MISSISSIPPI DIVISION OF
MEDICAID

MISSISSIPPI DIVISION OF MEDICAID

PROVIDER BILLING HANDBOOK

2020 Edition

MISSISSIPPI DIVISION OF MEDICAID

MISSISSIPPI MEDICAID PROVIDER BILLING HANDBOOK

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Current Dental Terminology (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright © 2012 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

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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 Administrative Code, Title 23. Key Medicaid reimbursement issues are addressed in the Administrative Code, and fee schedules are also found on the http://www.medicaid.ms.gov website.

The Billing 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 (02/12). 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 – 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 1-800-884-3222.

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 contain 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.

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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 the Mississippi Administrative Code Title 23. 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://ms-medicaid.com) or by calling Conduent 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://ms-medicaid.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: (http://edisolutionsmmis.portal.conduent.com/gcro/) **Must have completed the EDI (Electronic date Interchange) Submitter Enrollment Packet.** **EDI Questions and Assistance** **1-800-884-3222, option 2, then 4**
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 sections 2.0, 2.3, 3.0, 3.2, 4.0, 5.0 in the billing handbook at (http://www.medicaid.ms.gov) under Provider Billing Handbook 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 Handbook	Go to: (http://www.medicaid.ms.gov). This handbook gives general information on the Medicaid program, claims submission, and more.
Refer to the Mississippi Administrative Code Title 23	Go to: (http://www.medicaid.ms.gov). This manual gives 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://ms-medicaid.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://ms-medicaid.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 Handbook Section 1.10.**
Filing Claims	When filing claims: ● Use correct beneficiary Medicaid ID number ● Bill accurately using the current HIPAA Transaction and Code Sets: CPT, HCPCS, UB Revenue, NDC, ICD-9 and ICD-10 (as of 10/01/2015). ● 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 Pharmacy Switch Vendor • 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 links **Resources/ Helpful Links/Envision/Quick Billing Tips.**

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 links **Resources / Forms**. Claims can also be adjusted or voided though the web portal: https://ms-medicaid.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:** **Conduent** P. O. Box 23076 Jackson, MS 39225 1-800-884-3222 https://ms-medicaid.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 Office of Recovery (OR). Office of Recovery staff will research and update the beneficiary file appropriately. The request to update the information may be submitted to OR via the web portal at https://ms-medicaid.com under the links **Contacts / Reporting Requirements** or by fax at **601-359-6294**. 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 Office of Recovery** (OR) 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 links **Resources / Forms**, or utilize the Provider Update link under Provider Submission Options on the web portal at https://ms-medicaid.com.

MEDICAL NECESSITY CONTACT INFORMATION

Treatment Authorization Number (TAN)

Alliant Health Solutions is the UM/QIOs for the Division of Medicaid. The purpose of a UM/QIO is to evaluate medical necessity for specific Medicaid services (see Mississippi Medicaid Provider Billing Handbook).

	Toll Free Number	Fax Number
Inpatient Services	(888) 243-1846	(888) 503-1812
Other Services	(888) 224-3067	(888) 506-2768

Office Location:	*PO Box for sending any records or review requests:*
Alliant Health Solutions 775 Woodlands Parkway, Suite #308 Ridgeland, MS 39157 https://ms.allianthealth.org/	**Alliant Health Solutions** PO Box 105755 Atlanta, GA 30348

Prior Authorization (PA) Requests

Prior Authorization (PA) requests can be made through Alliant Health Solutions, (contact information provided above), the Pharmacy Prior Authorization Unit, and the Division of Medicaid (DOM).

The Pharmacy Prior Authorization Unit provides Pharmacy prior authorizations (PAs) designed to encourage appropriate use of cost-effective pharmaceuticals for Medicaid beneficiaries.

Telephone # 877-537-0722
Fax# 877-537-0720

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 Handbook.

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.

IMPORTANT CONTACT INFORMATION	
Division of Medicaid Walter Sillers Building, Suite 1000 550 High Street Jackson, MS 39201 601-359-6050 or 1-800-421-2408 http://www.medicaid.ms.gov	**Conduent** P.O. Box 23076 Jackson, MS 39225 1-800-884-3222 https://ms-medicaid.com
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	**Conduent 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 Conduent Call Center at 1-800-884-3222.

Alliant Health Solutions

	Toll Free Number	Fax Number
Inpatient Services	**(888) 243-1846**	**(888) 503-1812**
Other Services	**(888) 224-3067**	**(888) 506-2768**

eQHealth Solutions

Toll Free Number	Fax Number
(866) 740- 2221	**(601) 352-6358**

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.

24 Hour Help Desk
1-800-884-3222

Please visit the Mississippi Medicaid website http://www.medicaid.ms.gov at the Contact link for a complete listing of important contact information.

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 https://www.medicaid.gov/medicaid/program-integrity/ncci/reference-documents/index.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 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.

MS Global Package Value	Value Description
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.
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 Package must be appropriately designated on the claim as follows:

*Modifier 54 - T*he 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 Administrative Code Title 23.

MISSISSIPPI DIVISION OF MEDICAID

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 handbook, Administrative Code, 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
Office of Medical Services EPSDT Services	601-359-6150
Office of Client Relations	601-359-6133
Office of Recovery	601-359-6095

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**
Provider/Beneficiary Services Fax Number	**1-888 495 8169**
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**
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://ms-medicaid.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 DOM, eQ Health Solutions, and Pharmacy Prior Authorization Unit.

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://ms-medicaid.com DOM website – http://www.medicaid.ms.gov Conduent EDI website – www.acs-gcro.com

1.4 Utilization Management and Quality Improvement Organization

Alliant Health Solutions is the fee-for-service (FFS) Utilization Management and Quality Improvement Organization (UM/QIO) contracted with the Division of Medicaid (DOM) to review FFS services, except for Advanced Imaging Services [refer to section 1.4, page 3], provided to Medicaid beneficiaries in the State of Mississippi. Under this contract, Alliant Health Solutions assures that all Medicaid services meet medical guidelines for medical necessity, appropriateness and length of service.

Please be aware that this Alliant Health Solutions' determination does not guarantee Medicaid payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms, conditions and limitations of the Medicaid program.

Alliant Health Solutions performs medical review or prior authorization certification for the following:

- Cardiac Rehabilitation Services
- Certain Community Mental Health Services
- Continuous Glucose Monitoring
- Dental
- Dental Surgery
- Diabetes Self-Management Training
- Disable Child Living at Home Level of Care (LOC) Determinations
- Durable Medical Equipment and Some Supplies (Diapers/Underpads)
- Expanded Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) Benefits
- Hearing
- Expanded Home Health Services
- Hospice
- Inpatient Hospital and some Surgical Services
- Inpatient Psychiatric Services
- Some Laboratory Services and Molecular (Genetic) Testing
- Long Term Care Clinical Eligibility Determinations
- Mississippi Youth Programs Around the Clock (MYPAC)
- Occupational Therapy
- Organ Transplant Services
- Orthodontia
- Orthotics
- Outpatient Hospital Mental Health Services
- Physical Therapy
- Some Physician Administered Drugs (PADs) and Implantable Drug System Devices
- Prescribed Pediatric Extended Care (PPEC)
- Private Duty Nursing (PDN)
- Prosthetics

- Psychiatric Residential Treatment Facility (PRTF)
- Remote Patient Monitoring
- Speech Therapy
- Vision Services

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.

Alliant Health Solutions 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.

ALLIANT'S GENERAL CONTACT INFORMATION

Alliant Health Solutions
775 Woodlands Parkway, **Suite #308** **Ridgeland, MS 39157**
Telephone and FAX Numbers
Inpatient: Telephone: (888) 243-1846 Facsimile: (888) 503-1812 Other Services: Telephone: (888) 224-3067 Facsimile: (888) 506-2768
Website Address
https://ms.allianthealth.org/

eQHealth Health Solutions is the fee-for-service (FFS) Utilization Management vendor contracted with the Division of Medicaid (DOM) to review **FFS Advanced Imaging Services** provided to Medicaid beneficiaries in the State of Mississippi. Under this contract, eQHealth Health Solutions assures that Advanced Imaging Medicaid services meet medical guidelines for medical necessity, appropriateness and length of service.

