	Field Name	RA Field Description
1	**Date**	Remittance Advice cycle date. Program generated.
2	**Provider Number**	The 8-digit number of the provider or group that is to receive payment. The pay to provider is not necessarily the same as the provider who performed the service.
3	**Remittance**	The remittance advice number uniquely identifies the remittance advice prepared for the provider for a given payment cycle.
4	**NPI Number**	The pay to provider's NPI number.
5	**Page**	Page number starting at 1 within each provider's RA.
6	**RPT Page**	Internal page number spanning all providers for this cycle.
7	**Remit Sequence**	Unique number for each provider. Program generated.

Claim Header for Paid/Denied Claims

Page Header Information



```
DATE: 01/07/08     1                MISSISSIPPI ENVISION MMIS                    5      PAGE: 00000005
PROVIDER NO: 00099999 2               DIVISION OF MEDICAID                     6      RPT PAGE: 000013542
REMITTANCE: 04952126      3           REMITTANCE ADVICE                        7   REMIT SEQ: 000004800
NPI NUMBER: 1234567890 4               PAID / DENIED              INPATIENT
```

```
BENEFICIARY NAME    MEDICAID ID     TCN                    PAT ACCT NUM                MED REC NO
DATES OF SERVICE    TOB SVC PVDR SERVICE PROVIDER NAME SUBMITTED AMT  FEE REDUCTION AMT   PAT RESP AMT TOT        PAID AMT   STATUS
```

```
JANE A DOE        00000988877651  08000377777005107         37191JANEC2000           4A9JANES6C2000
12/21/07-12/23/07  111  0009999  ANYTOWN MEDICAL CENT     6,964.77       4,555.11          .00                    2,409.66 PAID
DRG CODE: DRG WEIGHT: 0.00000
EXCEPTION CODES: 0674

JANE A DOE        00000988877651 08000311111031597          3493JANE6C2000           4A93JANE6C2000
04/01/07-04/03/07 111 00099999   ANYTOWN MEDICAL CENT     7,802.67       5,489.99          20.00                  2,312.68 PAID
DRG CODE:         DRG WEIGHT:        0.00000

JANE A DOE        00000988877651 08000311111031607          3816JANEC2000           4A93JANE6C2000
12/19/07-12/21/07 111 00099999 ANYTOWN MEDICAL CENT       4,551.95       2,142.29          .00                    2,409.66 PAID
DRG CODE:         DRG WEIGHT:        0.00000

JOHN H DOE        00000998877665 07000387910026237          3805JOHN1C2000           3D80JOHNS1C2000
12/10/07-12/14/07 111 00099999 ANYTOWN MEDICAL CENT        8,264.10     3,484.78          40.00                   4,779.32 PAID
DRG CODE:         DRG WEIGHT:        0.00000

JIM Q DOE         0000999888777  08000380101031617          3809JIM3C2000           5D5JIM4S1C2000
12/17/07-12/19/07 111 00099999 ANYTOWN MEDICAL CENT        5,243.92     2,834.26          .00                    2,409.66 PAID
DRG CODE:         DRG WEIGHT:        0.00000

JIM Q DOE         0000999888777  07000311111035597          3810JIMS1C2000           5D5JIM4S1C2000
12/13/07-12/18/07 111 00099999 ANYTOWN MEDICAL CENT        13,355.55    13,355.55         .00                        .00 DENY
DRG CODE: DRG WEIGHT: 0.00000
EXCEPTION CODES: 0104
```

7.4 Paid/Denied Claims

The following section is designed to help you understand the Paid/Denied section of the RA.

Understanding Paid/Denied Claims

Paid claims are line items passing adjudication that are acceptable for payment. They may be paid as submitted or at reduced amounts according to Medicaid program's reimbursement methodology. Reductions in payments such as fee reduction or patient responsibility will be noted in the claim header information and the line item information.

Denied claims represent services which have been through adjudication that are unacceptable for payment. Claim denial may occur if the fiscal agent cannot validate claim information, if the billed service is not a program benefit, or if a line item fails the edit/audit process. **Denied claims may be reconsidered for payment if the provider submits corrected or additional claim information to the fiscal agent for further processing**. A service may be reconsidered for payment if errors were made in submitting or processing the original claim.

Field	Field Name	RA Field Description
	Claim Header Information for Paid/Denied Claims	
1	**Beneficiary Name**	Patient name
2	**Medicaid ID**	Medicaid beneficiary's ID for this patient
3	**Transaction Control Number**	(TCN) This number uniquely identifies the claim.
4	**Patient Account Number**	Patient Account Number
5	**Medical Record Number**	The number assigned by a health care provider to a beneficiary or a claim for reference purposes. This number is printed on the RA to assist providers in identifying the patient for whom the service was rendered.
6	**Dates of Service**	First and last dates of service for this claim
7	**Type of Bill**	Depending on the type of claim submitted, the code will either be the Facility Type Code or Place of Service Code.
8	**Servicing Provider**	The Medicaid ID number of the healthcare provider who rendered the service
9	**Servicing Provider Name**	Name of the healthcare provider who rendered the service
10	**Submitted Amount**	Total charges submitted for this TCN
11	**Fee Reduction Amount**	The difference between the submitted amount and the paid amount
12	**Patient Responsible Amount**	Amount payable by the patient
13	**Total Paid Amount**	Total amount paid on this TCN. (For balancing purposes, this amount should equal submitted charges minus adjustments.)

Field	Field Name	RA Field Description
		Claim Header Information for Paid/Denied Claims
14	**Claim Status**	Claim Status (Paid – Denied – Suspended)
		Claim Line Item Information for Paid/Denied Claims
15	**Item Number**	The line item number on the claim
16	**Procedure Code**	The line item procedure code, if applicable
17	**Type/Description**	The type of code listed in the procedure code field
18	**M1, M2, M3, M4**	The procedure code modifiers
19	**Revenue Code**	The line item revenue code, if applicable
20	**Tooth Code**	Tooth number or quadrant (applies to dental providers only)
21	**Servicing Provider ID**	The line item servicing provider ID
22	**Provider Control Number**	The line item control number submitted in the 837, which is utilized by the provider for tracking purposes.
23	**Dates of Service**	First and last dates of service for this line item
24	**Units**	Number of units
25	**Submitted Amount**	Submitted amount for this line item

Field	Field Name	RA Field Description
		Claim Header Information for Paid/Denied Claims
26	**Fee Reduction Amount**	The difference between the submitted amount and the paid amount
27	**Paid Amount**	Amount paid for this line item
28	**Status**	The line item status
29	**Exception Codes**	The line item exception codes
30	**DRG Code**	(Not currently used)
31	**DRG Weight**	(Not currently used)

Header Information for Paid/Denied Claims

```
DATE: 01/14/08                          MISSISSIPPI ENVISION MMIS                          PAGE: 00000006
PROVIDER NO: 00099999                     DIVISION OF MEDICAID                       RPT PAGE: 000077770
REMITTANCE: 00000065                       REMITTANCE ADVICE                         REMIT SEQ: 00000996
NPI NUMBER: 1234567890                       PAID / DENIED                  VISION AND HEARING
================================================================================================================================
(1)BENEFICIARY NAME      (2)MEDICAID ID        (3)TCN          (4) PAT ACCT NUM          (5) MED REC NO
(6)DATES OF SERVICE (7)TOB (8)SVC PVDR (9)SERVICE PROVIDER NAME (10)SUBMITTED AMT (11)FEE REDUCTION AMT (12)PAT RESP AMT (13)TOT PAID AMT (14)STATUS
(15)LINE    (16)PROC    (17)TYPE/DESC    (18) M1 M2 M3 M4    (19) REVCD    (20) THCD    SVC PROV (21)        (22)PROV CONTROL NO
(23)DATES OF SERVICE  (24)LINE UNITS  (25)LN SUBM AMOUNT  (26)LN FEE REDUCT AMT  (27)LN PAID AMOUNT     (28)LN STATUS
================================================================================================================================
JOHN A BENEFICIARY   00000995588771   08000000360109867      59A92
01/15/08-01/15/08   11   00011111  CHARLES Q PROVIDER        181.23            9.06                  .00       172.17    PAID
    1     99204         HC/HCPCS/CPT CODE                                  00011111       0801111114700
          01/15/08-01/15/08   1.00          114.09            5.70                 108.39    PAID
    2     V2020         HC/HCPCS/CPT CODE                                  00011111       08011111114701
          01/15/08-01/15/08   1.00          36.00             1.80                  34.20    PAID
    3     V2100         HC/HCPCS/CPT CODE                                  00011111       08011111114702
          01/15/08-01/15/08   1.00          19.49              .97                  18.52    PAID
    4     92340         HC/HCPCS/CPT CODE                                  00011111       08011111114703
JIM Q BENEFICIARY     00000994488775    08000000000920007          59J19
01/16/08-01/16/08  11    00011111       CHARLES Q PROVIDER      161.28          11.74               3.00      149.54       PAID
    1     92014         HC/HCPCS/CPT CODE                                  00011111       08010007999991
          01/16/08-01/16/08   1.00          76.28             6.81                 69.47     PAID
    2     92015         HC/HCPCS/CPT CODE                                  00011111       08010007999992
          01/16/08-01/16/08   1.00          25.00              1.25                 23.75    PAID
    3     2021F        HC/HCPCS/CPT CODE                                 00011111       08010007999993
          01/16/08-01/16/08   1.00          0.00               .00                  .00      DENY
(29)EXCEPTION CODES:   0132    0439
```

