Mississippi Medicaid DRG Payment Method
Billing Quick Tips for FY 2016

- The Division of Medicaid webpage at www.medicaid.ms.gov/providers/finance/ includes key information about the Medicaid inpatient hospital payment method effective July 1, 2015, such as:

    − Frequently asked questions
    − DRG pricing calculator (a spreadsheet file that shows pricing calculations and includes the FY 2016 table of 3M APR-DRGs and relative weights)
    − Provider training presentation

- For Xerox Provider and Beneficiary Services assistance call 1.800.884.3222.

- All newborns must be billed on their own claim, not on their mother's claim.

- All claims must contain a gender code; otherwise the claim will be suspended.

- Outpatient services within three (3) days prior to the admission date that are considered to be part of the inpatient stay will not be paid separately. As with Medicare payment methodology, hospitals may indicate that outpatient services are unrelated to the inpatient stay through the appropriate use of condition code 51 on the outpatient claim. Please take care not to bill Medicaid or the Medicaid managed care plans for outpatient services that are defined to be within the window.

- Interim claims (bill types 112 and 113) are not required but may be submitted if the stay exceeds 30 days. Hospitals should ensure proper use of the correct discharge status code when an interim claim is filed. When a patient is discharged, the interim claims should be voided or adjusted and the hospital should submit a single claim for the entire stay.

    − Claims with frequency codes 4 (last interim claim) and 5 (late charges) will be denied. Use frequency codes 1 (admit thru discharge) and 6 (adjustment) as appropriate.

- Mississippi Medicaid no longer has annual service limits (e.g., 30 days of inpatient care per year). If the patient meets existing criteria for medically necessary care, appropriate care will be reimbursed.

- Treatment Authorization Number (TAN):

    − Stays that exceed 19 days require continued stay review.

    − The TAN begin date must equal the admit date, unless Medicaid eligibility begins after the admit date. In this case the TAN begin date will equal the Medicaid eligibility begin date.

    − For newborns, a TAN is necessary only if the length of stay will exceed six (6) days (including the discharge date).

    − To request a TAN: http://ms.eqhs.org/Home.aspx (eQHealth Solutions, 866.740.2221)

- Hospitals do not need to buy APR-DRG V.32 software and need not show the APR-DRG on the claim. The APR-DRG is assigned by the Medicaid claims processing system based on the diagnoses, procedures and other information submitted by the hospital.

- If a patient is transferred to a psychiatric or rehabilitation unit within the same hospital, this situation is considered to be two stays. Separate claims should be submitted and separate payments will be made. Each stay is subject to applicable TAN requirements.

- Hospitals are required to submit valid values for the Present on Admission (POA) indicator.

- MSCAN (managed care) beneficiaries: Providers need not submit inpatient claims to the coordinated care organizations (CCOs) for denial prior to submitting to the Mississippi Medicaid.

Please note that these billing tips, while intended to be helpful, do not supersede applicable statutes, regulations and policies.