Please be aware that this eQHealth Health Solutions' determination does not guarantee Medicaid payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms, conditions and limitations of the Medicaid program.

EQHEALTH'S GENERAL CONTACT INFORMATION

eQHealth Solutions
460 Briarwood Drive **Suite 400** **Jackson, MS 39206**
Telephone and FAX Numbers
Advanced Imaging: Telephone: (888) 204-0502 Facsimile: (601) 352-6358 Helpline: (866) 740-2221
Website Address
http://ms.eqhs.com/Home.aspx

1.5 Pharmacy Prior Authorization

The Mississippi Division of Medicaid (DOM) 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 fee for service (FFS) beneficiaries.

The DOM Prior Authorization (PA) Unit handles prior authorization services for Medicaid FFS beneficiaries. The PA Unit is comprised of pharmacist and pharmacy technicians who review and process prior authorization requests from Mississippi Medicaid providers.

DOM's Pharmacy Services webpage, found at http://medicaid.ms.gov/Pharmacy.aspx, provides access to prior authorization criteria and forms, as well as the current Mississippi Medicaid preferred drug list (PDL).

The Pharmacy PA Unit can be contacted by telephone. Telephones lines are staffed from 8:00 a.m. to 5:00 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

Telephone and FAX Numbers
Telephone: 1-877-537-0722 Facsimile: 1-877-537-0720

1.6 DOM Prior Authorization

Refer to Section 1.4.

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/Conduent. Prepare a facsimile cover page and include the following information in transmitting your NPI information to the Conduent Provider Enrollment fax number, 888-495-8169:

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://ms-medicaid.com/NPI%20Submission%20Form.pdf . It is recommended that you print the completed form and fax it, along with the NPI Certification Form, to Conduent 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 Conduent 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.

MISSISSIPPI DIVISION OF MEDICAID

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 Mississippi Administrative Code, Title 23. Be reminded that service limits may change, so always refer to the Mississippi Administrative Code Title 23, 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	Not Applicable	No
Chiropractic services	$700 maximum per fiscal year	No
Christian Science Sanatoria services	Not Applicable	N/A
Therapeutic and Evaluative Mental Health Services for Expanded EPSDT (T&E)	Mississippi State Plan. Section 3.1, Attachment 3.1A Exhibit 4b, Page 4	Yes, for evaluations, or to exceed the service standard. *Prior Authorization is required for ALL services provided to individuals under the age of 3.*
Community Mental Health Center (CMHC)/Private Mental Health Center (PMHC) Services	Refer to Administrative Code Title 23, Medicaid Part 206.	Yes, for evaluations, or to exceed the service standard. *Prior Authorization is required for ALL services provided to individuals under the age of 3.*
Dental services Children • Preventive • Diagnostic	Dental $2,500 maximum per fiscal year- adults and children; additional benefits if prior authorized. Orthodontia $4,200 maximum per	If applicable Administrative Code Title 23,

Benefit	Limitation	Prior Authorization
• Restorative • Orthodontia Adults • Emergency pain relief • Palliative care	lifetime per child.	Medicaid Part 204
Dialysis (freestanding or hospital-based) Center services	Not Applicable	No
Durable Medical Equipment	Refer to Administrative Code Title 23 Medicaid Part 209.	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
Eyeglasses (Vision) Services	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	36 visits per fiscal year	*Yes **After the 36th 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	Unlimited as of 10/1/2012 per Perspective Payment System.	 Yes No Yes
ICF/MR services	Therapeutic Leave days limited to 90 days per fiscal year.	No
Inpatient psychiatric services	Refer to Administrative Code Title 23 Medicaid Part 202.	Yes
Laboratory and X-Ray services	Not Applicable	Yes, for certain

Benefit	Limitation	Prior Authorization
		outpatient, non-emergency advanced imaging procedures (CT, MRI, PET and Nuclear cardiac studies)
Medical Supplies	Refer to Administrative Code Title 23 Medicaid Part 209.	*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.	No
Orthotics & Prosthetics	Limited to beneficiaries under 21 years of age.	Yes
Outpatient PT, OT, ST	Not Applicable	Yes
Pediatric skilled nursing (Private Duty Nursing) services	Limited to beneficiaries under 21 years of age.	Yes
Perinatal High Risk Management services	Not Applicable	N/A
Pharmacy Disease Management Services	12 visits per fiscal year	No
Physician Assistant services	Applies to physician office visit limit.	No
Physician services • Office & ER visits • Psychiatry • Hospital inpatient visits • Long-term care visits	 16 per fiscal year 16 per fiscal year 36 per fiscal year	 No **Yes – See Psychiatry Services** Yes No
Podiatrist services	Applies to physician office visit limit.	No
Prescription drugs	6 per month with no more than 2 of the 6 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 6 prescriptions per month

Benefit	Limitation	Prior Authorization
Psychiatric Residential Treatment Facility (PRTF) services	Refer to Administrative Code Title 23 Medicaid Part 202.	Yes
Psychiatry services	Refer to Administrative Code Title 23 Medicaid Part 203.	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	Not Applicable	No

Refer to the Administrative Code Title 23 Medicaid 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 Administrative Code Part 200)
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.	
*Groups only applicable to POS	

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://ms-medicaid.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	Managed Care
001	SSI Individual via SDX	Full Medicaid Benefits	Pharmacy coverage – Medicare Part D (If Medicare eligible)	MSCAN Optional (Age 0 – 19) MSCAN Mandatory (Age 19- 64)
002	SSI Retro Eligibility	Full Medicaid Benefits	Pharmacy coverage – Medicare Part D (If Medicare eligible)	
003	IV-E Foster Care/Adoption Assistance Related	Full Medicaid Benefits		MSCAN Optional (Age 0 – 19)
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		MSCAN Optional (Age 0 – 19)
020	Emergency SSI Limitations Case	Full Medicaid Benefits		
021	Emergency Immigrant	Medicaid Benefits for Date of Service Only	Full Medicaid Benefits for date of service ONLY for emergency	
025	Working Disabled	Full Medicaid Benefits		MSCAN Mandatory

COE	COE DESCRIPTION	BENEFITS	EXCLUSIONS	Managed Care
				(Age 19 – 64)
026	CWS Foster Care/Adoption Assistance Child	Full Medicaid Benefits		MSCAN Optional (Age 19 – 64)
027	Breast/Cervical	Full Medicaid Benefits		MSCAN Mandatory (Age 19 – 64)
029	Family Planning	Limited Medicaid; Family Planning Benefits Only	All other benefits	
031	Qualified Medicare Beneficiary (QMB)	Medicare Part B premium and Medicaid payment of Medicare Parts A and B • Premiums • Deductibles • Coinsurance	All other benefits	
035	Qualified Working Disabled Individual (QWDI)	Medicaid payment of Medicare Part A • Premium • Deductible • Coinsurance	All other benefits	
045	Healthier MS Waiver Only (No Medicare)	All State Plan services are covered for beneficiaries enrolled in the Healthier MS Waiver.	Exceptions are for the following: • Long-term care services (including nursing facility and Home and Community Based waivers); • Swing bed in a skilled nursing facility; and • Maternity and newborn care. Children under age 21 are eligible for these services with an approved plan of care	
051	Specified Low-Income	Medicaid payment of	All other Medicaid	

