



Mississippi Medicaid DRG Payment Method

Billing Quick Tips for SFY 2021

1. The Division of Medicaid webpage at <https://medicaid.ms.gov/providers/reimbursement/> includes key information about the Medicaid inpatient hospital payment method effective July 1, 2020, such as:
 - Frequently asked questions.
 - DRG pricing calculator (a spreadsheet file that shows pricing calculations and includes the State Fiscal Year (SFY) 2021 table of 3M™ APR-DRGs (V.35) and Hospital Specific Relative Value (HSRV) relative weights).
 - Provider update presentation.
2. For Conduent Provider and Beneficiary Services assistance, call 1.800.884.3222.
3. All newborns must be billed on their own claim, not on their mother's claim.
4. All claims must contain a gender code; otherwise the claim will be suspended.
5. Outpatient services within three 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 three-day window.
6. 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 type of bill frequency codes (third digit in the type of bill) of 4 (last interim claim) or 5 (late charges) will be denied. Use type of bill frequency codes 1 (admit thru discharge) and 6 (adjustment) as appropriate.
7. 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.
8. Treatment Authorization Number (TAN):
 - Stays that exceed 19 days require continued stay review. See below for information on requesting a TAN.
 - 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 days (including the discharge date).
 - To request a TAN: <https://ms.allianthealth.org/> (Alliant Health Solutions, 888-243-1846), click on the menu option for Advanced Imaging, Forms.
9. Hospitals do not need to purchase APR-DRG 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.
10. 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.
11. Hospitals are required to submit valid values for Present on Admission (POA) indicators.

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