

# MS Medicaid

## PROVIDER BULLETIN



MISSISSIPPI DIVISION OF  
**MEDICAID**

## 2017 Year-End Roundup



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*Executive Director*  
*MS Division of Medicaid*

With 2018 just around the corner, it is a good time to take stock of the many developments and happenings within the Mississippi Division of Medicaid (DOM) over the last 12 months. As usual, it was a busy year for the agency brimming with changes. What follows is a roundup of a few noteworthy activities from calendar year 2017.

### DOM REQUESTS LESS FOR NEXT BUDGET YEAR

On Sept. 22, I presented the annual DOM budget request to the Joint Legislative Budget Committee of the Mississippi Legislature. This presentation actually included two requests in one: A budget request of \$984 million for fiscal year (FY) 2019, and a deficit appropriation of \$47 million for the current year, FY 2018, which began on July 1.

The point I emphasized to the committee was that our budget request for FY 2019 is actually lower than our requests for the last three years. There are several reasons for that, such as the increase in the federal medical assistance percentage rate, but the key thing is our spending has leveled off. I was able to relay to the committee members that Medicaid spending is not, in fact, skyrocketing.

Meanwhile, our deficit request is modest compared to what it was during the last legislative session. That's because DOM was underfunded for FY 2017, and on top of that several

budget cuts were imposed by the governor. During the 2017 legislative session, DOM received a deficit appropriation which offset a good portion of that shortfall, just not all of it.

Another point I tried to get across was that the \$47 million deficit for the current fiscal year really translates into a combined shortfall of \$241 million, because of the federal match. In other words, that is \$241 million that would not be going to providers if our deficit remains unfunded.

The presentation hit a few other highlights as well:

- For state fiscal year 2017, DOM recovered \$8.6 million through various audits of medical claims paid to health-care providers.
- DOM's average monthly enrollment for 2016 was 772,395. As of the end of September 2017, enrollment was 754,855. That is noticeably down from the high of 796,103 beneficiaries DOM reached in March of 2015.
- More than 25 percent of Mississippians receive Mississippi Medicaid health benefits.
- Medicaid covers approximately 65 percent of all births in Mississippi, and children up to age one.
- For state FY 2018, DOM's total expenditure is expected to be a combined state and federal budget of \$6.1 billion. Out of that, approximately 95 percent goes to reimburse providers for health-care services for beneficiaries.

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## NEW CONTRACTS PROCURED FOR MISSISSIPPICAN

In February, DOM released a request for proposals (RFP), inviting entities to bid on contracts for the Mississippi Coordinated Access Network – or MississippiCAN – our coordinated care program.

The original MississippiCAN contracts, which began when the program was initiated in 2011, were set to expire in the summer, and we are required by law to rebid them in a fair, competitive process, carefully overseen by the Office of Procurement. Since MississippiCAN began, it has been administered by two coordinated care organizations (CCOs) – Magnolia Health and UnitedHealthcare Community Plan.

After a thorough procurement process, DOM announced on June 15, that the new contracts would be awarded to Magnolia Health, Molina Health, and UnitedHealthcare. So, three new contracts have been awarded and executed, which are awaiting final approval from the Centers for Medicare and Medicaid Services. MississippiCAN will offer three different plans to beneficiaries.

Even though the contracts are already effective, the work has just begun, and both DOM and staff from each of the CCOs are quickly working toward an October 1, 2018 go-live date.

## CONGRESSIONAL EFFORTS AFFECTING MEDICAID AND CHIP

Meanwhile on the national stage, two issues played out which had the potential to impact Mississippi Medicaid. Congress spent most of the spring and summer of 2017 working on legislation to repeal and replace the Affordable Care Act (ACA), commonly known as Obamacare.

By late March, the House had passed the American Health Care Act (AHCA), which would have impacted all state Medicaid programs, even those states that did not expand Medicaid as encouraged by the ACA. As early as January 10, the news media began reaching out to DOM, eager to learn what ACA repeal might mean for Mississippi.

During the summer, the House bill became known as the Better Care Reconciliation Act (BCRA) in the Senate, but Republicans failed to produce the votes to pass it on July 25. The bill wasn't quite dead yet, though. In September, lawmakers attempted to muster enough votes for an amended version of the BCRA ahead of a September 30 deadline, which was the end of the federal fiscal year. That effort also came up short, and a vote was never held.

At the same time, Congress failed to reauthorize funding for the Children's Health Insurance Program (CHIP), which expired on September 30. DOM estimates that funding for CHIP in Mississippi will last through April 2018.

Enacted in 1997, CHIP provides health coverage for uninsured children up to the age of 19. To receive CHIP, a child cannot be eligible for Medicaid nor have any other health insurance at the time they apply.

CHIP is a joint state and federal program similar to Medicaid, but technically an entirely separate program. Administration of CHIP varies from state to state, and DOM is tasked with overseeing the program for Mississippi. As of the end of September, there were over 48,000 children in CHIP. (This number does not include the Quasi-CHIP population.)

