Title 23: Division of Medicaid

Part 200: General Provider Information

Part 200 Chapter 4: Provider Enrollment

Rule 4.2: Conditions of Participation

A. Providers must comply with the following conditions to participate in the Mississippi Medicaid program:

1. All providers must complete provider agreements and/or provider enrollment application packages per the requirements of the Division of Medicaid.

2. The provider must be licensed and/or certified by the appropriate federal and/or state authority, as applicable.

3. Agree to furnish required documentation of the provider's business transactions per 42 C.F.R. § 455.105(b) to the Division of Medicaid or to the Department of Health & Human Services (HHS) within thirty-five (35) days of the date on the request.

4. Agree to abide by the requirements of the Affordable Care Act (ACA) concerning the following:

    a) Provider Screening Procedures (42 C.F.R. §§ 455.400-470), based on the category of the provider type, which includes license verifications, database checks of eligible professionals, owners, managing employees, etc., fingerprinting and criminal background checks, and/or unscheduled or unannounced site visits based on required screening rules.

        1) Providers with an expired license will be denied enrollment.

        2) Providers with any current disciplinary limitations on their license may be denied enrollment.

        3) Providers that meet any of the exclusion requirements according to state and/or federal law will be denied enrollment.

    b) Provider Application Fees (42 C.F.R. § 455.460).

    c) Temporary Moratorium (42 C.F.R. § 455.470).

    d) Provider Termination (42 C.F.R. § 455.416).

    e) Payment Suspensions (42 C.F.R. § 455.23).

5. The provider agrees to review, complete and submit a completed re-validation document as required by the policies of Division of Medicaid. All providers must undergo a revalidation screening process at least once every five years in accordance with 42 C.F.R. § 455.414.

6. 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 (5) years in order to comply with all federal and state regulations and laws. When there is a change of ownership or retirement, a provider must continue to maintain all Medicaid beneficiary records, unless an alternative method for maintaining the records has been established and approved by the Division of Medicaid. Upon request, providers are required to make such records available to representatives of the Division of Medicaid and others as provided by law in validation of any claims. The Division of Medicaid staff shall have immediate access to the provider's physical location, facilities, records, documents, and any other records relating to medical care and services rendered to beneficiaries during regular business hours. Providers must maintain records as indicated in Part 200 Chapter 1, Rule 1.3: Maintenance of Records.

7. The provider must comply with the requirements of the Social Security Act and federal regulations concerning: (a) disclosure by providers of ownership and control information; and (b) disclosure of information by a provider's owners of any persons with convictions of criminal offenses against Medicare, Medicaid, or the Title XXI services program. If the Division of Medicaid ascertains that a provider has been convicted of a felony under federal or state law for an offense that the Division of Medicaid determines is detrimental to the best interests of the program or of Medicaid beneficiaries, the Division of Medicaid may refuse to enter into an agreement with such provider, or may terminate or refuse to renew an existing agreement.

8. The provider must agree to accept payment for Medicaid covered services in accordance with the rules and regulations for reimbursement, as declared by the Secretary of Health and Human Services and by the state of Mississippi, and established under the Mississippi Medicaid program.

9. The provider must agree to accept, as payment in full, the amount paid by the Medicaid program for all services covered under the Medicaid program within the beneficiary's service limits with the exception of authorized deductibles, co-insurance, and co-payments. All services covered under the Medicaid program will be made available to the beneficiary. Beneficiaries will not be required to make deposits or payments on charges for services covered by Medicaid. A provider cannot pick and choose procedures for which the provider will accept Medicaid. At no time shall the provider be authorized to split services and require the beneficiary to pay for one type of service and Medicaid to pay for another. All services provided to Medicaid beneficiaries will be billed to Medicaid where Medicaid covers said services, unless some other resources, other than the beneficiary or the beneficiary's family, will pay for the service.

10. For most medical services rendered, the provider must agree to take all reasonable measures to determine the legal liabilities of third parties including Medicare and private health insurance to pay for Medicaid covered services, and if third party liability is established, to bill the third party before filing a Medicaid claim. Exceptions to this rule are outlined in Part 306 Third Party Recovery. For the purpose of this provision, the term "third party" includes an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the medical costs of injury, disease or disability of a Medicaid beneficiary and to report any such payments as third parties on claims filed for Medicaid payment.

11. Participating providers of services under the Medicaid program, i.e., physicians, dentists, hospitals, nursing facilities, pharmacies, etc., must comply with the requirements of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age of Discrimination Act of 1975. Under the terms of these Acts, a participating provider or vendor of services under any program using federal funds is prohibited from making a distinction in the provision of services to beneficiaries on the grounds of race, color, national origin or handicap. This includes, but is not limited to, distinctions made on the basis of race, color, national origin, age or handicap with respect to: (a) waiting rooms, (b) hours of appointment, (c) order of seeing patients, or (d) assignment of patients to beds, rooms or sections of a facility. The Division of Medicaid is responsible for routine and complaint investigations dealing with these three (3) Acts.

12. Participating providers are prohibited from making a distinction in the provision of services to Medicaid beneficiaries on the grounds of being Medicaid beneficiaries. This includes, but is not limited to, making distinctions with regard to waiting rooms, hours of appointment, or order of seeing patients, third party sources (pursuant to federal regulations), and quality of services provided, including those provided in a facility.

13. The provider must agree that claims submitted will accurately reflect both the nature of the service and who performed the service.