COE	COE DESCRIPTION	BENEFITS	EXCLUSIONS	Managed Care
	Medicare (SLMB)	Medicare Part B Premium	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		
071	Newborns age 0 – 1 with income at or below 194% FPL **(EFFECTIVE: 1/1/2014)**	Full Medicaid Benefits		MSCAN Mandatory (Age 0 – 1)
072	Children 1 – 5 with income at or below 143% FPL **(EFFECTIVE 1/1/2014**)	Full Medicaid Benefits		MSCAN Mandatory (Age 1 – 5)
073	Children 6 – 19 with income at or below 107% FPL **(EFFECTIVE: 1/1/2014)**	Full Medicaid Benefits		MSCAN Mandatory (Age 6 – 19)
074	Quasi-CHIP – Children age 6 – 19 with income between 107% and 133% FPL who would have qualified for CHIP under per-ACA rules. **(EFFECTIVE: 1/1/2014)**	Full Medicaid Benefits		MSCAN Mandatory (Age 6 – 19)
075	Parents/Caretakers of children under the age 18 **(EFFECTIVE: 1/1/2014)**	Full Medicaid Benefits		MSCAN Mandatory (Age 19 – 64)
085	Medical Assistance – Intact Family **(END: 12/31/2013)**	Full Medicaid Benefits		
087	Children up to Age 6 **(END: 12/31/2013)**	Full Medicaid Benefits		
088	Pregnant Women and children under Age 1, under 185% FPL **(END: 12/31/2013)**	Full Medicaid Benefits, Except beneficiaries Age 21 and older	Eyeglasses & Dental for beneficiaries Age 21 and older **(END: 12/31/2013)**	
088	Pregnant Women under 194% **(EFFECTIVE:**	Full Medicaid Benefits		MSCAN

COE	COE DESCRIPTION	BENEFITS	EXCLUSIONS	Managed Care
	1/1/2014)			Mandatory (Age 8 – 64)
091	Child Under Age 19, under 100% **(END: 12/31/2013)**	Full Medicaid Benefits **(END: 12/31/2013)**		
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) **(EFFECTIVE: 1/1/2014**) • Children age 1 – 19 with income between 133% and 200% FPL • Children age 0 – 1 with income above 194% to 209% FPL	No Medicaid Benefits, Administered by United Healthcare 1-800-992-9940 and effective **1/1/2015** Magnolia Health 1-866-912-6285 will also administer CHIP	All	
099	CHIP (pre-MAGI) – Children under 200% **(END: 12/31/2013)**	No Medicaid Benefits	All **(END: 12/31/2013)**	

***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 also automatically entitled to the one-year period of eligibility.

Well newborn services provided in the hospital must be billed separately from the mother's hospital claim. Hospitals must notify the Division of Medicaid within 5 calendar days of a newborn's birth using the Newborn Enrollment Form located on the Envision Web Portal. The Division of Medicaid, Office of Eligibility, will notify the provider within 5 business days of the newborn's permanent Medicaid Identification (ID) number.

Failure to notify DOM of the birth within 5 calendar days may result in delay in assignment of the infant's Medicaid ID number. By extension, a delay in the hospital receiving the newborn's Medicaid ID may result in Prior Authorization (PA) denials, claims denials (for claims billed without the infant's Medicaid ID number or with the mother's ID number), denials for claims that exceed timely filing requirements and other administrative challenges. The birthing hospital should also provide the baby's Medicaid ID number to any hospital to which the infant may have been transferred.

Questions about the newborn enrollment process should be directed to The Division of Medicaid, Office of Eligibility at 1-800-421-2408.

Billing for Newborn Hospital Stays and Inpatient Services

Normal well-baby and sick newborn services provided in the hospital should be billed separately from the mother's hospital claim for labor, delivery, and immediate postpartum services. 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 five (5) days, 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. 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

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

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

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

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

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

Timely Filing- Medicare Crossover Claims

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

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

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

Mass Adjustments

If the Division of Medicaid adjusts claims after the processing period has ended, providers may submit a written request for an Administrative Review within ninety (90) calendar days of the date of the remittance advice (RA). Providers must submit additional documentation to support claims payment.

Administrative Claim Review

Providers may request an Administrative Review of a claim when:

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

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

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

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

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

- Documentation supporting the reason for the Administrative Review, and

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

- Submit Administrative Reviews to:

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

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

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 website at http://www.medicaid.ms.gov or at the website of the fiscal agent https://ms-medicaid.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 accurately using the current HIPAA Transaction (Standards and Code Sets: CPT, HCPCS, UB Revenue, NDC, ICD-9, and ICD-10 (as of 10/1/2014).
- 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 office at DOM 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.**

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 Mississippi Administrative Code Title 23. The Administrative Code 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/Private Mental Health Centers
- Durable Medical Equipment (DME)
- EPSDT Screening Providers
- Federally Qualified Health Centers
- Hearing Aid Providers
- Independent Laboratory
- Independent Radiology
- Mental Health Services
- 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://ms-medicaid.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

Transition to the updated CMS-1500 Claim Revision 02/12

On August 1, 2014, Mississippi Medicaid will begin receiving and processing paper claims submitted only on the revised CMS-1500 Claim Form (version 02/12).

The CMS-1500 Claim Form (version 08/05) will no longer be accepted or processed by Mississippi Medicaid beginning on August 1, 2014.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) 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. RESERVED FOR NUCC USE

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. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

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: ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. 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 Fam. 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. Rsvd for NUCC Use

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.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

CARRIER

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

CMS-1500 Claim Form Instructions for Mississippi Medicaid

Field	Requirement	Field Name and Instructions for CMS-1500 (02/12) 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	**Not Required**	Reserved for NUCC Use
9c	**Not Required**	Reserved for NUCC Use
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**	Claim Codes (Designated by NUCC)
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.
11d	**Required if Applicable**	**Is There Another Health Benefit Plan?**

Field	Requirement	Field Name and Instructions for CMS-1500 (02/12) Form
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 (LMP)
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:** Enter the name of the ordering/referring provider.
17a	**Optional**	**Other ID#:** Enter the eight-digit Mississippi Medicaid provider number of the ordering/referring provider.
17b	**Required if Applicable**	**NPI #:** Enter the NPI of the ordering/referring provider.
18	**Required if Applicable**	**Hospitalization Dates Related to Current Services:** Enter the admission/discharge dates in MM/DD/YY
19	Not Required	Additional Claim Information (Designated by NUCC)
20	Not Required	Outside Lab Charges
21	**Required**	**Diagnosis or Nature of Illness or Injury:** Enter the beneficiary's ICD- CM Codes in priority order. Up to twelve diagnoses may be entered.
22	**Required if Applicable**	**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 beginning ("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.
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).

Field	Requirement	Field Name and Instructions for CMS-1500 (02/12) Form
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 an 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	Reserved for NUCC Use
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.
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#

Field	Requirement	Field Name and Instructions for CMS-1500 (02/12) Form
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 or when applicable the Taxonomy Code for one to many linkages of provider NPI to numerous Medicaid Provider Numbers.***

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 Ordering/Referring Physician Or Other Source		✓		

CMS-1500 Checklist for Required Fields		Required	Required, if Applicable	Optional	Not Required
17a	I.D. Number Of Ordering/Referring Physician			✓	
17b	Ordering/Referring Provider NPI		✓		
18	Hospitalization Dates Related To Current Services		✓		
19	Additional Claim Information			✓	
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
01	Pharmacy
02	Telehealth
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
09	Prison/Correctional Facility
10	Unassigned
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment - Worksite
19	Off Campus-Outpatient Hospital **(Effective January 1, 2016)**
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
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance – Land
42	Ambulance – Air or Water
43-48	Unassigned
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/Individuals with Intellectual Diisabilities
55	Residential Substance Abuse Treatment Facility

56	Psychiatric Residential Treatment Facility
57	Non-residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End Stage Renal Disease Treatment Facility
66-70	Unassigned
71	Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Place of Service

2.1 CMS-1500 Billing Modifiers

DOM requires providers to bill current CPT and HCPCS modifiers according to coding guidelines and Administrative Code for the services provided. These modifiers provide the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but has not changed in its definition or code. Some modifiers impact reimbursement, while others are informational.

Please see the Mississippi Administrative Code appropriate for the services you are providing for information on modifier usage.