Congress is currently working to pass legislation to reauthorize CHIP, but as of publication deadline, lawmakers have not reached an agreement.

## PROVIDER COMMITTEE EXPLORES OPPORTUNITIES FOR IMPROVEMENTS

On March 9, 2017, a unique committee held its first meeting of the year following the swearing-in of the committee's members in late 2016. The Mississippi Medical Care Advisory Committee (MCAC) is required by federal regulation to advise DOM about health and medical care services.

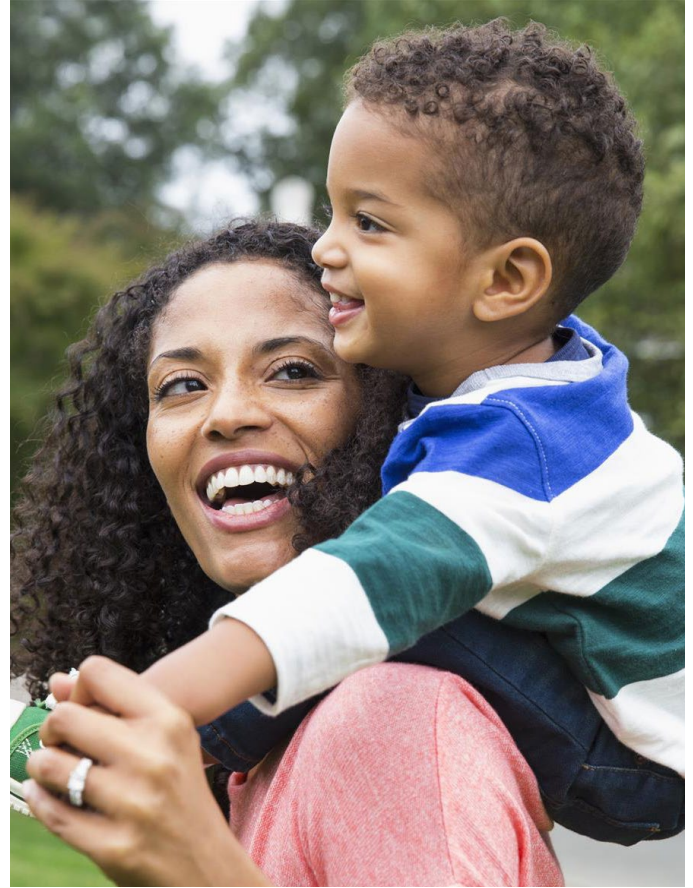
The MCAC is made up of 11 members appointed by the governor, lieutenant governor and the speaker of the House of Representatives who are either health-care providers or consumers of health-care services. Most of the committee members are physicians from across the state. This is not a DOM committee. Their function is to provide us with their perspectives on how DOM policies affect the health-care system outside of the agency. In turn, we provide them with information and support.

Required to meet at least quarterly, the committee began meeting monthly during the summer and scheduled its last meeting of the year for December 8.

During these meetings, which include representatives from DOM, both CCOs as well as presentations from special guests, the committee tackle a number of issues in depth, such as possibilities for reducing the rate of low birth-weight deliveries in the state. They also work with the CCOs to identify ways to make their prior authorization policies easier to navigate.

Representatives from Magnolia and UnitedHealthcare detail how changes written into the new coordinated care contracts include measures to ease restrictions on providers, such as universal provider credentialing.

With one meeting to go, the committee intends to compile a report of what they have learned throughout the year and submit it to legislators along with recommendations for lawmakers to address during the 2018 regular session.



## WEB PORTAL REMINDER

For easy access to up-to-date information, providers are encouraged to use the **Mississippi Envision 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. The **Mississippi Envision Web Portal** is available 24 hours a day, 7 days a week, 365 days a year via the Internet at [www.ms-medicaid.com](http://www.ms-medicaid.com).

# PROVIDER COMPLIANCE



## National Correct Coding Initiative (NCCI)

The Centers for Medicare and Medicaid Services (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 consists of two types of edits:

1. NCCI procedure-to-procedure, or PTP, edits that define pairs of Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes that should not be reported together for a variety of reasons. PTP edits prevent improper payments when specific codes are reported together.
2. Medically Unlikely Edits, or MUEs, outline the maximum units of service allowed for each HCPCS/CPT code that a provider would be able to report under normal circumstances for a single beneficiary on a single date of service (e.g., claims for excision of more than one gallbladder or more than one pancreas).

The files for PTP and MUE edits are updated at the beginning of each calendar quarter and completely replace the Medicaid NCCI edit files from previous calendar quarters. To locate the most up-to-date edit files, providers should visit the Medicaid NCCI website at <https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html> and locate the appropriate edit file under the “Medicaid NCCI Edit Files” section.