Line Item Information for Paid/Denied Claims

```
DATE: 01/07/08                          MISSISSIPPI ENVISION MMIS                                    PAGE: 00000005
PROVIDER NO:00099999                      DIVISION OF MEDICAID                                   RPT PAGE: 000013542
REMITTANCE: 04952126                       REMITTANCE ADVICE                                     REMIT SEQ: 00000480
NPI NUMBER: 1234567890                      PAID / DENIED                      INPATIENT
================================================================================================================================
================================================================================================================================
BENEFICIARY NAME     MEDICAID ID       TCN              PAT ACCT NUM                MED REC NO
DATES OF SERVICE  TOB  SVC PVDR  SERVICE PROVIDER NAME SUBMITTED AMT FEE REDUCTION AMT PAT RESP AMT TOT PAID AMT STATUS
================================================================================================================================
================================================================================
JANE A DOE      00000998877667   08001355000025107    3719JANEAC2000          3719JANEAC2000
12/21/07-12/23/07 111 00099999 ANYTOWN MEDICAL CENT      6,964.77      4,555.11               .00      2,409.66    PAID
DRG CODE: (30)        DRG WEIGHT:       0.00000 (31)
       EXCEPTION CODES:   0674
```

7.5 Claim Header/Line Information for Adjustments

Adjustment requests are used to change an original claim's information. The original payment can be increased or decreased, billed units can be changed, or other changes may occur. Adjustments can occur on either the claim header level or line item level. Claim header level adjustments cannot be applied to a line item because they are not specific to an individual procedure. Void requests are used to refund the entire original payment of a claim.

Field Name	Remittance Advice Field Description
Adjustment Header Information for Claims	
Beneficiary Name	Patient name
Medicaid ID	Medicaid beneficiary's ID for this patient
Transaction Control Number	(TCN) This number uniquely identifies the claim.
Patient Account Number	Patient Account Number
Medical Record Number	The number assigned by a health care provider to a beneficiary or a claim for reference purposes. This number is printed on the RA to assist providers in identifying the patient for whom the service was rendered.
Dates of Service	First and last dates of service for this claim
Type of Bill	Depending on the type of claim submitted, the code will either be the Facility Type Code or Place of Service Code.
Servicing Provider	The Medicaid ID number of the healthcare provider who rendered the service
Servicing Provider Name	Name of the healthcare provider who rendered the service
Submitted Amount	Total charges submitted for this TCN
Fee Reduction Amount	The difference between the submitted amount and the paid amount
Patient Responsible Amount	Amount payable by the patient
Total Paid Amount	Total amount paid on this TCN. (For balancing purposes, this amount should equal submitted charges minus adjustments.)
Claim Status	Claim Status (Paid – Denied – Suspended)

Field Name	Remittance Advice Field Description
Adjustment Line Item Detail for Claims	
Item Number	The line item number on the claim
Procedure Code	The line item procedure code, if applicable
Type/Description	The type of code listed in the procedure code field
M1, M2, M3, M4	The procedure code modifiers
Revenue Code	The line item revenue code, if applicable
Tooth Code	Tooth number or quadrant (applies to dental providers only)
Servicing Provider ID	The line item servicing provider ID
Provider Control Number	The line item control number submitted in the 837, which is utilized by the provider for tracking purposes.
Dates of Service	First and last dates of service for this line item
Units	Number of units submitted for this adjustment
Submitted Amount	Submitted amount for this line item
Fee Reduction amount	The difference between the submitted amount and the paid amount
Paid Amount	Amount paid for this line item
Status	The line item status
REF: Original TCN	The original TCN of the original claim that is to be adjusted or voided
DRG Code	(Not currently used)
DRG Weight	(Not currently used)
Exception Codes	The line item exception codes

Adjustment Information Page

Adjustment Header Information

```
DATE: 01/07/08                          MISSISSIPPI ENVISION MMIS                              PAGE: 00000015
PROVIDER NO: 00099999                     DIVISION OF MEDICAID                          RPT PAGE: 000111098
REMITTANCE: 04957561                       REMITTANCE ADVICE                            REMIT SEQ: 00009515
NPI NUMBER: 1234567890                       ADJUSTMENTS                      CLINICS
================================================================================================================
================================================================================================================
BENEFICIARY NAME      MEDICAID ID             TCN                PAT ACCT NUM                MED REC NO
DATES OF SERVICE TOB SVC PVDR SERVICE PROVIDER NAME  SUBMITTED AMT  FEE REDUCTION AMT   PAT RESP AMT   TOT PAID AMT   STATUS
  LINE   PROC        TYPE/DESC                  M1 M2 M3 M4   REVCD    THCD      SVC PROV      PROV CONTROL NO
           DATES OF SERV        LINE UNITS    LN SUBM AMOUNT  LN FEE REDUCT AMT    LN PAID AMOUNT       LN STATUS
================================================================================================================
================================================================================================================
==
NANCY BENEFICIARY   00000444777906       08000400000009778        1NAN 01001B              1NAN 01001B
12/28/07-12/28/07 11 00001111  JAMES B PROVIDER         -80.00             -6.70           3.00           -73.30       CREDIT
REF:    ORIGINAL TCN: 08000385555144447     DRG CODE:            DRG WEIGHT: 0.00000
     1      99213              HC/HCPCS/CPT CODE                                  00001111    00042888000001
            12/28/07-12/28/07       -1.00         -80.00          -6.70              -73.30           CREDIT

NANCY BENEFICIARY   00000444777906       08000400000009779         1NAN 01001B              1NAN 01001B
12/28/07-12/28/07 11 00001111   JAMES B PROVIDER          80.00              6.70           3.00            73.30       DEBIT
REF:   ORIGINAL TCN: 08000385555144447      DRG CODE:            DRG WEIGHT: 0.00000
EXCEPTION CODES: 3222
     1     99213              HC/HCPCS/CPT CODE                                  00001111    00042888000001
           12/28/07-12/28/07         1.00          80.00           6.70               73.30           DEBIT
```

Adjustment Line Item Information

7.6 Suspended/Pended RA Field Descriptions

Claims requiring special handling or correction of errors will be temporarily pended. Correct items will be subject to further adjudication. Do not submit Adjustment/ Void Request forms for claims listed as pending on the most recent RA.

Additionally, do not resubmit these claims while they are still in a pended status. Pended claims are in the processing cycle and will be adjudicated. In some instances, claims are in a pended status due to conditions which are not the Medicaid providers' fault, such as eligibility mismatches, claims requiring manual pricing, etc. These conditions will be resolved internally by the fiscal agent. Once these conditions have been resolved, the claim s will be released from the pended status to complete adjudication and will be posted on the RA indicating a paid or denied status.