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 DOM's website at http://www.medicaid.ms.gov. Select the Resources 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

Often the contractual amount sometimes referred to as "co-pay/co-insurance", "co-pay/deductible", 'co-pay/co-insurance/deductible", or "member-patient responsibility" will be indicated on the Medicare Part C Advantage Plan EOMB. However, if not specifically stated use the criteria below to enter amount in appropriate field(s).

The following are examples of Medicare Part C Advantage Plan EOMB scenarios for TPL Payment.

Scenario 1: If EOMB states co-pay/co-insurance only, enter amount on claim in Field 17.

Scenario 2: If EOMB states co-pay/deductible only, enter amount on claim in Field 17.

Scenario 3: If EOMB states co-pay only, enter amount on claim in Field 17.

Scenario 4: If EOMB states amounts separately for co-pay/co-insurance/deductible enter amount for deductible on claim in Field 16 and combined amounts for both co-pay/co-insurance on claim in Field 17.

Scenario 5: If EOMB states amounts separately for co-pay, no amount for co-insurance and amount for deductible, enter amount on claim in Field 16 for deductible and Field 17 for co-insurance.

Scenario 6: If EOMB states member-patient responsibility only, enter amount on claim in Field 17.

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 (05/12) For Part C Claims ONLY

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part B Crossover Claim Form (03/14/2016)
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).
2c	Required if applicable	**Taxonomy Code:** Enter the provider taxonomy of the billing provider if the provider is a subpart of the facility.
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-10) 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.
8a	Required	**National Drug Code:** Enter the appropriate NDC 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.

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part B Crossover Claim Form (03/14/2016)
16	**Required**	**Medicare Deductible:** Enter the total Medicare deductible (dollars.cents) amount which is to be paid by Medicaid.
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

Revised 03/14/16

MISSISSIPPI CROSSOVER CLAIM FORM
State of Mississippi Medicaid Program

For Medicare Part C ONLY

1. Provider Name and Address	2a. Medicaid Provider Number	2c. Taxonomy Code	3. Beneficiary Name and Address
	2b. NPI Number	4. Beneficiary Medicaid ID	

5. Patient Acct. / Med Rec Num.	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 Amount	14. Medicare Blood Deductible	15. Medicare Paid Amount	16. Medicare Deductible	17. Medicare Co-insurance	18. Medicare Paid Date	19. Third Party Payment Amount
1							
	8a. NDC						
2							
	8a. NDC						
3							
	8a. NDC						
4							
	8a. NDC						
5							
	8a. NDC						
6							
	8a. NDC						

PART C 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

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 Administrative Code. You may refer to the administrative code 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 Individuals with Intellectual Disabilities (**ICF/IID)**
- 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 0001** (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 a b | 9 PATIENT ADDRESS a b c d e

10 BIRTHDATE | 11 SEX | 12 DATE | ADMISSION 13 HR 14 TYPE 15 SRC | 16 DHR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 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 a b

38 | 39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT a b c d

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23	PAGE ____ OF ____	CREATION DATE		TOTALS			23

50 PAYER NAME A B C | 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 A B C | 59 P. REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES A B C | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX | 67 I | A J | B K | C L | D M | E N | F O | G P | H 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

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

79 OTHER NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d

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.

SAMPLE

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.

Field	Requirement	Field Name and Instructions for UB-04 Form
9a-e	Not Required	Patient Address
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 0001 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

Field	Requirement	Field Name and Instructions for UB-04 Form
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.
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.**

Field	Requirement	Field Name and Instructions for UB-04 Form
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, Ordering, or Referring Provider NPI if the admit source is 2 – Clinics; 4 – Transfer from Different Hospital; 6 – TRN from Other HCF/Born Outside; E – Transfer from ASC or F – Transfer from Hospice. Enter the Attending, Referring, or Ordering Provider's last name and First Name. Qualifier Code- Not Required.
77	Not Required	Operating Physician Name and Identifiers
78	**Required if Applicable**	**Other Provider (Individual) Names and Identifiers:** Enter the NPI 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	✓			
48 Non-Covered Charges		✓		

UB-04 Checklist for Required Fields	Required	Required if Applicable	Optional	Not Required
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, Ordering, or Referring Physician Information		✓		
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
0111	Hospital Inpatient—complete stay, admission through discharge
0112	Hospital Inpatient—patient is admitted and is still a patient, first half of a split bill
0113	Hospital Inpatient—patient is a patient for the full month, interim bill
0114	Hospital Inpatient—patient is discharged in a different month from admission, second half of a split bill
0131	Outpatient
0181	Swing bed – used when the claim is for a complete stay, admission through discharge
0182	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.
0183	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.
0184	Swing bed - used when a patient is discharged in a different month from admission. This claim is the final bill.
0721	Freestanding renal dialysis centers or hospital based dialysis units
0811	Hospice (non-hospital based)
0821	Hospice (hospital-based)
0891	PRTF and Nursing Facility-complete stay, admission through discharge.
0892	PRTF and Nursing Facility – patient is admitted and is still a resident, first half of a split bill
0893	PRTF and Nursing Facility – patient is a resident for the full month, interim bill
0894	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)

Definition
Emergency: The patient requires immediate intervention as a result of severe, life-threatening, or potentially disabling conditions.
Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder.
Elective: The patient's condition permits adequate time to schedule the availability of a suitable accommodation.
Newborn: Any newborn infant born within a hospital setting.
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.
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

Note: Admission Source Codes with * require NPI in Field 76

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	
0651	Routine home care
0652	Continuous home care
0655	Inpatient respite care
0656	General inpatient care (non-respite)
0659	Other hospice (nursing facility hospice)
Psychiatric Residential Treatment Facilities	
1001	All inclusive room and board
0183	Therapeutic leave
0185	Hospital leave
Nursing Facilities and ICF/IID	
0101	All inclusive room and board
0181	Hospital leave* **(End Date: 6/30/17)**
0183	Therapeutic leave
0185	Hospital Leave* **(Effective: 7/1/17)**
0194	Ventilator Dependent Care (VDC) – services became effective 1/1/2015. This code is applicable to residents of Nursing Facilities, but not Intermediate Care Facilities / Individuals with Intellectual Disabilities (ICF/IID).
Dialysis Centers	
0250	Pharmacy General Classification
0636	Drugs Requiring Detailed Coding
0821	Outpatient or Home Dialysis – Hemodialysis/Composite or Other Rate
0831	Outpatient or Home Dialysis – Peritoneal/Composite or Other Rate
0841	Continuous Ambulatory Peritoneal Dialysis (CAPD) – Outpatient or Home CAPD/Composite or Other Rate
0851	Continuous Cycling Peritoneal Dialysis (CCPD) – Outpatient or Home CCPD/Composite or Other Rate
Home Health	
0270	Medical/Surgical Supplies and Devices – General
0421	Physical Therapy Visit
0441	Speech Therapy Visit
0551	Skilled Nurse Visit
0571	Home Health Aide Visit

****Note**: Effective July 1, 2017 revenue code 0185 – "leave of absence-reserved-nursing home (for hospitalization) is required for all hospital leave claims. This change is being made to meet compliance of the National Uniform Billing Committee.**

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.

MISSISSIPPI DIVISION OF MEDICAID

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 DOM'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 pay the member-patient responsibility to include co-pay/co-insurance and/or deductible. Claims with these types of EOMBs should be submitted by the provider. Medicaid does 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 (03/14/2016)
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.
3a	Optional	**Medicaid Provider Number:** Enter the 8 digit Medicaid number of the health care.
3b	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).
3c	Required if applicable	**Taxonomy Code:** Enter the provider taxonomy of the billing provider if the provider is a subpart of the facility.
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-10) 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.