Please make note of other Medicaid NCCI updates below:

- Medicaid NCCI - The Medicaid NCCI page has moved to a new location within the [Medicaid.gov](https://www.medicaid.gov) website. Please update your bookmarks with the new location: <https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html>
- Medicaid NCCI FAQs – The NCCI FAQs have been recently updated. Please click <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/ncci-faqs.pdf> to review the newly revised information.
- Medicaid NCCI Policy Manual – The NCCI Policy Manual was updated January 2017. The most current Medicaid NCCI Policy Manual (.zip) files can be viewed at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/medicaid-ncci-policy-manual-2017.zip>.
- Modifier 59 – The modifier 59 article has been revised. Click the following link [https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/ncci\\_modifier\\_59.pdf](https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/downloads/ncci_modifier_59.pdf) to view the updated information regarding the correct usage of modifier 59.

## Attention Nursing Facilities

The Mississippi Division of Medicaid (DOM) has updated the Civil Money Penalty (CMP) Grants section on our website. CMP Grant Applications Frequently Asked Questions and the Annual





CMP Grant Transparency Report have been added. You may visit our website at <https://medicaid.ms.gov/programs/civil-money-penalty-cmp-grant-awards-program/> to receive answers to questions regarding CMP Grants and to gain inspiration for grant ideas for your facility.

For more information, contact the Office of Long Term Care at 601-359-6141.

## Attention All Elderly and Disabled (E&D) Waiver Providers; Rate Changes

### IN-HOME RESPITE

For dates of service on or after July 1, 2017, the rate for In-Home Respite (S5150) has been changed to \$4.41 per 15 minute unit. A mass adjustment is being completed for all In-Home Respite claims previously submitted at the old rate for dates of services on or after July 1, 2017. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.

### ADULT DAY CARE

For dates of service on or after November 1, 2017, the rate for Adult Day Care has been changed to \$3.88 per 15 minute unit for the duration of time the services were provided. Services will be reimbursed by DOM the lessor of the total amount of the 15 minute increment units billed or the maximum daily rate of \$62.08. The requirement for a person to attend the ADC for a minimum of four (4) hours per day has been removed. These changes optimize autonomy and independence in choices for ADC attendance.

Also, please note that the procedure code for Adult Day Care has been changed from S5102 to S5100. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.

### CASE MANAGEMENT

For dates of service on or after November 1, 2017, the rate for Case Management (T2022) has been changed to \$180.68 per month. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.

### PERSONAL CARE SERVICES

For dates of service on or after July 1, 2017, the rate for Personal Care Services (T1019) has been changed to \$4.41 per 15 minute unit. A mass adjustment is being completed for all Personal Care Service claims previously submitted at the old rate for dates of service on or after July 1, 2017. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.





## 2017 Annual Fee Schedule Updates for Mental Health Providers

Effective July 1, 2017, the Mississippi Division of Medicaid (DOM) revised reimbursement rates for mental health providers as required by State law and the State Plan. New fee schedules for mental health program areas are posted under the provider tab on the DOM website and accessible through the following links:

Community/Private Mental Health Centers:  
<https://medicaid.ms.gov/wp-content/uploads/2014/03/CommunityMentalHealthCenter.pdf>

Psychiatry:  
<https://medicaid.ms.gov/wp-content/uploads/2014/03/MentalHealthPsychiatry.pdf>

Therapeutic and Evaluative Services for Expanded EPSDT (T&E):  
[https://medicaid.ms.gov/wp-content/uploads/2015/11/TherapeuticEvaluativeMentalHealth\\_ExpandedEPSDT.pdf](https://medicaid.ms.gov/wp-content/uploads/2015/11/TherapeuticEvaluativeMentalHealth_ExpandedEPSDT.pdf)

Please refer to the most current CPT Code Book for the

appropriate procedure code(s) for services provided.

You may contact the Office of Mental Health at 601-359-9545 with any questions.

## Attention All Providers

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), effective October 1, 2017, the Mississippi Division of Medicaid will no longer require a secondary mental illness diagnosis when reimbursing for medically necessary services to treat a substance use disorder (SUD). This change does not affect normal prior authorization requirements.

The final rules under the MHPAEA can be found here:  
<https://webapps.dol.gov/federalregister/PdfDisplay.aspx?DocId=27169>

For questions related to this change, contact the Office of Mental Health at 601-359-9545.

## Fee Schedule Updates for Intellectual Disability/ Developmental Disabilities (ID/DD) Waiver Providers

The Mississippi Division of Medicaid (DOM) revised reimbursement rates, effective May 1, 2017, for ID/DD providers based on waiver amendment approval by the Centers for Medicare and Medicaid Services (CMS). The updated fee schedule for ID/DD waiver services is posted under the Provider tab on the DOM website and accessible through the following link:

Intellectual and Developmental Disabilities (ID/DD) waiver:  
<https://medicaid.ms.gov/providers/fee-schedules-and-rates/#>

You may contact the Office of Mental Health at 601-359-9545 with any questions.