Field Name	RA Field Description
Suspended/Pended Claim Header Information	
Beneficiary Name	Patient name
Medicaid ID	Medicaid beneficiary's ID for this patient
Transaction Control Number	(TCN) This number uniquely identifies the claim.
Patient Account Number	Patient Account Number as submitted on the claim
Medical Record Number	The number assigned by a health care provider to a beneficiary or a claim for reference purposes. This number is printed on the RA to assist providers in identifying the patient for whom the service was rendered.
Dates of Service	First and last dates of service for this claim
Status Date	Date the claim was suspended (generally the cycle date)
Type of Bill	Depending on the type of claim submitted, the code will either be the Facility Type Code or Place of Service Code.
Servicing Provider	The Medicaid ID number of the healthcare provider who rendered the service
Servicing Provider Name	Name of the healthcare provider who rendered the service for the following claims (either a person's name or entity name)
DRG Code	(Not currently used)
DRG Weight	(Not currently used)
Total Submitted	Total charges submitted for this TCN
Status	The overall claim status

Field Name	RA Field Description
Suspended/Pended Claim Line Item Information	
Item Number	The line item number on the claim
Dates of Service	First and last dates of service for this line item
Servicing Provider ID	The line item servicing provider ID
Procedure Code	The line item procedure code, if applicable
Type/Description	The type of code listed in the procedure code field
M1, M2, M3, M4	The procedure code modifiers
Revenue Code	The line item revenue code, if applicable
Tooth Code	Tooth number or quadrant (applies to dental providers only)
Units	Number of units
Submitted Amount	Submitted amount for this line item
Exception Codes	The line item exception codes that are posted to the header level or the line item

Suspended Claims Header

```
DATE: 01/07/08                          MISSISSIPPI ENVISION MMIS                          PAGE: 00000023
PROVIDER NO: 00099999                    DIVISION OF MEDICAID                          RPT PAGE: 000123321
REMITTANCE: 09975561                      REMITTANCE ADVICE                            REMIT SEQ: 00005915
NPI NUMBER: 1234567890                     SUSPENDED CLAIMS                CLINICS
================================================================================================================
================================================================================================================
BENEFICIARY NAME       MEDICAID ID          TCN           PAT ACCT NO                MED REC NO
DATES OF SERV   STAT DT   TOB  SVC PVDR    SVC PRV NAME     DRG CODE    DRG WEIGHT      TOTAL SUBMITTED    STATUS
 LN DATES OF SERVICE   SVC PVDR    PROC     TYPE/DESC          M1 M2 M3 M4 REVCD  THCD     UNITS        SUBMITTED
================================================================================================================
================================================================================================================
WILLIAM B BENEFICIARY 00000999997771  07000322222033477  WB67 010026             WB67 010026
12/21/07-12/21/07 01/01/01 11 00001111  SUSAN T PROVIDER   0.00000                          88.00         PEND
     EXCEPTION CODES:  0142

  1 12/21/07-12/21/07   00001111  99213   HC/HCPCS/CPT CODE                                 1.00         88.00

SAMPSON T BENEFICIARY 00000999994440  07000100033333247     11SAM
08/27/07-08/27/07 01/01/01 11 00001111 SUSAN T PROVIDER    0.00000                        80.00         PEND
     EXCEPTION CODES:  0142

  1 08/27/07-08/27/07   00001111  99213   HC/HCPCS/CPT CODE                                 1.00         80.00
  EXCEPTION CODES: 0771
```

Line Item Detail

```
---END OF PENDED CLAIMS FOR PROVIDER 00099999---
```

7.7 Provider Adjustments/Legend Page

The final page of the RA (Provider Adjustments/Legend) consists of provider adjustments and a summary of all claims that were paid/denied and suspended. Provider Adjustments can be any of the following: creation of a receivable, payoff of a receivable, extra payment, IRS withholdings, or Deferred Compensation withholdings. Claim voids and advance payments create new receivables, which will be paid off later or on this cycle. Extra payments are usually refunds from providers who are repaying DOM for receivables; specifically the refund exceeded the Medicaid payment for the specific claims. A positive amount is the creation of a receivable (money owed by the provider to the state) to be paid off either now or in the future. A negative amount is the payoff of a new receivable, existing receivable, or a withholding of some sort.

Field	Field Name	RA Field Description
1	**Provider Adjustments**	Provider level financial transactions; will only appear if adjustments have been applied to this RA. This is dollar amount withheld from the total payment.
2	**Claim Totals**	Totals for all categories of the RA
3	**Status**	Claims transactions during weekly payment cycle
4	**Count**	Total number of claim lines specific to category
5	**Submitted Amount**	Amount submitted by the provider
6	**Paid Amount**	Amount paid by Medicaid
7	**Outstanding Credit Balance**	Total outstanding credit balance as of current RA date.
8	**Exception Legend**	A full description of any exceptions that showed up on this RA

Provider Adjustments/Legend Page

DATE: 01/07/08 MISSISSIPPI ENVISION MMIS PAGE: 00000026
PROVIDER NO: 00099999 DIVISION OF MEDICAID RPT PAGE: 000123109
REMITTANCE: 09957711 REMITTANCE ADVICE REMIT SEQ: 00005915
NPI NUMBER: 1234567890 PROVIDER ADJUSTMENTS/LEGEND

PROVIDER ADJUSTMENTS:	CS Adjustment	RECIVABLE-CLAIM PAYMENT	2008-01-08	15.36
(1)	WO Overpayment Recovery	RECOUPMENT-CLAIM PAYMENT	2008-01-08	-15.36
	TL Third Party Liability	REDUCTION - DEF. COMPENSATION	2008-01-08	-433.27

(2) CLAIM TOTALS	(3) STATUS	(4) COUNT	(5) SUBMITTED AMT	(6) PAID AMT
	ORIGINAL PAID	96	14,434.00	3,622.63
	CREDIT ADJUSTMENTS	27	5,846.00-	1,619.61-
	DEBIT ADJUSTMENTS	25	5,686.00	1,619.61
	VOIDS	1	19.71-	15.36-
	APPROVED SUBTOTAL		14,274.00	3,622.63
	SUSPENDED	11	1,060.00	
	DENIED	26	3,235.00	
	CLAIM PROCESSED TOTAL		18,569.00	3,622.63
	PROVIDER ADJUSTMENTS			433.27-
	PAYMENT TOTAL			3,189.36

(7) OUTSTANDING CREDIT BALANCE AS OF 01/07/2008 0.00

ADJUSTMENT SUBTOTALS	-FIRST QUARTER-	-SECOND QUARTER-	--THIRD QUARTER-	-FOURTH QUARTER-
CREDIT ADJUSTMENTS 07	0.00	73.30-	11.08-	1,319.40-
CREDIT ADJUSTMENTS 06	0.00	0.00	190.65-	25.18-
DEBIT ADJUSTMENTS 07	0.00	73.30	11.08	1,319.40
DEBIT ADJUSTMENTS 06	0.00	0.00	190.65	25.18

--- END OF REMITTANCE FOR PROVIDER 00099999 ---

(8) EXCEPTION LEGEND:

0238	SUBMITTED UNITS EXCEED MAXIMUM ALLOWED UNITS
3708	PHYSICIAN OFFICE VISIT SERVICE LIMIT EXCEEDED
0104	EXACT DUPLICATE CLAIM
0143	BENEFICIARY NOT ELIGIBLE OR NOT FOUND
3075	SERVICES NOT COVERED FOR SLMB/QI1/QI2 BENEFICIARIES
0142	BENEFICIARY NOT ELIGIBLE - RECYCLE

8.0 Adjustment/Void Request Form

The Division of Medicaid and the fiscal agent allow adjusting and voiding of claims. The following procedures allow providers to find solutions to payment difficulties. These procedures and forms are used to correct under/ over payments.

If you are paid incorrectly on the remittance advice for a Medicaid claim or have received monies from a third party payer after payment of Medicaid, you may submit an Adjustment/ Void Request Form to request an adjustment. Adjustment requests are used to change the original amount paid on a claim. The original payment can be increased or decreased. Void requests are used to refund the entire original payment on a claim.