14. The provider must maintain a copy of the Administrative Code for Mississippi Medicaid and all revisions.

15. Participating providers must be eligible to participate in the Medicaid program as determined by DHHS-Office of Inspector General (DHHS-OIG). Certain individuals and entities are ineligible to participate in the Medicaid program on the basis of their exclusion as sanctioned by DHHS-OIG by authority contained in Sections 1128 and 1156 of the Social Security Act. The effect of exclusion is that no program payment will be made for any items or services, including administrative and management services, furnished, ordered or prescribed by an excluded individual or entity under the Medicare, Medicaid, and State Children's Health Insurance Programs during the period of the exclusion. Program payments will not be made to an entity in which an excluded person is serving as an employee, administrator, operator, or in any other capacity, for any services including administrative and management services furnished, ordered, or prescribed on or after the effective date of the exclusion. In addition, no payment may be made to any business or

facility that submits bills for payment of items or services provided by an excluded party. The exclusion remains in effect until the subject is reinstated by action of the DHHS-OIG. It is the responsibility of each Medicaid provider to assure that no excluded person or entity is employed in a capacity which would allow the excluded party to order, provide, prescribe, or supply services or medical care for beneficiaries, or allow the excluded party to hold an administrative, billing, or management position involving services or billing for beneficiaries.

16. The provider must verify with the NET Broker that all non-emergency transportation (NET) services are for a Medicaid covered service only. The provider is only required to verify the date, time, beneficiary's Medicaid number, and provide confirmation that a Medicaid covered service will be provided at the appointment.

17. A provider that has not rendered services as evidenced on claims to the Division of Medicaid or coordinated care organization (CCO) for a one (1) year period will be disenrolled except for certain providers that are necessary to maintain access to covered services, as determined by the Division of Medicaid. Once disenrolled, the provider may reapply in accordance with the current enrollment policy.

B. Out-of-State Providers –

1. The Division of Medicaid may enroll an out-of-state provider to cover medical services if one (1) of the following conditions is met:

   a) That are needed because of an emergency medical condition as defined in Miss. Admin. Code Title 23, Part 201, Rule 1.2.G.

   b) That are needed because the beneficiary's health would be endangered if they were required to travel to their state of residence.

   c) That the Division of Medicaid has determined, on the basis of medical advice, are needed and more readily available in the other state.

      1) The provider must submit documentation supporting the need for out of state services, including, but not limited to:

         (a) A description of how the provider's enrollment will meet the needs of Mississippi Medicaid members and documentation of an insufficient existing provider base for the specified services in Mississippi.

         (b) A description of how the provider's enrollment will provide a unique service that is currently unavailable in Mississippi.

      2) Requests to cover specific procedure codes should not be submitted through provider enrollment and will not be reviewed.

d) The location of services provided is within:

1) Thirty (30) miles of the Mississippi state border for a pharmacy, or

2) Sixty (60) miles from the Mississippi state border for certain other provider types.

e) Or as determined by the Division of Medicaid.

2. The Division of Medicaid may use the results of the provider screenings performed by another state's Medicaid or Children's Health Insurance Program (CHIP) agency in the state in which the out-of-state provider is located or by a Medicare Contractor.

3. Out-of-state providers must adhere to the Division of Medicaid's policies and procedures.

C. Providers that are closing, discontinuing a service, or otherwise stopping services for reasons unrelated to the beneficiary's condition or medical necessity of the services must provide a thirty (30) day written notice to beneficiaries and the Division of Medicaid prior to ending the services:

1. Providers must assist with the transition of the beneficiary to another service provider.

2. Providers who fail to provide proper notice will not be reimbursed for services provided during the thirty (30) day period the beneficiary should have been notified unless the provider was prevented from making the notification due to causes beyond the reasonable control of the Provider, including but not limited to fire, floods, embargoes, war, acts of war, insurrections, riots, strikes, lockouts or other labor disturbances, or acts of God; provided, however, that a Provider so affected shall use reasonable commercial efforts to avoid or remove such causes of nonperformance, and shall provide proper notice hereunder immediately whenever such causes are removed. Changes to the scope of available services or reimbursement methodology for the provision of certain services through legislative or regulatory action shall not constitute an unforeseeable circumstance within the meaning of this section.

3. Facilities and/or entities that employ multiple enrolled providers are not required to provide the thirty (30) day notice when an enrolled provider that is employed leaves the facility and/or entity as long as the beneficiary has been transitioned to another provider within the same facility/entity and there is no interruption in services.

Source: 42 C.F.R. §§ 431.52, 431.107, 447.15, 455.412, 455.416, 455.460, 455.470; Miss. Code Ann. §§ 43-13-117, 43-13-118, 43-13-121.

History: Revised eff. 01/01/2025; Revised eff. 11/01/2021; Revised eff. 04/01/2021; Revised eff. 10/01/2020; Revised eff. 04/01/2020; Revised Miss. Admin. Code Part 200, Rule 4.2.B. eff. 01/01/2020; Revised eff. 12/01/2019.

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2. The Division of Medicaid may use the results of the provider screenings performed by another state's Medicaid or Children's Health Insurance Program (CHIP) agency in the state in which the out-of-state provider is located or by a Medicare Contractor.

~~3. An out-of-state provider that has not billed the Division of Medicaid within a three (3) year period will be disenrolled except for certain providers, as determined by the Division of Medicaid, that are necessary to maintain access to covered services not available in Mississippi. Once disenrolled, the out-of-state provider may reapply in accordance with the out-of-state enrollment policy.~~

~~4~~3. Out-of-state providers must adhere to the Division of Medicaid's policies and procedures.

C. Providers that are closing, discontinuing a service, or otherwise stopping services for reasons unrelated to the beneficiary's condition or medical necessity of the services must provide a thirty (30) day written notice to beneficiaries and the Division of Medicaid prior to ending the services:

1. Providers must assist with the transition of the beneficiary to another service provider.

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