## Attention Nursing Facilities

The Mississippi Division of Medicaid (DOM) Supportive Documentation Requirements User Guide was revised effective November 28, 2017 for Minimum Data Set (MDS) assessments with an assessment reference date on or after the effective





date. This important resource should be utilized to support MDS coding by nurses and other members of your interdisciplinary team. Documentation for case mix reimbursement must adhere to DOM's Supportive Documentation Requirements and the User Guide can be found at <http://www.mslc.com/Mississippi/Resources.aspx> in the Supportive Documentation Requirements folder. For more information, contact the Office of Long Term Care 601-359-6141.

## **Attention EPSDT Providers; National Correct Coding Initiative (NCCI) Edit for Adolescent/Maternal Depression Screening (96160/96161) and Vision Screening (99173) When Billed on Same Date of Service**

The Centers for Medicare and Medicaid Services (CMS) developed 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.

Effective January 1, 2017, the NCCI procedure to procedure (PTP) edit is applied when 96160/96161 and 99173 are billed on the same date of service. The purpose of the NCCI PTP edit is to prevent improper payment when incorrect code combinations are reported. Column 1/Column 2 tables are comprised of PTP code pairs. If a provider submits the two (2) codes of an edit pair for payment for the same beneficiary on the same date of service, the Column 1 code is eligible for payment and the Column 2 code is denied.

However, if both codes are clinically appropriate and an appropriate NCCI-associated modifier is used, the codes in both columns are eligible for payment. Supporting documentation must be in the beneficiary's medical record to substantiate use of the modifier. A modifier should not be appended to a CPT code solely to bypass a PTP code pair edit when clinical circumstances do not justify its use. Concerns regarding specific NCCI edits should be submitted in writing to:

National Correct Coding Initiative  
Correct Coding Solutions, LLC  
P.O. Box 907  
Carmel, IN 46082-0907

Attention: Niles R. Rosen, MD, Medical Director and Linda S. Dietz, RHIA, CCS, CCS-P, Coding Specialist

Fax: 317-571-1745

## **Attention Long Term Care Providers**

The Mississippi Division of Medicaid's Bridge to Independence (B2I) program, funded by the U.S Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), completed its final year as a demonstration project. Effective November 3, 2017, DOM no longer accepts B2I referrals. B2I staff and providers will continue to work with those individuals who have been referred to the program on or before the deadline through March 29, 2018. All B2I participants that transition through March 29, 2018 will receive a 365 day follow along.

Beginning January 1, 2018, DOM will process referrals for Community Transition Services for individuals transitioning to the Elderly and Disabled Waiver. These services will utilize the same referral process previously used for B2I.



3. referral to treatment for brief therapy or additional treatment to a pregnant woman whose assessments or screenings indicate a need for additional services.

DOM covers one (1) SBIRT service per pregnancy when performed by one (1) of the following licensed practitioners:

1. Physician,
2. Nurse Practitioner,
3. Certified Nurse Midwife,
4. Physician Assistant,
5. Licensed Clinical Social Worker,
6. Licensed Professional Counselor, or
7. Clinical Psychologist

SBIRT services should be billed with HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment, and brief intervention 15 - 30 min) or G0397 (Alcohol and/or substance (other than tobacco) abuse structured assessment >30 min) and is only allowed once per pregnancy.

For more information regarding SPA 17-0003 SBIRT, please refer to the DOM website at [medicaid.ms.gov/about/state-plan/approved-state-plan-amendments/](https://medicaid.ms.gov/about/state-plan/approved-state-plan-amendments/) or contact the Office of Medical Services at (601) 359-6150.

## Attention Maternity Providers

Effective July 1, 2017, Mississippi Division of Medicaid (DOM) received Centers for Medicare and Medicaid Services (CMS) approval of State Plan Amendment (SPA) 17-0003 Screening, Brief Intervention, and Referral to Treatment (SBIRT). As a result, DOM covers early intervention services for pregnant women with nondependent substance use and to prevent problematic substance use disorders.

SBIRT is an early intervention approach that targets pregnant women with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.

SBIRT services must include:

1. screening for risky substance use behaviors using evidence based standardize assessments or validated screening tools,
2. brief intervention of a pregnant woman showing risky substance use behaviors in a short conversation, providing feedback and advice, and

## Medicaid Provider Revalidation

In April 2017, the Mississippi Division of Medicaid (DOM) implemented Federal Regulation 42 CFR §455.414 which requires state Medicaid agencies to revalidate the enrollment of all providers every five years.

A revalidation notification letter initiates the process with each provider. The letter provides instructions for completing the revalidation and indicates the due date. As part of the revalidation, the state must conduct a full screening appropriate to the provider's risk level in compliance with 42 CFR 455 Subparts B & E and the provider must comply with any requests made by the state as part of the revalidation process within the specified timeframe. A complete revalidation packet must be submitted by the due date in the letter to prevent termination.

Please note that all notifications are sent to the "Mail Other Address for Provider Communications." If there is no "Mail Other for Provider Communications" address noted on the provider file, the notification will be sent to the billing address on file.





Providers must access their revalidation electronically through the Envision web portal. This will allow providers to enter their own information and will streamline the revalidation process. If the revalidating provider is not a registered user, the provider must register by going to [www.ms-medicaid.com](http://www.ms-medicaid.com) and clicking the “web registration” link to find the registration instructions for becoming a web portal user.