Field	Requirement	Field Name and Instructions for Mississippi Medicaid Part A Crossover Claim Form (03/14/2016)
14	Required	**Total Medicare Allowed Amount:** Enter the total amount payable for the claim (dollars.cents) as determined by Medicare.
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	**Revenue Code:** Enter the appropriate revenue code from the Uniform Billing Manual.
22	Required if applicable	**Procedure Code:** Enter the HCPCS code for laboratory, radiology, and dialysis services provided.
23	Required	**Units:** Enter the number of days or units of service provided for each detail line.
24	Required	**Medicare Billed Amount:** Enter the total charges (dollars.cents) billed to Medicare for each detail service.
25	Required if applicable	**Medicare Non-covered Amount:** Enter the charge (dollars.cents) for any non-covered service such as take-home drugs.
26	Required	**Provider Signature:** The provider or an authorized representative must sign the claim form. Original rubber stamp signatures are acceptable.
27	Required	**Billing Date:** Enter the date the claim was submitted to the Medicaid fiscal agent for processing in MM/DD/CCYY format.

Medicare Part A

MISSISSIPPI CROSSOVER CLAIM FORM
State of Mississippi Medicaid Program

1. Type of Bill

For Medicare Part C ONLY

2. Provider Name and Address	3a. Medicaid Provider Number	3c. Taxonomy Code	4. Beneficiary Name and Address
	3b. NPI Number		

5. Beneficiary Medicaid ID	6. Patient Account/Medical Record Number	Admission			10. Dates of Service	
		7. Date	8. Hour	9.Type	From	Thru

11. Covered Days	12.Diagnosis		13. Total Medicare Billed Charges	14. Total Medicare Allowed Amount	15. Total Medicare Paid Amount
	Primary	Secondary			
	3rd	4th			

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	22. Procedure Code	23. Units	24. Medicare Billed Amount	25. 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					

PART C 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.

26. Provider Signature	27. Billing Date

Revised 03/14/16

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 Administrative Code Title 23 Part 204. The Dental Fee Schedule is available on the Medicaid web site at http://www.medicaid.ms.gov or on the Web Portal at https:/ / ms-medicaid.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.

Current Dental Terminology (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright © 2008 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

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 ADA American Dental Association Dental Claim form. Mississippi Medicaid will only accept the ADA American Dental Association 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 American Dental Association Dental claims form 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 American Dental Association 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 Treatment Authorization Number (TAN), timely filing Transaction Control Number (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

ADA American Dental Association Dental Claim Form

ADA American Dental Association® Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization
☐ EPSDT / Title 30X

2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

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

OTHER COVERAGE (Mark applicable box and complete items 5-11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5-11 for dental only.)

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

POLICY HOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #2)

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. Reserved For Future Use

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	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

34. Diagnosis Code List Qualifier (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A ____ B ____ C ____ D ____

31a. Other Fee(s)
32. 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 ( ) - | 52a. Additional

ANCILLARY CLAIM/TREATMENT INFORMATION

39. Place of Treatment ____ (e.g. 11=Office; 22=O/P Hospital) (Use "Place of Service Codes for Professional Claims") | 39. Enclosures (Y or N) ☐

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

42. Months of Treatment | 43. Replacement of Prosthesis ☐ No ☐ Yes (Complete 44) | 44. Date of 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 ( ) - | 58. Additional

© 2012 American Dental Association
J430D (Same as ADA Dental Claim Form – J430, J431, J432, J433, J434)

To reorder call 800.947.4746 or go online at adacatalog.org

SAMPLE

ADA American Dental Association Dental Claim Form Instructions for Mississippi Medicaid

Field	Requirement	Field Name and Instructions for ADA Dental Claim Form
1	Not Required	Type of Transaction: Not Required.
2	**Required if Applicable**	**Predetermination/Preauthorization Number**: Enter TAN number for services that require PA and approval by the UM/ QIO. Refer to the Administrative Code 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 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 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.
29a	**Required**	**Diag Pointer: ("A" through "D": as applicale from Item 34a)**
29b	Not Required	Qty
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.
31a	Not Required	Other Fee(s): Not required
32	**Required**	**Total Fee:** Enter the sum of all fees from lines in field #31.
33	**Required if Applicable**	**Missing Teeth Information:** Report a missing tooth/ teeth when pertinent to periodontal, prosthodontic (fixed and removable), or implant procedures.

Field	Requirement	Field Name and Instructions for ADA Dental Claim Form
34	**Required**	Diagnosis Code List Qualifier: (B for ICD-9-CM; AB for ICD-10-CM)
34a	**Required**	Diagnosis Code(s)/ A, B, C, D (up to four, with the primary adjacent to the letter "A")
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.
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.

Field	Requirement	Field Name and Instructions for ADA Dental Claim Form
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.
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	✓			
29a Diag Pointer	✓			
29b Qty				✓
30 Description	✓			
31 Fee	✓			
31a Other Fee(s)				✓
32 Total Fee	✓			
33 Missing Teeth Information		✓		
34 Diagnosis code List Qualifier	✓			
34a Diagnosis Code	✓			
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 Administrative Code Title 23: Medicaid. You may refer to the Administrative Code 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.

		Telephone #	**Fax #**
Conduent	Fiscal Agent	800-844-3222	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
Pharmacy Prior Authorization Unit	Prior Authorizations	877-537-0722	877-537-0720
Pharmacy Helpdesk	Fiscal Agent	800-884-3222	888-495-8169

340B Covered Outpatient Drugs

340b Pharmacy Providers are required to report a value of '08" in NCPDP field # 423 DN when billing POS claims for drugs purchased through the 340b drug program. The actual acquisition cost of the drug must be submitted in the 'Ingredient Cost' field.

72 Hour Emergency Supply

Federal law requires that a 72-hour emergency supply of a prescribed drug be dispensed without delay when prior authorization (PA) is not available. The rule applies to non-preferred drugs and any drug that is affected by clinical or PA edits which require prior approval. The 72-hour emergency procedure should only be used in emergencies and not routinely for continuous overrides.

Enter a value of '3' in NCPDP Field 418-DI (Level of Service) and a value of '3' in Field 405-D5 (Day Supply). The quantity submitted in Field 442-E7 (Quantity Dispensed) should not exceed a three day supply. These claims count toward the monthly service limits.

For products in unbreakable packaging the same procedure should be used including entering the full

quantity dispensed and either entering the correct days' supply or a '3' day supply.

If/when a PA is issued for the drug, the 72-hour emergency claim should be reversed and the claim resubmitted for the full days' supply.

Beneficiary Eligibility

A beneficiary's MS Medicaid blue 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.

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

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. A day supply greater than 31 is also allowed for some drugs supplied in unbreakable packaging. Examples include, but are not limited to cyanocobalamin injection, Femring, and Sesonale.

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 with prior authorization.

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 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 Conduent'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 mean 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 Office 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

Mississippi Medicaid does not generally reimbursed for replacement of prescriptions that are not lost, stolen, or otherwise destroyed. Prior Authorization may be granted on a case by case basis.

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.

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/Pharmacy.aspx click on the "OTC List".

Paper Claims

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

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

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

Payer Sheet

A separate NCPDP Payer sheet can be located at the following link:
http://www.medicaid.ms.gov/Documents/Pharmacy/MS%20NCPDP.pdf.

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 to MS Medicaid beneficiaries 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.

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, Retro eligibility 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://ms-medicaid.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 quarterly, with the majority of changes being made every January 1st.. To view the current PDL, go to http://www.medicaid.ms.gov/Pharmacy.aspx. The PDL is maintained by Goold Health Systems, an Emdeon Company.

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://ms-medicaid.com/msenvision/prescribingProviderList.do or
https://nppes.cms.hhs.gov/NPPES/Welcome.do .

Effective 1-1-2014, in accordance with Federal guidelines, prescribers who write prescriptions for Medicaid beneficiaries must be enrolled as MS Medicaid providers. Prescribers who do not bill Medicaid for professional services, but write prescriptions for Medicaid patients must enroll as an Ordering, Referring, Prescribing (ORP) provider type.

It is the pharmacist's responsibility to ensure that the NPI number submitted on a claim is that of the prescriber on the prescription. Any other NPI used is considered fraud.