When refunding money to Medicaid, it is not necessary to remit a refund check. If an adjustment will result in a reduction in the original Medicaid payment and no refund check is included, an adjustment will be made on the weekly remittance advice. If a refund check is included, the adjustment will be applied against the refund check. The only time the actual Medicaid check should ever be returned is in the rare event that all claims on the remittance advice were paid incorrectly and the entire amount is to be refunded.

An adjustment/void form cannot be used for denied claims. A denied claim must be resubmitted on the appropriate claim form, and the error must be corrected. The EOB message on the remittance advice will provide guidance for submitting the corrected claim.

If an adjustment appears on a remittance advice and is not correct, another adjustment request may be submitted using the transaction control number (TCN) from the debit line of the adjusted claim.

Billing Tip

Electronically submitted claims cannot be adjusted using the adjustment/void form. Electronically submitted claims must be adjusted electronically; however, the adjustment/void form may be used to void either paper or electronically submitted claims.

Time Limit for Adjustment Requests

Positive adjustment requests must be submitted within two (2) years from the date of service as shown on the Medicaid remittance advice. When submitting adjustment requests, a copy of the original claim form and the remittance advice which reflects the payment must be attached. If money is owed to the Medicaid program (negative adjustment or voids), the 2-year filing limitation is not applicable.

Completing the Adjustment/ Void Request Form

Instructions for completing the Adjustment/ Void Request Form are on the page following the form, and correspond to the line numbers on the form. All information requested on this form is required. Submit only one request per form.

ADJUSTMENT/VOID Request Form

Please complete this form and attach appropriate documentation. If filing for an adjustment attach a corrected claim form.

Mail to: **Mississippi Medicaid Program**
P.O. Box 23077
Jackson, Mississippi 39225

1 Provider Information	2 Beneficiary Information
1a Provider Number	*2a Name*
1b NPI	
1c Provider Name	*2b Recipient ID Number*
	2c Date(s) of Service
1d Provider Address	*2d Transaction Control Number (TCN)*
	2e Line Numbers
	2f RA Date

3 Adjustment or Void *(Please check one of the following options)*

- ☐ 3a Adjustment
- ☐ 3b Void

4 Overpayment *(Please check one of the following, 4a is preferred option)*

- ☐ 4a Please deduct the overpayment from the future claims payments.
- ☐ 4b I have attached my personal check in the amount of the overpayment.
- ☐ 4c I have returned the State Warrant.

5 Description of Request *(Please check one of the following if applicable, if not please explain in the space below)*

- ☐ 5a Third Party Liability Recovery (Attach EOB)
- ☐ 5b Provider Corrections
- ☐ 5c Fiscal Agent Error
- ☐ 5d Claim Paid for Wrong Recipient
- ☐ 5e Claim Paid to Wrong Provider
- ☐ 5f LTC Medicaid Income Change
- ☐ 5g TPL Provider Audit Findings (Attach EOB as necessary)

Other Explanation:

6 Signature Block

6a Signature of Sender	*6b Mailing Date*

Mississippi Medicaid Use Only

Reason Code	*Initials*	*Date Stamp*
FCN	*Date*	
Claim Type / *TXN Code*	*COS*	

All of the fields below are required. Complete the Adjustment/Void Request Form as described below:

Field	Adjustment/Void Form Instructions
1a	**Provider Number*:*** Enter 8-digit Mississippi Medicaid provider number.
1b	**NPI Number:** Enter the 10-digit National Provider Identifier of the billing provider.
1c	**Provider Name:** Enter the physician's name or name of healthcare entity.
1d	**Provider Address:** Enter the address of healthcare entity.
2a	**Name:** Enter the beneficiary's name.
2b	**Recipient ID Number:** Enter the first 9-digits of the beneficiary's Mississippi Medicaid number as it appears on the ID card omitting the last three digits found after the ID number.
2c	**Date(s) of Service:** Enter the date that the service was performed.
2d	**TCN—**Enter the transaction control number from the remittance advice. (Only enter 1 ***TCN*** per request.)
2e	**Line Numbers—**Enter the number of each line to be adjusted.
2f	**RA Date—**Enter the date of the remittance advice in which the claim originally paid.
3	**Adjustment or Void—**Check the appropriate option.
4	**Overpayment—**Check the appropriate refund option. In most cases option 4a is preferred.
4a	**Deduct Overpayment from Future Claims Payments—**Use this option in most cases.
4b	**Personal Check—**Check this option if a personal check is enclosed.
4c	**Return of State Warrant—**Check this option if the State Warrant is enclosed.
5	**Description of Request—**Check the option which best describes the reason for the request.
6a	**Signature Of Sender**—Sign the form, as it cannot be processed without a signature.
6b	**Mailing Date**—Enter the Adjustment/Void Request Form mailing date.

If the claim is being voided, no documentation for this request is required. If the claim is being adjusted, a copy of the corrected claim must be attached. A copy of the remittance advice may also be supplied. If proper documentation is not provided, the forms will be returned.

Mail the completed form to:

Mississippi Medicaid Program
P.O. Box 23077
Jackson, Mississippi 39225

8.1 Claim Inquiry Form

The Division of Medicaid and the fiscal agent provide telephone and written claim inquiry processes. These procedures allow providers to determine claim status. Descriptions of these procedures are provided in the following sections.

Telephone Inquiry

The fiscal agent staffs a Provider and Beneficiary Services call center to answer your claim inquiries, which cannot be answered through the Automated Voice Response System (AVRS). The Provider and Beneficiary Services call center accepts calls from providers during the hours of 8:00 a.m. to 5:00 p.m. central time, Monday through Friday. **The Provider and Beneficiary Services call center can answer most of your questions immediately. The call center may be contacted at 1-800-884-3222 or 601-206-3000. Callers within the Jackson calling area may use either number.**

Using the Automated Voice Response System (AVRS)

The fiscal agent has installed an AVRS using automated response technology to give Mississippi Medicaid providers free access to important and up-to-date information pertaining to the Medicaid program. The system is designed to allow providers to verify all of these items by using your touch-tone telephone. The AVRS cannot be accessed with a rotary dial telephone. The AVRS is as simple and convenient to use as the telephone. Providers choose the time for their inquiries. It allows members of the provider's staff, who previously would not have been able to ask the appropriate questions, to make inquiries because the AVRS prompts the caller throughout the inquiry. This permits better utilization of staff in the provider's office and permits more efficient use of available telephone facilities. The system encourages use by offering prompt and accurate responses to eligibility inquiries.

The AVRS is accessible twenty-four (24) hours a day, seven (7) days a week with the exception of a few hours each week when eligibility files are updated. This will generally occur by Wednesday morning but may occur at another time. If you dial the AVRS during this time, you will be informed that the system is unavailable.

The AVRS can support telephone inquiries regarding:

- Verification of beneficiary eligibility
- Verification of other health insurance coverage for beneficiaries
- Beneficiary benefits remaining
- Current check amount
- National drug code (NDC) coverage
- Number of days remaining for therapeutic dosage of H2Antagonists, Prilosec, and Carafate.

Whenever providers call the fiscal agent at 1-800-884-3222, they will be greeted by the AVRS and can access information through a variety of options. The AVRS will be improved and changed periodically. Providers will be notified of the changes via the Monthly Medicaid Bulletin, RA banner messages or voice messages recorded on the AVRS.

Any problems which may occur with the AVRS are to be reported Monday-Friday, 8:00 a.m. – 5:00 p.m. central time, to the fiscal agent at 1-800-884-3222 (Mississippi and border states). For those providers who do not have a touch-tone telephone, please contact the Provider and Beneficiary Services call center at 1-800-884-3222.