DOM has also added a Six Month Revalidation Due List on the secure and nonsecure sides of the Envision web portal located at <https://www.ms-medicaid.com>. The list is housed under the Provider tab and will be updated weekly noting those providers who are due to be revalidated within the next six (6) months. The list will identify information unique to the provider including the Revalidation Notification Date which indicates the date that the provider can begin the revalidation process. The list will also indicate the address used for the mailing of the Revalidation Due Notice. Providers whose addresses are incorrect are encouraged to submit the Change of Address form located at [www.ms-medicaid.com](http://www.ms-medicaid.com). The form is housed under the Provider tab in the Forms submenu.

Enrollment must be terminated for any provider who does not

comply with revalidation requirements. A new application will then be required for the provider to re-enroll in the Mississippi Medicaid program.

In addition, if a provider’s revalidation is not completed in the allotted time and the provider is also enrolled with one or both MississippiCAN coordinated care organizations (CCO), Magnolia Health and United Healthcare Community Plan, enrollment with the CCO(s) will be terminated.

Providers with questions or needing additional assistance concerning revalidation should contact Conduent at (800) 884-3222.

## Allowable Board of Directors Fees for Long-Term Care Facilities 2017 Cost Reports

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2017 cost reports filed by nursing facilities (NFs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and psychiatric residential treatment facilities (PRTFs) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for all Urban Consumers - All Items. The amounts listed below are the per-meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2017 are as follows:

<u>Category</u>	<u>Maximum Allowable Cost for 2017</u>
0 – 99 Beds	\$ 4,121
100 – 199 Beds	\$ 6,182
200 – 299 Beds	\$ 8,242
300 – 499 Beds	\$10,303
500 Beds or More	\$12,363



## New MississippiCAN Contract

The following Offerors have been awarded the contract for MississippiCAN RFP #20170203:

### 1. **Magnolia Health**

Contracting and Network Development  
Telephone 866.912.6285

[Richard.B.Enis@centene.com](mailto:Richard.B.Enis@centene.com)

[www.MagnoliaHealthPlan.com](http://www.MagnoliaHealthPlan.com)

[magnoliacredentiaing@centene.com](mailto:magnoliacredentiaing@centene.com)

<https://www.magnoliahealthplan.com/providers/become-a-provider.html>

### 2. **Molina Healthcare of Mississippi, Inc.**

Contracting and Network Development  
Telephone 877-902-1207

[MHINewMarketsNetDev@Molinahealthcare.com](mailto:MHINewMarketsNetDev@Molinahealthcare.com)

### 3. **UnitedHealthcare of Mississippi, Inc.**

Contracting and Network Development  
Telephone 866-574-6088

[J\\_Parnell@uhc.com](mailto:J_Parnell@uhc.com)

[unitedhealthgroup.com](http://unitedhealthgroup.com)

[www.CAQH.org](http://www.CAQH.org)

[www.uhccommunityplan.com](http://www.uhccommunityplan.com) >Provider Forms

[www.CAQH.org](http://www.CAQH.org) >CAQH ProView (888-599-1771)

Coordinated Care Organizations (CCOs) Magnolia, Molina, and UnitedHealthcare will be contacting Mississippi Medicaid providers for enrollment into their networks. This new MississippiCAN contract will not be operational until October 1, 2018, which is:

- the effective date of Member enrollment with new CCO,
- the effective date that providers may begin filing claims with new CCO, and
- the date that service authorizations begin with new CCO.

## Newborns Frequently Asked Questions (FAQs)

### 1. **What is the timeframe for receiving a Medicaid Beneficiary ID number for Newborns?**

Infants born to Medicaid-eligible mothers are eligible for the first (1st) year of the infant's life provided the mother was eligible during her pregnancy and the child lives with her. These are considered Deemed Newborns.

- The hospital must notify the Mississippi Division of Medicaid within five (5) calendar days of a newborn's birth using the Newborn Enrollment Form located on the Mississippi Division of Medicaid's website.
- The Mississippi Division of Medicaid will notify the provider within five (5) business days of receipt of form of the newborn's permanent Medicaid identification (ID) number.

Infants born to non-Medicaid-eligible mothers at the time of birth must obtain a Medicaid identification (ID) number by submitting an application to the appropriate Medicaid Regional office. If eligibility criteria are met and there are unpaid bills, eligibility may be established for as much as three (3) months prior to the date of application.

### 2. **Please consider creating a tracking number for Newborn Enrollment Forms submitted in the Envision web portal.**

At this time, no tracking system is available for these forms.

### 3. **Why are Newborn and Mother not linked to the same CCO?**



Newborns born to a Medicaid mom who is currently enrolled in MississippiCAN will automatically be placed in the same plan as the mother usually, but not always.