Prior Authorizations

The Mississippi Division of Medicaid requires prior authorization for reimbursement of pharmacy claims under certain circumstances. The prior authorization (PA) process is designed to encourage appropriate use of cost-effective pharmaceuticals for Medicaid fee for service (FFS) beneficiaries. The Pharmacy PA Unit can be contacted by telephone. Telephone lines are staffed from 8:00 a.m. to 5:00 p.m., Monday through Friday, except holidays.

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

Telephone and FAX Numbers
Telephone: 1-877-537-0722 Facsimile: 1-877-537-0720

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 require prior authorization.

Reimbursement

For the current DOM reimbursement methodology, visit the DOM website at:
http://www.medicaid.ms.gov/Manuals/Title23Part214PharmacyServicesChapter1Rule1.31.41.6and1.12eff.07.01.2013.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.

MS Medicaid Electronic Billing Procedure for Cost Avoidance

A. Beneficiaries whose data on file with Medicaid indicates other third party coverage OR beneficiaries whose data on file indicates no coverage, but provider is aware of other insurance coverage:

Provider must report the beneficiary's other insurance to Medicaid. Follow steps under "B" below.

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.

Example of claim submission to Medicaid **AFTER OTHER INSURANCE has been billed:**

- Claim Submitted to BCBS with a total submitted Charge of $200.00 (Usual and Custormary)
- Blue Cross Blue Shield Pays Pharmacy $100.00 and receipt states that Patient must pay $100.00 Deductible.
- Submit Secondary claim to Medicaid –
  - **i.** Submit a **Total Charge of $200.00**
  - **ii.** Enter a '02' in the "Other Coverage Code" field (NCPDP 308-C8)
  - **iii.** Enter $100.00 in the 'TPL AMOUNT PAID' field (NCPDP 431-DV) **Do not bill only the copay amount to Medicaid.**

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** (this field is optional when Field #308-C8 'Other Coverage Code' = 01, 03, or 04)

ii. In Field **#308-C8,'Other Coverage Code'** one of the following applicable values **should** be entered:

01 = No Other Coverage Exists (Ex: Claim denies due to coverage expired)
03 = Other Coverage Exists – Claim Not Covered (Ex: Claim denies due to non-coverage of drug by insurance and drug is covered by Medicaid)
04 = Other Coverage Exists – Payment Not Collected

Examples:

- Beneficiary has insurance coverage (ex:70-30), which requires the beneficiary to pay for the prescription, then the insurance company would reimburse the beneficiary a certain percentage of the claim
- Pharmacy submits claim to other payer. The beneficiary must meet a deductible before benefits pay for pharmacy claims. The other payer applies the claim to the beneficiary's deductible for

the other insurance. The provider then submits the usual and customary charge to Medicaid.

- Other insurance requires prior authorization for claim submitted. The prior authorization process should be initiated by the provider. Should the access of the beneficiary's prescription be delayed due to this process, the pharmacy may submit the claim to Medicaid. Once the prior authorization is acquired, the claim must be reversed then coordinated with the insurance carrier.

05 = Managed Care Plan Denial – Not an acceptable value
06 = Other Coverage Denied – Not Participating Provider (Ex: Beneficiary has insurance coverage but the pharmacy and/or prescriber is out of the insurance company's network.
07 = Other Coverage Exists – Not in Effect on Date of Service
08 = Billing for Copay – Not an acceptable value

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

B. Provider <u>must</u> report the beneficiaries' other insurance to Medicaid. Provider may report changes in beneficiaries' insurance coverage as follows:

- FAX information to: (601) 359-6294 (PREFERRED)
- CALL Third Party Recovery – Division of Medicaid – (601) 359 6095
  Email or mail form – Visit MS Medicaid Website -
  http://www.medicaid.ms.gov/UpdateHealthInsuranceInformation.aspx

Notes:
Pharmacy providers must keep explanation of benefits (EOB) from other insurance companies. These records must be available to Medicaid upon request.

If a beneficiary tells the provider that his/her insurance policy is no longer in effect, the policy never existed, or 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 Third Party Recovery. Upon receipt of this information, the patient's statement will be researched and, if necessary, the third party resource file will be updated.

Remember, Medicaid is always the payer of last resort.

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 preferably 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 billing manual 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

Division of Medicaid (DOM)	http://www.medicaid.ms.gov
Goold Health Systems	http://ghsinc.com
Conduent	https://ms-medicaid.com

Web Portal Claims Entry

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

- 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.

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5.1 Pharmacy Claim Form Instructions

Medicaid Title XIX Pharmacy Invoice

Check One Box:
☐ Retro Eligibility
☐ TPN

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
	9 Medicaid ID	Medicare #	

BENEFICIARY INFORMATION

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 National Drug Code	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 National Drug Code	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 National Drug Code	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 National Drug Code	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 National Drug Code	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: _____

MS-PHARM REV. 2/2014 ORIGINAL TO FISCAL AGENT

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.

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 the Administrative Code Title 23 Part 306.

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 Office 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 Office 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 Office 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

6.2 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 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 Office 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 Office 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 Office 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 Office 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”.

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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 DOM, Office 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.

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 Resources. Then choose the link Forms. 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.

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

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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---
```

MISSISSIPPI DIVISION OF MEDICAID

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

```
                                                                                  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)                     (3)                    (4)              (5)                    (6)
CLAIM TOTALS        --------STATUS-----------   ---COUNT---      --SUBMITTED AMT---    ------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 Quarterly 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***

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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
ADA	American Dental Association
Alliant Health Solutions	The current Division of Medicaid contractor for the Utilization Management and Quality Improvement Organization.
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.*)
APC	Ambulatory Payment Classifications are used to reimbursed hospital outpatient services.
APR-DRG	All Patient Refined Diagnosis Related Groups are used to reimburse hospital inpatient services.
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.

Term	Definition
CLIA	Clinical Laboratory Improvement Amendments
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.
Conduent	Current fiscal agent contracted by the Mississippi Division of Medicaid. **(Formerly Xerox)**
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

Term	Definition
	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.
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
eQHealth Solutions	The current Division of Medicaid contractor for the Imaging.
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
GHS	Goold Health Systems – Current pharmacy preferred drug list vendor

Term	Definition
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.
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-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification (Diagnosis Codes)
ICD-10-PCS	International Classification of Diseases, Tenth Revision, Procedure Coding System (In-Patient Procedure Codes)
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/IID	Intermediate Care Facility/Individuals with Intellectual Disabilities
Legend Drug	Any drug that requires a prescription under federal code 21 USC 353(b)
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.
Medicare Part B	Coverage which helps pay for medical and surgical services by physicians, providers of service, and suppliers, as well as certain other

Term	Definition
	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 Medicaid Provider Billing Handbook	Handbook which addresses billing procedures through the Division of Medicaid (must be used in conjunction with the Mississippi Administrative Code, Title 23).
Mississippi Administrative Code, Title 23	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).
MYPAC	Mississippi Youth Programs Around the Clock
NCPDP	National Council for Prescription Drug Programs
National Council for Prescription Drug Programs	This entity governs the telecommunication formats used to submit prescription claims electronically.
NDC	National Drug Code

Term	Definition
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.
ORP Provider	Ordering, Referring, Prescribing Provider
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. Covered benefits is payment of their Part B premium only.
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. In addition, covered benefits also includes payment by Medicaid of Medicare premiums.