Written Inquiry—Completing the Claims Inquiry Form

A Claims Inquiry Form, as shown on the following page, should be used to obtain information regarding the status of a submitted claim. The Claims Inquiry Form should be used if a claim has been submitted to the fiscal agent, and it has not appeared on your remittance advice within 30 days as having been pended, paid, or denied. A Claims Inquiry Form should also be used if the provider needs clarification of an adjudicated claim, which has appeared on his/ her RA. The fiscal agent will respond in writing to all written inquiries:

All fields on the Claim Inquiry form must be completed. Directions for completing the form are as follows:

Field	Claim Inquiry Form Field Name and Instructions
1a	**Provider Number*:*** Enter 8-digit Mississippi Medicaid provider number for the billing and/or servicing provider.
1b	**Provider NPI:** Enter the 10-digit National Provider Identifier for the billing and/or servicing provider.
1c	**Provider Name and Address:** Enter the physicians name or name of healthcare entity and the address.
1d	**Point of Contact:** Enter the name of the point of contact for the healthcare entity.
1e	**Provider Telephone:** Enter the telephone number for the point of contact.
2a	**Name:** Enter the beneficiary's name exactly as it appears on the beneficiary's Mississippi Medicaid card.
2b	**Recipient ID Number:** Enter the patient's nine-digit Medicaid beneficiary identification number as it appears on the Medicaid card omitting the last three digits found after the ID number.
2c	**Date(s) of Service:** Enter the date that the service was performed.
2d	**TCN:** Enter the Transaction Control Number from the Remittance Advice.
3	***N*ature of Inquiry:** Check the appropriate option.
4a	**Signature Of Sender:** Sign the form, as it cannot be processed without a signature.
4b	**Date:** Enter date the form is signed.

Attach any supporting documentation that may assist with the inquiry, such as a claim or remittance advice. Mail the completed form to:

Mississippi Medicaid Program
P.O. Box 23078
Jackson, Mississippi 39225

CLAIMS INQUIRY Form

Please complete this form and attach appropriate documentation.

Mail to: **Mississippi Medicaid Program**
P.O. Box 23078
Jackson, Mississippi 39225

1 Provider Information

1a Billing Provider Number and/or Servicing Provider Number

1b NPI

1c Provider Name and Address

1d Point of Contact	***1e Provider Telephone***

2 Beneficiary Information

2a Name	***2b Recipient ID Number***
2c Date(s) of Service	***2d Transaction Control Number (TCN)***

3 Nature of Inquiry *(Please check one of the following if applicable, if not please explain in the space below)*

☐ 3a Claim Status ☐ 3b Explanation of denied Claim

Other Inquiry:

4 Signature Block

4a Signature	***4b Date***

Mississippi Medicaid Use Only

Reviewed by	***Date Stamp***
Action Taken	

9.0 Miscellaneous Information and Forms in Appendix

This Appendix contains relevant information to aid a provider in understanding Medicaid terminology and commonly used provider forms, as listed below. The forms may be copied. Always remember to retain a copy of the original for your records.

The following item may aid you in understanding Medicaid terminology:

- ***Glossary and Acronyms***

List of Forms included in this Appendix:

- ***Adjustment/Void Request Form***—Submit if you need an adjustment or to void a payment.
- ***Claim Inquiry Form***—Submit if you have an inquiry about a claim.
- ***Direct Deposit Authorization/Agreement Form***—Submit this form if you need to enroll in Direct Deposit or to change your existing direct deposit information.
- ***Change of Name Form***—Submit if you are changing your name (to and from).
- ***Claim Form Reorder Request Form***—Submit if you need to order claim forms, prior authorization and consent forms.
- ***Change of Address Form***—Submit if you are changing the address where services are rendered to Medicaid beneficiaries or your preferred mailing address.
- ***Trading Partner Service Agreement***—Submit to enroll in Electronic Data Interchange.
- ***TPL EDIT OVERRIDE ATTACHMENT: NO RESPONSE***
- ***Pharmacy Claim Form***—Submit if you are filing a paper claim for pharmacy services.
- **Mississippi Crossover Claim Form Medicare Part A** —Submit if you are filing a Medicare Part C claim (Advantage Plan) for Part A services.
- **Mississippi Crossover Claim Form Medicare Part B**—Submit if you are filing a Medicare Part C claim (Advantage Plan) for Part B services.

9.1 Glossary and Acronyms

Term	Definition
ACS	Affiliated Computer Systems
Affiliated Computer Systems	Current fiscal agent contracted by the Mississippi Division of Medicaid.
ADA	American Dental Association
American Dental Association	ADA is a professional association of dentists committed to the public's oral health, ethics, science and professional advancement.
ANSI X12 N Format	American National Standards Institute (ANSI) Accredited Standards Committee X12 (ASC X12, *q.v.*)
Atypical Providers	Atypical Providers are individuals or organizations that are not defined as healthcare providers under the National Provider Identifier (NPI) Final Rule. Atypical providers may supply non-healthcare services such as non-emergency transportation or homemaker services.
AVRS	Automated Voice Response System
Beneficiary	Term used to identify any individual eligible for Medicare or Medicaid.
Brand medically necessary	Phrase that must appear in the prescriber's own handwriting on the face of each new prescription order for DOM to reimburse an innovator drug at an amount greater than the Medicaid maximum allowable cost (MAC) because the prescription is "medically necessary" for that beneficiary as documented in the beneficiary's medical record.
Billing Provider	The provider who is submitting the claim to the Medicaid program for payment. Usually, the billing provider and the pay-to-provider are the same.
COE	Category of Eligibility
CMS	Centers for Medicare & Medicaid Services
Centers for Medicare & Medicaid Services	The division of the Department of Health and Human Services responsible for administering the Medicare and Medicaid program.
CRNA	Certified Registered Nurse Anesthetist
Clearinghouse	A business that receives claim data from the provider, performs a series of validation checks, and forwards the claim data to Mississippi Division of Medicaid on behalf of the provider.
CLIA	Clinical Laboratory Improvement Amendments

Term	Definition
Clinical Laboratory Improvement Amendments	Congress passed the CLIA in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. Centers for Medicare & Medicaid Services (CMS) assumes primary responsibility for financial management operations of the CLIA program.
Co-insurance	The percentage of covered hospital or medical expense, after subtraction of any deductible, for which an insured person is responsible.
Co-payment	A form of cost-sharing whereby the insured pays a specific amount at the point of service or use.
Crossover claim	A Medicare-allowed claim for a dual eligible beneficiary (entitle) sent to DOM for possible additional payment of the Medicare co-insurance and deductible.
Crosswalk(ing)	The systematic process of changing a provider submitted value for a specific field on a claim to a value required by the system when they are not the same.
CPT	Current Procedural Terminology
Current Procedural Terminology	A listing of descriptive terms and codes for reporting medical, surgical, therapeutic, and diagnostic procedures.
DOS	Date of service.
Date of Service	The calendar date on which a specific medical service is performed.
Days' supply	The estimated days' supply of tablets, capsules, fluids, cc's, etc. that has been prescribed for the beneficiary. Days' supply is not the duration of treatment, but the expected number of days the drug will be used.
Deductible	The amount a beneficiary must pay before Medicare or another third party begins payment for covered services.
DME	Durable Medical Equipment
DOM	Division of Medicaid
Division of Medicaid	The state agency in Mississippi who administers the Medicaid program under statutory provisions, administrative rules, and the state's Medicaid Plan, in conformity with federal law and CMS policy.
DUR	Drug Utilization Review
Drug Utilization Review	There are two components of DUR, prospective and retrospective. Prospective DUR is a system within the Pharmacy point-of-sale (POS) system that assists pharmacy providers in screening selected drug categories for clinically important potential drug therapy problems before the prescription is dispended to the beneficiary. Retrospective DUR screens after the prescription has been dispensed to the beneficiary through drug profiling and peer grouping.