Occasionally, a child is not placed in the same CCO as the mom. Since this is an automated process, there are various reasons for a child not to be placed in the same plan:

- Newborn forms not submitted timely or appropriately
- Non-Medicaid eligible mother
- Retroactive Medicaid eligible mothers and Hospital Presumptive Eligibility (HPE)
- Newborn name changes
- SSI newborns eligibility

#### **4. What is the timeframe for retrospective review authorization for Newborns?**

A Retrospective Review is a review for medical necessity after services are initiated or a member retroactively switches to another payer after services are initiated/rendered.

Requests for retrospective reviews will be considered in

extenuating circumstances (i.e. retroactive eligibility of newborns, out of state non-Mississippi Medicaid provider, or other)

Services requiring prior authorization provided during the period of retroactive eligibility cannot be denied due to failure to secure prior authorization. Authorization for such services must be obtained before reimbursement is made.

Please note that in instances in which the member is assigned to a different payer than the payer assigning authorization, then the provider must contact the assigned payer and provide documentation of previous authorization.

The Contractor shall have the capability and established procedures to receive Retrospective Review requests and conduct prepayment reviews. The Contractor shall ensure determinations for Retrospective Reviews are completed ninety-eight percent (98%) of the time within twenty (20) business days of receipt.

#### **5. When a baby is in the NICU and authorization is required, what Medicaid number is used when the baby does not have its own number?**

DOM no longer processes authorizations or claims based on the Newborn Mother's Medicaid number. The Medicaid number for the Newborn must be used for medical payments.

However, when there is an immediate need for medication for the Newborn, please contact DOM Pharmacy or CCO Pharmacy departments. <https://medicaid.ms.gov/wp-content/uploads/2015/12/Mississippi-Medicaid-pharmacy-contact-and-billing-information.pdf>

#### **6. Why are there so many medical record requests for NICUs?**

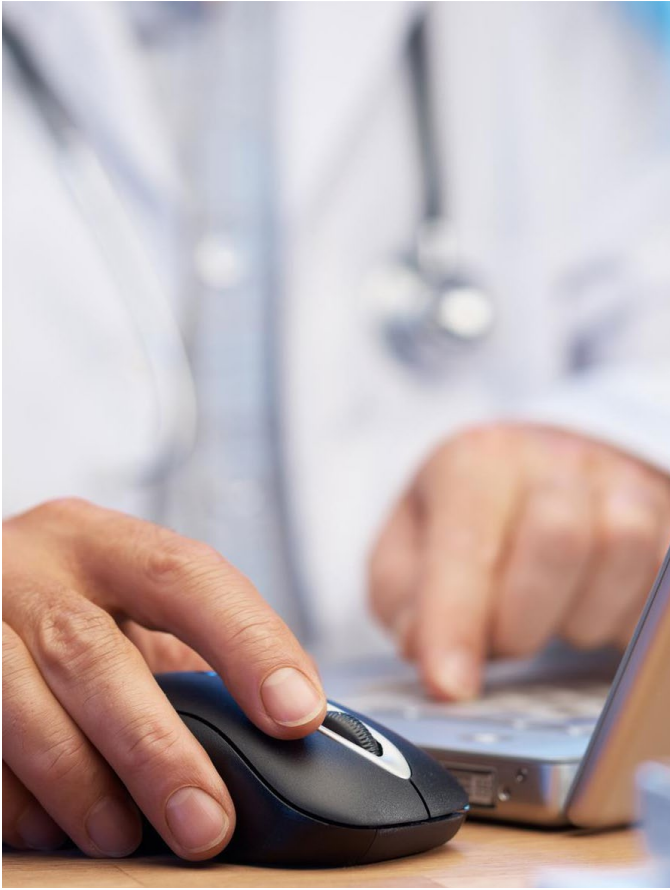
Some reasons for Record Requests:

- Use of the TH – modifier
- Incongruence between hospital and professional charges
- Abnormal Evaluation & Management (E&M) CPT code distribution
- Billing of CPT codes with uncommonly linked ICD codes

#### **7. How are the CCOs linking the Newborn Medicaid ID number to the Authorization number for the claim to adjudicate timely?**

Claims cannot be processed without the Newborn Medicaid ID number.





Claims can be processed without an authorization number when deliveries do not exceed federally mandated timeframe. Claims cannot be processed without an authorization number when:

- Deliveries exceed federally mandated timeframe; however, notification is required within one (1) business day of mother's admission for delivery;
- Newborn is not a well baby;
- Continued or concurrent stay; or
- Retrospective reviews are required.

How should an authorization be submitted to **CCO-UHC**?  
Authorizations can be submitted one of three ways:

- Submitted via Link at [UnitedHealthcareOnline.com](https://www.unitedhealthcare.com), select Notifications/Prior Authorizations, follow the prompts and complete the inquiry form, click submit.
- Submitted by calling 866-604-3267
  - Monday-Friday 8 a.m. – 5 p.m. CST
  - 24 hours a day for emergencies
- Faxed to 888-310-6858

How should an authorization be submitted to **CCO-Magnolia**?