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. Covered benefit is payment of their Part B premium only.
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 office which is responsible for administering third party liability program.
Transaction Control Number	Unique 17-digit identifier for a claim line assigned by the MMIS

Term	Definition
Usual and customary charge	The amount charged by the provider for the same service when provided to private-pay patients.
UM/QIO	Utilization Management/Quality Improvement Organization
WAL	Wavier Assisted Living
WED	Wavier Elderly Disabled
WIL	Wavier Independent Living
WMR	Wavier Mentally Ret Dev Dis (ID/DD Wavier)
WTB	Wavier Traumatic Brain Injury/Spinal Cord Injury

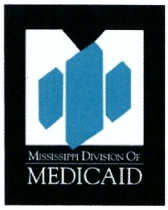
9.2 Forms

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***	

Appointment of Authorized Provider Representative or Agent Form

MISSISSIPPI DIVISION OF MEDICAID

Provider:	Provider Number: NPI:

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicaid the provider or supplier):

I appoint this individual or agent,_____, to act as my representative to submit claims and other billing documents at my direction to the Mississippi Division of Medicaid. This individual may also use my electronic signature, typed signature, stamped signature on my behalf, at my direction, to make such submissions. When using my electronic, typed, or stamped signature, this individual must also accompany my electronic, typed, or stamped signature with their own printed name, either in electronic or handwritten form.

Signature of Provider		Date
Street Address		Phone Number
City	State	Zip Code
Email Address		

Section 2: Acceptance of Appointment

To be completed by the representative:

I,_____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS), licensure agency or Mississippi Department of Health (MSDH). I additionally certify that I have not been convicted of or pleaded guilty to or nolo contendere to a felony or certain misdemeanors including, but not limited to, fraud, forgery, counterfeiting, embezzlement, identity theft, tax evasion, money laundering, or any other crime related to dishonesty or concealment, or that any such conviction or plea was reversed on appeal or a pardon was granted for the conviction or plea.

I am a / an _____

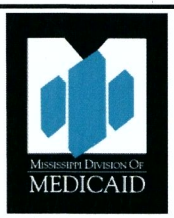
(Professional title as it relates to the Provider)

Signature of Representative		Date
Street Address		Phone Number
City	State	Zip Code
Email Address		

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

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 otherwise 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.**

You may contact Mississippi's Provider Relations Unit at 1.800.884.3222, Monday-Friday 8AM-5PM CST if you have any questions about the Direct Deposit Authorization/Agreement Form or wish to inquire upon the status of a form that has already been submitted.

Attention! It is the Provider's responsibility to contact their financial institutions to arrange for delivery of the CCD+ (addenda detail record) data elements needed for re-association of the payment and the ERA.

Instructions for filling out this form are provided at the end. Required fields are denoted with an asterisk(*).

Provider Information

Provider Name*

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN)* **or** Employer Identification Number (EIN)

National Provider Identifier (NPI)*

Provider Contact Information

Provider Contact Name

Title

Telephone Number

Telephone Number Extension

Email address

Fax Number

Financial Institution Information

Financial Institution Name*

Financial Institution Address

Street

City

State

Zip

Financial Institution Routing Number*

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

Type of Account at Financial Institution*

O Checking
O Savings

Provider's Account Number with Financial Institution*

Account Number Linkage to Provider Identifier*
(**Must Match ERA Preference**)

O Provider Tax Identification Number (EIN/TIN)
O National Provider Identification Number (NPI)

Submission Information

Reason for Submission*

O New Enrollment
O Change Enrollment
O Cancel Enrollment

Authorized Signature

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 was 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.**

Written Signature of Person Submitting Enrollment*

Printed Name of Person Submitting Enrollment

Submission Date

DIRECT DEPOSIT AUTHORIZATION /AGREEMENT FORM

INSTRUCTIONS
Required fields on this form are denoted with an asterisk (*).

Provider Information

Provider Name* - If the provider is an individual, enter the provider's name. If the provider is a group, enter the group name.

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)* - Enter the Federal Tax Identification Number (TIN) or the Employer Identification Number (EIN), if available. If the provider is an individual who doesn't have a Federal Tax Identification Number (TIN), or Employer Identification Number (EIN), enter the provider's own Social Security Number.

National Provider Identifier (NPI)* - Enter the provider's National Provider Identifier Number.

Provider Contact Information

Provider Contact Name* - Enter the name of the person to be contacted for questions or clarification.

Title – Enter the title of the Provider Contact person.

Telephone Number – Enter the telephone number, including area code, of the Provider Contact Person.

Telephone Number Extension – Enter the telephone number extension of the Provider Contact Person, if applicable.

Email address – Enter the email address of the Provider Contact Person.

Fax Number – Enter the fax number of the Provider Contact Person.

Financial Institution Information

Financial Institution Name* - Enter the name of the financial institution that is to receive the provider's payments.

Financial Institution Address (Street) – Enter the street address of the financial institution.

Financial Institution Address (City) – Enter the city address of the financial institution.

Financial Institution Address (State) – Enter the two digit state abbreviation of the financial institution.

DIRECT DEPOSIT AUTHORIZATION /AGREEMENT FORM

INSTRUCTIONS
Required fields on this form are denoted with an asterisk (*).

Financial Institution Address (Zip) – Enter the zip code address of the financial institution.

Financial Institution Routing Number* - Enter the nine digit routing number of the financial institution.

Type of Account at Financial Institution* - Check the Checking radio button if the account at the financial institution is a checking account. Check the Savings radio button if the account is a savings account.

Provider's Account Number with Financial Institution* - Enter the provider's account number with the financial institution.

Account Number Linkage to Provider Identifier* - Check the Provider Tax Identification Number (EIN/TIN) radio button if the provider is an atypical provider, otherwise check the National Provider Identification Number (NPI) radio button.

Submission Information

Reason for Submission* - Check the New Enrollment radio button if this application is to enroll a new provider for EFT. Check the Change Enrollment radio button if this application is to make a change to an existing provider's EFT information. If the Cancel Enrollment radio button is checked, the cancellation will be denied since an EFT is required to be on file for all active providers.

Authorized Signature

Written Signature of Person Submitting Enrollment* - This application should be signed by the provider or an authorized person.

Printed Name of Person Submitting Enrollment – Enter the name of the person who signed the form to submit enrollment.

Submission Date – Enter the current date.

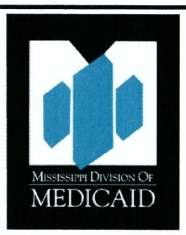
Missing or Late EFT Procedures

- The provider will contact the Xerox Call Center at (1-800-884-3222) to verify their banking information that is currently on file.
- The Call Center Agent will verify the banking account and routing numbers.
- If the account number is correct, the Call Center Agent will advise the provider to contact their financial institution's ACH department.
- If the banking account or routing number isn't correct, the Call Center Agent will direct the provider to update their banking account information via the Direct Deposit Authorization/Agreement form which is available on the Mississippi Medicaid website at http://msmedicaid.acs-inc.com under Provider→Provider Enrollment for online submission to be downloaded.

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 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						
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 Instructions

Signature

- The individual provider's signature is required for all changes requested for an individual provider number.
- Signature of the authorized representative for the group/facility is required for changes to group/facility provider numbers.

General

- Incomplete forms will be returned to the provider.
- If you have any questions, please contact Xerox Provider Enrollment at (800) 884-3222.

MISSISSIPPI DIVISION OF
MEDICAID

CHANGE OF ADDRESS FORM

Mail the completed form to: **Mississippi Medicaid Provider Enrollment**
P.O. Box 23078
Jackson, Mississippi 39225
or Fax to: (888) 495-8169

Provider Information

Provider Name:

National Provider Identifier (NPI):

MS Medicaid Provider Number:

Contact Information

Contact Name: Phone Number:

Email Address:

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
		Phone Number		Fax Number	
☐ 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**

Revised 6/3/2014

Xerox EDI Gateway, Inc. Provider Agreement

Please return to:

Mississippi Medicaid Program

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

Xerox EDI GATEWAY TRADING PARTNER AGREEMENT

THIS TRADING PARTNER AGREEMENT ("Agreement") is by and between **SUBMITTER** ("Submitter") and **Xerox EDI GATEWAY, INC.** ("Trading Partner"), collectively "the Parties."

Whereas, Submitter desires to transmit Transactions to Trading Partner for the purpose of submitting data to the Mississippi Division of Medicaid;

Whereas, Trading Partner desires to receive such Transactions for this purpose; and

Whereas, Submitter is subject to the Transaction and Code Set Regulations with respect to the transmission of such Transactions.