Term	Definition
Dual eligible	A beneficiary who is eligible for Medicaid and Medicare, either Medicare Part A, Part B, or both.
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EDI	Electronic Data Interchange
EDI Gateway Division	Electronic Data Interchange Gateway Division
EDI Support Unit	Electronic Data Interchange Support Unit
EFT	Electronic Funds Transfer
ERA	Electronic Remittance Advice
EVS	Eligibility Verification System
Eligibility Verification System	An electronic system used by all providers to verify eligibility before rendering services, both to determine eligibility for the current date and to discover any limitations to a beneficiary's coverage.
ER	Emergency Room
EOB	Explanation of Benefits
Explanation of benefits	Appears on the provider's Remittance and Status (R/S) report and notifies the Medicaid provider of the status of or action taken on a claim.
EOMB	Explanation of Medicare Benefits
FFS	Fee for service
Fee for Service	The traditional health care payment system under which physicians and other providers receive a payment for each unit of service provided rather than a capitation payment for each beneficiary.
FAQ	Frequently Asked Questions
Fee Schedule	A list of certain services with the Medicaid allowable for the service.
Fiscal Agent	A contractor that processes and audits provider claims for payment and performs other functions, as required, as an agent of DOM.
FQHC	Federally Qualified Health Center
FFY	Federal Fiscal Year
FY	Fiscal Year
HCBS	Home and Community Based Services
HCPCS	Healthcare Common Procedure Coding System
Healthcare Common Procedure Coding System	A listing of services, procedures, and supplies offered by physicians and other providers. HCPCS includes CPT codes, national alphanumeric codes, and local alphanumeric codes. The national codes are developed by the CMS to supplement CPT codes.

Term	Definition
HID	Health Information Design
Health Information Design	The current Division of Medicaid contractor that processes prior authorization for pharmacy services.
HSM	HealthSystems of Mississippi
HealthSystems of Mississippi	The current Division of Medicaid contractor for the Utilization Management and Quality Improvement Organization.
HIPAA	Health Insurance Portability and Accountability Act of 1996: A federal law that include requirements to protect patient privacy, protect security and data integrity of electronic medical records, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers.
ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
International Classification of Diseases, Ninth Revision, Clinical Modification	Nomenclature for medical diagnoses required for billing.
ID	Identification
ID/DD	Intellectual Disabilities/Developmental Disabilities
Innovator	Brand name of the original patented drug of those listed on the Maximum Allowed Cost (MAC) list.
ICF/MR	Intermediate Care Facility/Mental Retardation
Legend Drug	Any drug that requires a prescription under federal code 21 USC 353(b)
MCH	Maternal Child Health
Medicaid	The joint Federal and State medical assistance program that is described in Title XIX of the Social Security Act.
MEVS	Medicaid Eligibility Verification Services
MMIS	Medicaid Management Information System
Medicare	The Federal medical assistance program that is described in Title XVIII of the Social Security Act.
Medicare Part A	Coverage which helps pay for inpatient hospital care, some inpatient care in a skilled nursing facility; some home healthcare, and hospice care.

Term	Definition
Medicare Part B	Coverage which helps pay for medical and surgical services by physicians, providers of service, and suppliers, as well as certain other health benefits such as ambulance transportation, durable medical equipment, outpatient hospital services, and independent laboratory services; designated to complement the coverage provided by Part A of the program.
Medicare Part C	Another name for Medicare Advantage Health Plans. These are health plan options that are approved by Medicare and run by private companies that are contracted with Medicare. Medicare pays a set amount of money to these private health plans for their members' health care. Participants must have both Medicare Part A and Medicare Part B to join these health plans. These plans provide Medicare-covered benefits to members through the plan, and may offer extra benefits that Medicare does not cover, such as vision or dental services. Members may have to pay an additional monthly premium for the extra benefits. These plans can charge different copayments, coinsurance, or deductibles for these services.
Medicare Part D	A Part D drug may be dispensed only upon a prescription, is being used for a medically accepted indication as defined by section 1927(k)(6) of the Act, and is either: 1) A drug that is described in sections 1927(k)(2)(A)(i) through (iii) of the Act; 2) A biological product described in section 1927(k)(2)(B)(i) through (iii) of the Act; 3) Insulin described in section 1927(k)(2)(C) of the Act; 4) Medical supplies associated with the injection of insulin; or 5) A vaccine licensed under section 351 of the Public Health Service Act.
Mississippi Cool Kids Program	Name for Mississippi's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program.
Mississippi Medicaid Provider Billing Handbook	Handbook which addresses billing procedures through the Division of Medicaid (must be used in conjunction with the Mississippi Medicaid Provider Policy Manual.
Mississippi Medicaid Provider **Policy Manual**	The manual which provides policy for the Mississippi Medicaid Program.
MM/DD/YYYY	Month/Day/Year
Modifiers	Two digit codes that indicate services or procedures have been altered by some specific circumstance (modifiers do not change the definition of the reported procedure code).
NCPDP	National Council for Prescription Drug Programs

Term	Definition
National Council for Prescription Drug Programs	This entity governs the telecommunication formats used to submit prescription claims electronically.
NDC	National Drug Code
National Drug Code	An 11-digit code assigned to each drug. The first five numbers indicate the labeler code (CMS assigned), the next four numbers indicate the drug and strength (labeler assigned), and the remaining two numbers indicate the package size (labeler assigned).
NET	Non Emergency Transportation
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
OT	Occupational Therapy
OBRA	Omnibus Budget Reconciliation Act.
Omnibus Budget Reconciliation Act	Federal legislation that defines Medicaid drug coverage requirements and drug rebate rules.
PA	Physician Assistant
PA	Prior Authorization
Payment Register	A remittance advice mailed to providers after each payment cycle that identifies the beneficiary(s) for which Medicaid made payment(s), other claims that have been entered into the system and are pending, and/or rejected claims.
Pay-to-Provider	The provider who is to receive payment for services rendered. Usually, the billing provider and the pay-to-provider are the same.
PC	Personal Computer
PT	Physical Therapy
POS	Point of Sale
POS	Place of Service
Point of Sale	A system that enables Medicaid-certified providers to submit electronic pharmacy claims in an online, real-time environment.
PRTF	Psychiatric Residential Treatment Facility
QI-1	Qualified Individual
QMB	Qualified Medicare Beneficiary
Qualified Medicare Beneficiary	Under the Medicare Catastrophic Health Act, these beneficiaries are only eligible for the payment of the coinsurance and the deductible for Medicare-allowed claims.

Term	Definition
QWDI	Qualified Working Disabled Individual
RA	Remittance Advice
Real-time processing	Immediate electronic claim transaction allowing for an electronic pay or deny response within seconds of submitting the claim.
Real-time response	Information returned to a provider for a real-time claim indicating claim payment or denial.
Remittance Advice	A computer generated document that displays the status of all claims submitted to the fiscal agent along with a detailed explanation of adjudicated claims.
Rendering Provider	The provider that offered the medical services or products. Also another name for servicing provider.
Servicing Provider	The provider that offered the medical services or products. Also another name for rendering provider.
SLMB	Specified Low-Income Medicare Beneficiary
SSI	Supplemental Security Income: A Federal needs-based, financial assistance program administered by SSA.
ST	Speech Therapy
State Plan	The State plan is a comprehensive statement describing the nature and scope of its Medicaid program. The State plan must contain all information necessary to determine whether the plan can be approved, as a basis for Federal financial participation in the State program.
Switch transmissions	System that routes real-time transmissions from a pharmacy to the processor. Also called Clearinghouse or Value-Added Network (VAN) system.
TAN	Treatment Authorization Number
TCN	Transaction Control Number
TPL	Third Party Liability
Third Party Liability	Insurance coverage a Medicaid beneficiary has which the provider must file before submitting the claim to Medicaid as the payer of last resort.
Third Party Recovery	The Division of Medicaid's bureau which is responsible for administering third party liability program.
Transaction Control Number	Unique 17-digit identifier for a claim line assigned by the MMIS
Usual and customary charge	The amount charged by the provider for the same service when provided to private-pay patients.

Term	Definition
UM/QIO	Utilization Management/Quality Improvement Organization

9.2 Forms

The forms on the following pages may be photocopied for your use.

ADJUSTMENT/VOID Request Form

Please complete this form and attach appropriate documentation. If filing for an adjustment attach a corrected claim form.

Mail to: **Mississippi Medicaid Program**
P.O. Box 23077
Jackson, Mississippi 39225

1 Provider Information	2 Beneficiary Information
1a Provider Number	***2a Name***
1b NPI	
1c Provider Name	***2b Recipient ID Number***
	2c Date(s) of Service
1d Provider Address	***2d Transaction Control Number (TCN)***
	2e Line Numbers
	2f RA Date

3 Adjustment or Void *(Please check one of the following options)*

- ☐ 3a Adjustment
- ☐ 3b Void

4 Overpayment *(Please check one of the following, 4a is preferred option)*

- ☐ 4a Please deduct the overpayment from the future claims payments.
- ☐ 4b I have attached my personal check in the amount of the overpayment.
- ☐ 4c I have returned the State Warrant.