- Provider must submit the Newborn Enrollment Form to DOM, which includes maternal information, to acknowledge maternity admission, and necessary information for routine deliveries and well-baby care (standard 3 day stay for vaginal deliveries, 5 day stay for C sections).
  - This form will be emailed to Magnolia to process authorization information and generate an authorization number.
- If complications develop with mother or baby that may necessitate additional hospital days or a non well-baby or NICU admission, a prior authorization should be submitted along with clinical information to support the stay within one business day of the decision that the higher level of care is needed.
- Well Baby DRGS: 6261, 6262, 6263, 62624, 6401, 6402, 6403, 6404.

## Medicaid's Provider Bulletin is Transitioning

Effective January 2018, the Mississippi Division of Medicaid (DOM) will no longer mail quarterly publications of the provider bulletin. Providers may still download the provider bulletin by visiting the Envision web portal at <https://www.ms-medicaid.com>.

Providers will have the option to subscribe (for FREE) to receive a printed copy of the provider bulletin, e-newsletter or both. Providers must complete the provider bulletin subscription request form and fax (601-359-4185) it to the Office of Provider Beneficiary Relations no later than December 31, 2017. The provider bulletin subscription request form is located on DOM's website <https://medicaid.ms.gov> under forms as well as in this issue of the Provider Bulletin on page 13.

## Provider Bulletin Subscription Request Form

The Mississippi Division of Medicaid (DOM) wants to ensure all enrolled providers, in addition to medical and health-care associations, are receiving the most recent policy changes and agency updates. One of the ways DOM communicates this information is through the Provider Bulletin.

The Provider Bulletin is a publication aimed at informing providers and other health-care professionals of Medicaid news, policy changes, resources for claims processing and reimbursements, a directory of the provider field representatives, as well as a way to connect with our executive director and other valuable Medicaid information. The Provider Bulletin is a quarterly publication, and special editions are published as necessary.

As of December 31, 2017, Provider Bulletins will only be distributed to those who have subscribed to receive this **FREE** publication. You can subscribe to receive a printed and mailed hard copy, e-newsletter or both.

Below are the ways to subscribe to receive DOM's **FREE** quarterly Provider Bulletin publication:

- ✓ Visit our website at <https://medicaid.ms.gov/providers/provider-resources/provider-bulletins> and click the subscribe button.
- ✓ Mail or fax the completed form below (all fields are required) by December 31, 2017.

**Mail the Provider Bulletin Subscription Request form to:**

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Attn. Office of Provider Beneficiary Relations  
550 High Street, Suite 1000  
Jackson MS, 39201

**Fax:** 601-359-4185

### Provider Bulletin Subscription Request Form

<b>Provider / Association:</b>	
<b>Medicaid Provider Number (if enrolled):</b>	
<b>Contact Person:</b>	
<b>Phone Number:</b>	
<b>Email Address:</b>	
<b>Mailing Address:</b>	
<b>City / State / Zip Code:</b>	

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☐ Printed and mailed copy    ☐ E-Newsletter    ☐ Both

# PHARMACY NEWS



## Pharmacy Reimbursement Changes

Implementation of the CMS approved point of sale pharmacy reimbursement methodology for fee for service and MississippiCAN began on September 1, 2017.

I. The Mississippi Division of Medicaid reimburses the following drugs as described below:

- A. Brand Name drugs – Ingredient cost based on actual acquisition cost (AAC) which is defined as the lesser of:
1. National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee of \$11.29, or
  2. Wholesale Acquisition Cost (WAC) plus zero percent (0%) plus a professional dispensing fee of \$11.29 when no NADAC is available, or
  3. A rate set by the Mississippi Division of Medicaid's rate-setting vendor plus a professional dispensing fee of \$11.29 when no NADAC or WAC are available,

or

4. The provider's usual and customary charge.

B. Generic drugs – Ingredient cost based on AAC which is defined as the lesser of:

1. NADAC plus a professional dispensing fee of \$11.29, or
2. WAC plus zero percent (0%) plus a professional dispensing fee of \$11.29 when no NADAC is available, or
3. A rate set by the Mississippi Division of Medicaid's rate-setting vendor plus a professional dispensing fee of \$11.29 when no NADAC or WAC are available, or
4. The provider's usual and customary charge.

C. Reimbursement for 340B covered entities as described in section 1927(a)(5)(B) of the Act, including an Indian Health Service, tribal and urban Indian pharmacy as follows:

1. Purchased 340B drugs – Ingredient cost must be no more than the 340B AAC defined as the price at which the covered entity has paid the wholesaler or manufacturer for the covered outpatient drug plus a professional dispensing fee of \$11.29.
2. Drugs purchased outside of the 340B program by covered entities – Ingredient cost based on AAC which is defined as the lesser of:
  - a. NADAC plus a professional dispensing fee of \$11.29, or
  - b. WAC plus zero percent (0%) plus a professional dispensing fee of \$11.29 when no NADAC is available, or
  - c. A rate set by the Mississippi Division of Medicaid's rate setting vendor plus a professional dispensing fee of \$11.29 when no WAC is available, or
  - d. The provider's usual and customary charge.
3. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

D. Drugs acquired via the Federal Supply Schedule (FSS) – Ingredient cost based on AAC plus a professional dispensing fee of \$11.29.