Now, therefore, the Parties agree as follows:

1. Definitions

Trading Partner means Xerox EDI Gateway, Inc.

Submitter means the party identified as "Submitter" on the signature line of this Agreement who is a Health Care Provider as defined in 45 CFR 164.103.

Standard is defined in 45 CFR 160.103.

Transaction is defined in 45 CFR 160.103.

Transactions and Code Set Regulations means those regulations governing the transmission of certain health claims transactions as published by DHHS under HIPAA.

2. Obligations of the Parties Effective Upon Execution of this Agreement by Submitter

A. The Parties agree, in regard to any electronic Transactions between them:

(1) They will exchange data electronically using only those Transaction types as selected by Submitter on the Xerox EDI Gateway Trading Partner Enrollment Form (TPEF).

(2) They will exchange data electronically using only those formats (versions) as specified on the TPEF.

(3) They will not change any definition, data condition, or use of a data element or segment in a Standard Transaction they exchange electronically.

(4) They will not add any data elements or segments to the Maximum Defined Data Set.

(5) They will not use any code or data elements that are not in or are marked as "Not Used" in a Standard's implementation specification.

(6) They will not change the meaning or intent of a Standard's implementation specification.

(7) Trading Partner will accept Transactions from Submitter according to the Xerox EDI Gateway TPEF but may subsequently deny a Transaction for further processing if the Transaction is not submitted using the data elements, formats or Transaction types set forth in the TPEF. Trading Partner may return a Submitter to a test status if Submitter repeatedly submits Transactions which do not meet the criteria set forth in a TPEF or if Submitter repeatedly submits inaccurate or incomplete Transactions to Trading Partner.

B. Submitter understands that Trading Partner or others may request an exception from the Transaction and Code Set Regulations from DHHS. If an exception is granted, Submitter will participate fully with Trading Partner in the testing, verification, and implementation of a modification to a Transaction affected by the change.

C. Trading Partner understands that DHHS may modify the Transaction and Code Set Regulations. Trading Partner will modify, test, verify, and implement all modifications or changes required by DHHS using a schedule mutually agreed upon by Submitter and Trading Partner.

D. Neither Submitter nor Trading Partner accepts responsibility for technical or operational difficulties that arise out of third party service providers' business obligations and requirements that undermine Transaction exchange between Submitter and Trading Partner.

E. Submitter and Trading Partner will exercise diligence in protection of the identity, content, and improper access of business documents exchanged between the two parties. Submitter and Trading Partner will make reasonable efforts to protect the safety and security of individually assigned identification numbers that are contained in transmitted business documents and used to authenticate relationships between the parties.

F. Trading Partner may publish data clarifications ("Xerox Companion Guides") to complement each Implementation Guide. Submitter should use Xerox Companion Guides in conjunction with the HIPAA Implementation Guides available at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

G. Transactions are considered properly received only after accessibility is established at the designated machine of the receiving party. Once transmissions are properly received, the receiving party will promptly transmit an electronic acknowledgment that conclusively constitutes evidence of properly received transactions. Each party will subject information to a virus check before transmission to the other party.

H. Each party will implement and maintain appropriate policies and procedures and mechanisms to protect the confidentiality and security of PHI transmitted between the parties.

3. Miscellaneous

A. This Agreement is effective on the date last signed below. This Agreement shall continue until such time as either party elects to give written notice of termination to the other party or termination of Transaction services provided by Trading Partner to Submitter, whichever is earlier.

B. This Agreement incorporates, by reference, any written agreements between the parties relating to the subject matter hereof.

C. This Agreement shall be interpreted consistently with all applicable federal and state privacy laws. In the event of a conflict between applicable laws, the more stringent law shall be applied. This Agreement and all disputes arising from or relating in any way to the subject matter of this Agreement shall be governed by and construed in accordance with Mississippi law, exclusive of conflicts of law principles. THE EXCLUSIVE JURISDICTION FOR ANY LEGAL PROCEEDING REGARDING THIS AGREEMENT SHALL BE IN THE COURTS OF THE STATE OF MISSISSIPPI AND THE PARTIES HEREBY EXPRESSLY SUBMIT TO SUCH JURISDICTION.

D. Unless otherwise prohibited by statute, the parties agree that this Agreement shall not be affected by any state's enactment or adoption of the Uniform Computer Information Transaction Act, Electronic Signature or any other similar state or federal law. Each party agrees to comply with all other applicable state and federal laws in carrying out its responsibilities under this Agreement.

E. This Agreement is entered into solely between, and may be enforced only by, Submitter and Trading Partner. This Agreement shall not be deemed to create any rights in third parties or to create any obligations of Submitter or Trading Partner to any third party.

F. NO WARRANTIES, EXPRESS OR IMPLIED, ARE PROVIDED BY TRADING PARTNER UNDER THIS AGREEMENT. TRADING PARTNER'S MAXIMUM AGGREGATE LIABILITY FOR DAMAGES FOR ANY AND ALL CAUSES WHATSOEVER ARISING OUT OF THIS AGREEMENT, REGARDLESS OF THE MANNER IN WHICH CLAIMED OR THE FORM OF ACTION ALLEGED, IS LIMITED TO THE AMOUNT(S) PAID TO TRADING PARTNER BY SUBMITTER UNDER THIS AGREEMENT.

G. Trading Partner may provide proprietary software to Submitter to allow Submitter to submit Transactions to Trading Partner. Submitter will protect the software as it protects its own confidential information and will not, directly or indirectly, allow access to or the use of the software or any portion thereof, on any computer, server, or network, by any person, corporation, or business entity other than Submitter. Submitter may permit use of the software by contractors or agents of Submitter provided that any such contractors or agents are not competitors of Trading Partner and further provided that any such persons agree to protect the confidentiality of the software. Submitter and its contractors and agents are not permitted to use the software for any purpose other than submitting Transactions solely to Trading Partner.

H. This Agreement contains the entire agreement between the parties and may only be modified by an agreement signed by both parties.

f Submitter may elect to execute either a hard copy or an electronic copy of this Agreement. Hard Copy Execution: Submitter will sign a hard copy of this Agreement and mail to Trading Partner at the address indicated below. Trading Partner will return a copy of the fully executed Agreement to Submitter. The effective date of the hard copy Agreement is the date on which the Agreement is signed by Trading Partner. Electronic Copy Execution: Submitter should execute this Agreement by clicking on the "I AGREE" button that appears at the bottom of the Agreement. The effective date of the

f electronic copy agreement is the date Trading Partner receives the electronic transmission of Submitter's acceptance to the terms of this Agreement.

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

SUBMITTER:

_____
Signature

_____
Printed Name and Title

_____
Date

_____
Signature

_____
Printed Name and Title

_____
Date

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

Check One Box:
☐ Retro Eligibility
☐ TPN

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

[9]Medicaid ID | Medicare #

BENEFICIARY INFORMATION

[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]National Drug Code	[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]National Drug Code	[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]National Drug Code	[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]National Drug Code	[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]National Drug Code	[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

1. Type of Bill

For Medicare Part C ONLY

2. Provider Name and Address	3a. Medicaid Provider Number	3c. Taxonomy Code	4. Recipient Name and Address
	3b. NPI Number		

5. Recipient Medicaid ID	6. Patient Account/Medical Record Number	Admission			10. Dates of Service	
		7. Date	8. Hour	9.Type	From	Thru

11. Covered 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 6/16/10 rre

Medicare Part B

MISSISSIPPI CROSSOVER CLAIM FORM
State of Mississippi Medicaid Program

Revised 05/02/12

For Medicare Part C ONLY

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

5. Patient Acct. / Med Rec Num.	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 Amounts
	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							
	8a. NDC						
2							
	8a. NDC						
3							
	8a. NDC						
4							
	8a. NDC						
5							
	8a. NDC						
6							
	8a. NDC						

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