5 Description of Request *(Please check one of the following if applicable, if not please explain in the space below)*

- ☐ 5a Third Party Liability Recovery (Attach EOB)
- ☐ 5b Provider Corrections
- ☐ 5c Fiscal Agent Error
- ☐ 5d Claim Paid for Wrong Recipient
- ☐ 5e Claim Paid to Wrong Provider
- ☐ 5f LTC Medicaid Income Change
- ☐ 5g TPL Provider Audit Findings (Attach EOB as necessary)

Other Explanation:

6 Signature Block

6a Signature of Sender	***6b Mailing Date***

Mississippi Medicaid Use Only

Reason Code	***Initials***	***Date Stamp***
FCN	***Date***	
Claim Type / ***TXN Code***	***COS***	

CLAIMS INQUIRY Form

Please complete this form and attach appropriate documentation.

Mail to: **Mississippi Medicaid Program**
P.O. Box 23078
Jackson, Mississippi 39225

1 Provider Information

1a Billing Provider Number and/or Servicing Provider Number

1b NPI

1c Provider Name and Address

1d Point of Contact	***1e Provider Telephone***

2 Beneficiary Information

2a Name	***2b Recipient ID Number***
2c Date(s) of Service	***2d Transaction Control Number (TCN)***

3 Nature of Inquiry *(Please check one of the following if applicable, if not please explain in the space below)*

☐ 3a Claim Status ☐ 3b Explanation of denied Claim

Other Inquiry:

4 Signature Block

4a Signature	***4b Date***

Mississippi Medicaid Use Only

Reviewed by	***Date Stamp***
Action Taken	

DIRECT DEPOSIT AUTHORIZATION /AGREEMENT Form

Make one copy of this form for your records and mail original form with a copy of a voided check for the account to**:**

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

☐ New Application ☐ Change Bank Account Information

NOTE: Because of the Federal Cash Management Act, it is necessary for the Division of Medicaid to mandate the Direct Deposit of Medicaid payments to all Medicaid providers. With the weekly average Medicaid provider payments exceeding $20 million, without Direct Deposit the interest to the Federal government would have to be paid from all State funds that would other wise be used to match federal funds to make provider payments. Given Mississippi's favorable federal match rate, this would have the potential of reducing total program dollars by more than $10 million per year. This process has been underway since October 26, 1992 and has proven to be beneficial to both the State of Mississippi and the Medicaid providers. Please complete this form in order for us to complete your enrollment process and begin depositing your funds electronically.

Alert: If you choose not to complete this agreement you will not be assigned a Mississippi Medicaid Provider Number.

Provider Name	***Provider Contact***
Provider Number	***Provider Telephone Number***
NPI	

Provider's Address (City, State and Zip Code)

Bank Name

Bank Address (City, State and Zip Code)

Bank Account Number

Bank Transit/Routing Number

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents; or concealment of a material fact, may be prosecuted under applicable federal or state laws. I further authorize the Mississippi Medicaid agency to present credit entries (deposits) into the bank account referenced above and depository named above. These credits will pertain only to direct deposit transfer payments for Medicaid services that the payee has rendered.

I further understand that in the event my bank account information were to change, I must notify the Mississippi Medicaid agency in order to change my bank account information immediately. I will not hold the Mississippi Medicaid agency liable for presentation of any and all credit entries (deposits) into the bank account referenced above and the depository named above if I fail to notify the Division of Medicaid or the fiscal agent of my change in bank account information.

Provider Signature	***Date***

CHANGE OF NAME Form

Please complete form.

Mail to: **Mississippi Medicaid Program**
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

Required: Updated verification of the Tax ID and a copy of the new W-9 must be attached.

Provider Information

Medicaid Provider Number	***Name as Currently Shown on Remittance Advice***
NPI	
Name Change To (Please enter name as shown on W-9)	

Payee Bank Account Change

Prior Payment Bank
Prior Bank Routing Number
Prior Bank Account Number

Authorization for Change

Change Authorized By (Please Print Name)	
Signature	
Title	***Date***

CLAIM FORM REORDER REQUEST Form

Please complete form.

Mail to: **Mississippi Medicaid Program**
Attention Claim Form Reorder Request
P.O. Box 23076
Jackson, Mississippi 39225

Provider Information

Medicaid Provider Number	***Provider Name***
NPI	
Provider Address/Ship To (Street, City, State and Zip)	

Order Information

Order only a 2-3 month supply, allowing 2-3 weeks for delivery. A change of address may require 3-5 weeks for delivery. Be sure to notify the Provider Relations unit at ACS of any address change to avoid unnecessary delay.

Form Number	Title	25	50	100	300	Other	Quantity Shipped
DOM 210	Eyeglass/Hearing Aid Authorization Form						
DOM 260	Certification for Nursing Facilities						
DOM 260 DC	Certification for Disabled Child						
DOM 260HCBS	Certification for HCBS						
DOM 260 MR	Certification for ICF/MR						
DOM 301 HCBS	HM Comm-Based SVS/PH						
DOM 340	Pharmacy Authorization Request – Clorazil						
DOM 350	Pharmacy Authorization Request – Sandimmune						
DOM 413	Level II PASRR Billing Roster						
HCBS 105	Admit/Discharge HCBS for LTC						
MA 1001	Sterilization Consent Form						
MA 1002	Hysterectomy Acknowledgement Statement						
MA 1034	Medical Necessity for Abortion Form						
MA 1097	Dental Services for Orthodontics Authorization Request						
MA 1098	Dental Services Authorization Request						
MA 1103	DME Authorization						
MA 1148	Plan of Care Authorization Request						
MA-1104	DME/Home Health Authorization						
MA-1148A	Addendum to Plan of Care						
MS/ADJ	Adjustment Void Form						
MA 1165	Hospice Membership Form						
MS/INQ	Claim Inquiry Form						
MS/XOVE	Medicare/Medicaid Crossover Form – Part A						
MS/XOVE	Medicare/Medicaid Crossover Form Part – B						
MS PHAR	Pharmacy Claim Form						

Provider or Authorized Signature	***Date***

CHANGE OF ADDRESS FORM

Mail the completed form to: **Mississippi Medicaid Provider Enrollment**
P.O. Box 23078
Or Jackson, Mississippi 39225

Fax to: (601) 206-3015

Provider Information

Provider Name:

10-Digit National Provider Identifier (NPI):

8- Digit MS Medicaid Provider Number (Optional): Primary Taxonomy Code:

Change of Address Information

Please check the appropriate box below for the address type you wish to change.

☐ Servicing Address		Street Address City County State Zip Code
☐ Billing Address		Street Address City County State Zip Code
☐ Mail Other Address		Street Address City County State Zip Code
☐ Remittance Advice Address		Street Address City County State Zip Code
☐ 1099 Mailing Address	*W-9 Required	Street Address City County State Zip Code

**Please note that providers who wish to change the 1099 Mailing Address MUST submit a copy of the W-9 Form along with this form.*

☐ **All Addresses**	*W-9 Required	Street Address City County State Zip Code

Authorization for Change

I declare under penalty of perjury under the laws of the State of Mississippi that the information in this document and any attachments are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the aforesaid Provider. I understand that Mississippi Medicaid Provider Enrollment will use the information in this document and its attachments to change my provider file.

Provider/ Authorized Representative (Please Print Name)

Signature **Date**

Trading Partner Service Agreement

Mississippi Medicaid Program
Provider Enrollment
P.O. Box 23078
Jackson, Mississippi 39225

The following constitutes a Trading Partner Service Agreement ("Agreement") between the Mississippi Division of Medicaid ("DOM"), its designated Fiscal Agent and the Billing Agency or Clearinghouse listed in Section II ("Trading Partner").

Section I—Terms of Agreement

The Trading Partner agrees to abide by the requirements for Administrative Simplification as defined in the provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) based on the compliance date of the final rules or a date mutually agreed upon between the Trading Partner and the DOM or its designated Fiscal Agent.

The Trading Partner agrees to report to the DOM or its designated Fiscal Agent all billing information as directed by the Provider and agrees not to modify submitted information in any way unless directed to do so by the Provider.

The Trading Partner agrees to immediately report to the DOM or its designated Fiscal Agent when a DOM contracted Provider terminates services with the Trading Partner and to report all unsent transactions back to the Provider with the status of the individual transactions.

The Trading Partner agrees to send and receive data in a manner that protects the integrity and confidentiality of the transmitted information according to the relevant provisions of State and Federal laws and regulations.

The Trading Partner agrees to limit access to data to only those employees, agents, subcontractors and officials who need it to perform their duties in connection with this Agreement.

The Trading Partner agrees to not disclose any DOM beneficiary information without the prior consent of the DOM and the Provider and to remove beneficiary identifiers when appropriate and in compliance with State and Federal laws and regulations, such as in statistical reporting and in medical research studies.

The Trading Partner agrees to advise all personnel who will have access to the data of the confidential nature of the information, the safeguards required and the criminal sanctions for noncompliance contained in Federal and State Statutes.

The Trading Partner agrees to abide by the requirements for EDI submissions and submitters as published in the appropriate DOM Electronic Transactions Submission Manual.

The Trading Partner agrees to designate a person with whom the DOM or its designated Fiscal Agent can coordinate any activities that the DOM determines to be reasonable, necessary and proper for the effective performance of this Agreement.

If any information supplied in this Agreement changes at any time, the Trading Partner agrees to notify the DOM or its designated Fiscal Agent immediately in writing. Failure to do so may invalidate this Agreement.

In the event that State or Federal laws or regulations should change, alter or modify the present services, the terms, conditions and/or provisions of this Agreement shall be changed accordingly.

The Trading Partner agrees that the EDI Submitter ID is confidential and is not transferable or assignable.

This Agreement is not transferable or assignable and may be terminated by either DOM or the Trading Partner at any time upon giving to the other party thirty (30) days written notice of such termination.

Trading Partner agrees to indemnify and defend the DOM, its designated Fiscal Agent, agents, officers, and employees from and against any and all liability to third parties, including defense costs and reasonable legal fees, incurred in connection with claims for damages of any nature whatsoever, and arising from Trading Partner's wrongful performance or failure to perform its obligations hereunder.

This Agreement shall automatically terminate without notice to the Trading Partner in the event of liquidation or dissolution, adjudication as a bankrupt entity, the execution of an assignment for the benefit of creditors, the appointment of a receiver or a material portion of Trading Partner's assets and the Trading Partner will notify the DOM within five (5) days of such event.

Section II—Trading Partner Information
Please print or type. Complete all areas of the Agreement, unless otherwise indicated.

Billing Agency/Clearinghouse Name	***DOM's EDI Submitter Number (If Assigned)***
Contact Telephone Number	***Address***
Contact Facsimile Number	
Contact Name	
Authorized Agent's Name	***Contact E-Mail Address***
Authorized Agent's Title	***Authorized Agent's Signature***

I certify that all statements made herein are true and complete to the best of my knowledge.

Provider or Authorized Agent's Signature	***Date***

Mississippi Medicaid Program Use Only (Do not write in this section)

	Approved/Disapproved By
☐ Approved ☐ Disapproved	
EDI Submitter ID	***Password***
EDI Specialist	***Date Activated***
For Internal Use	

TPL EDIT OVERRIDE ATTACHMENT:
NO RESPONSE

This is to certify that a claim has been filed with the third party source named below with follow-up as required and that no response has been received in at least 60 days.

Name of Medicaid beneficiary: _____

Medicaid ID number: _____

TPL source name: _____

Address: _____

_____

Telephone number: _____

Policy number: _____

Date of original billing: _____

Date of follow-up: _____

I understand that the Division of Medicaid will research this matter. If no claim has been received by the TPL source, the Medicaid payment will be voided via the payment register with a message to bill the third party.

_____ _____

Signature of provider or billing clerk Date

_____

Phone Number

Medicaid Title XIX Pharmacy Invoice

☐ 72 Hour Emergency Supply
☐ Dispute Reimbursement
☐ Retro Eligibility
☐ TPN/ Special Pricing Claim

State of Mississippi
Division of Medicaid
P.O. Box 23076
Jackson, MS 39225

PROVIDER INFORMATION			
[1]Provider Name	[2]NPI _ _ _ _ _ _ _ _ _ _	[3]Medicaid Number _ _ _ _ _ _ _ _	[4]Phone # Fax #
[5]Street Address	[6]City	[7]State	[8]Zip Code

BENEFICIARY INFORMATION	[9]Medicaid ID _ _ _ _ _ _ _ _ _ Medicare # _ _ _ _ _ _ _	
[10]Last Name	[11]First Initial	[12]DOB _ _/_ _/_ _ _ _

1	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price
2	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price
3	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price
4	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price
5	[13]Rx Number	[14]Prescriber NPI _ _ _ _ _ _ _ _ _ _	[15]Prescriber Medicaid# _ _ _ _ _ _ _ _	[16]Date of Service _ _/_ _/_ _ _ _
[17]☐New ☐Refill	[18]Drug Name	[19]Days Supply	[20]Quantity	[21]Dispensing Fee
	[22]NDC _ _ _ _ _ _ _ _ _ _ _	[23]	[24]TPL Amt	[25] U&C Price

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under that state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency request. I further agree to accept as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized co-payment.

26. Pharmacist's Signature: _____ 27. Date: _____

28. Pharmacist's Name Printed: _____

Medicare Part **A**

MISSISSIPPI CROSSOVER CLAIM FORM

State of Mississippi Medicaid Program

For Medicare Part C ONLY

1. Type of Bill

2. Provider Name and Address	3. Medicaid Provider Number	4. Recipient Name & Address	5. Recipient Medicaid ID
	3a. NPI Number		

6. Patient Acct/Medical Record No.	Admission 7. Date	8. Hour	9. Type	10. Dates of Service From	Thru	11. Cov. Days

12. Diagnosis Primary	Secondary
3rd	4th

13. Total Medicare Billed Charges	14. Total Medicare Allowed Amount	15. Total Medicare Paid Amount

16. Total Medicare Deductible Amount	17. Total Medicare Co-insurance Amount	18. Total Medicare Blood Deductible Amount	19. Medicare Paid Date	20. Total Third Party Payment Amount

	21. Revenue Code	Procedure Code	22. Units	23. Medicare Billed Amount	24. Medicare Non-Covered Amount	
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized copayment.

25. Provider Signature	26. Billing Date

Revised 8/25/08

Medicare Part **B**

MISSISSIPPI CROSSOVER CLAIM FORM

State of Mississippi Medicaid Program

For Medicare Part C ONLY

1. Provider Name and Address	2a. Medicaid Provider Number	3. Recipient Name & Address	4. Recipient Medicaid ID
	2b. NPI Number		

5. Patient Account / Medical Record Number

6. Diagnosis	
Primary	Secondary
3rd	4th

	7. Service Dates From	Thru	8. Procedure Code	9. Modifier	10. Service Units	11. Medicare Billed Charges	12. Medicare Allowed Amount
	13. Medicare Non-covered Amt.	14. Medicare Blood Deductible	15. Medicare Paid Amount	16. Medicare Deductible	17. Medicare Co-insurance	18. Medicare Paid Date	19. Third Party Amount
1						.	.
2						.	.
3						.	.
4						.	.
5						.	.
6						.	.

I certify that the foregoing information is true, accurate, and complete, and understand that falsifying essential information to receive payments from federal and state funds requested by this form may upon conviction be subject to fine and imprisonment under applicable federal and state laws. I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the state's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the state agency may request. I further agree to accept, as payment in full, the amount paid by the Medicaid program for claims submitted, with the exception of authorized copayment.

20. Provider Signature	21. Billing Date

Revised 08/25/08