- E. Drugs acquired at Nominal Price (outside of 340B or FSS)
  - Ingredient cost based on AAC plus a professional dispensing fee of \$11.29.
- F. Specialty drugs not dispensed by a retail community pharmacy and dispensed primarily through the mail
  - Ingredient cost is defined as the lesser of:
    1. WAC plus zero percent (0%) plus a professional dispensing fee of \$61.14, or
    2. A rate set by the Division of Medicaid's rate-setting vendor plus a professional dispensing fee of \$61.14 when no WAC is available, or
    3. The provider's usual and customary charge.
- G. Drugs not dispensed by a retail community pharmacy (e.g., institutional or long-term care pharmacy when not included as part of an inpatient stay) – Ingredient cost based on AAC which is defined as the lesser of:
  1. NADAC plus a professional dispensing fee of \$11.29, or
  2. WAC plus zero percent (0%) plus a professional dispensing fee of \$11.29 when no NADAC is available, or
  3. A rate set by the Mississippi Division of Medicaid's rate-setting vendor plus a professional dispensing fee of \$11.29 when no NADAC or WAC are available, or
  4. The provider's usual and customary charge.
- H. Clotting Factor from Specialty Pharmacies, Hemophilia Treatment Centers (HTCs), or Centers of Excellence – Ingredient cost defined as:
  1. For a 340B covered entity:
    - a. Purchased 340B drugs – Ingredient cost must be no more than the 340B AAC defined as the price at which the covered entity has paid the wholesaler or manufacturer for the clotting factor product plus a professional dispensing fee of \$0.02 per unit.
    - b. Drugs purchased outside of the 340B program by covered entities – Ingredient cost which is defined as the lesser of:
      - 1) WAC minus ten percent (10%) plus a professional dispensing fee of \$0.02 per Unit, or
      - 2) A rate set by the Mississippi Division of Medicaid's rate setting vendor

- plus a professional dispensing fee of \$0.02 when no WAC is available, or
- 3) The provider's usual and customary charge.

2. For a non-340B covered entity – Ingredient cost is defined as the lesser of:
  - a. WAC minus ten percent (10%) plus a professional dispensing fee of \$0.02 per Unit, or
  - b. A rate set by the Mississippi Division of Medicaid's rate setting vendor plus a professional dispensing fee of \$0.02 when no WAC is available, or
  - c. The provider's usual and customary charge.

II. The Mississippi Division of Medicaid does not reimburse for Investigational Drugs.

### III. Usual and Customary Charges

The Mississippi Division of Medicaid defines usual and customary charge as the lowest price the pharmacy would charge to a particular customer if such customer were paying cash for the identical prescription drug services on the date dispensed. This includes any applicable discounts including, but not limited to, senior discounts, frequent shopper discounts, and other special discounts offered to attract customers such as four dollar (\$4.00) flat rate generic price lists. A pharmacy cannot have a usual and customary charge for prescription drug programs that differs from either cash customers or other third-party programs. The pharmacy must submit the accurate usual and customary charge with respect to all claims for prescription drug services.

IV. Overall, the Mississippi Division of Medicaid's payment will not exceed the federal upper limit (FUL) based on the NADAC for ingredient reimbursement in the aggregate for multiple source drugs.

## Pharmacy Reimbursement: Revised Reprocessing Schedule

*Effective date: April 1, 2017*

*Implementation date: Sept. 1, 2017*

*Reprocessing date: Oct. 1, 2017 (biweekly schedule)*

The Mississippi Division of Medicaid (DOM) has heard pharmacy providers' concerns and adjusted the claims reprocessing

schedule originally noted in the August 3, 2017 Late Breaking News titled "Pharmacy Reimbursement/Reprocessing." The dates noted in the schedule below reflect that reprocessing will be performed over 10 months, rather than five (5) months as originally scheduled.

Automatic pharmacy claims reprocessing of point-of-sale, fee-

for-service and MississippiCAN pharmacy claims with dates of service on April 1, 2017 through August 31, 2017, will be performed beginning the first week of October and reflected on the October 9, 2017 remittance advice statements. Reprocessing will be performed in biweekly increments over a total time frame of no less than 10 months. Providers do not need to reverse and resubmit claims manually.

### Revised Reprocessing/Adjustment Schedule

Date of Service		Date Adjustment Amount Reflected on Remittance Advice
April 1 – 8	(Saturday – Saturday)	October 9, 2017
April 9 – 15	(Sunday – Saturday)	October 23, 2017
April 16 – 22	(Sunday – Saturday)	November 6, 2017
April 23 – 29	(Sunday – Saturday)	November 20, 2017
April 30 – May 6	(Sunday – Saturday)	December 4, 2017
May 7 – 13	(Sunday – Saturday)	December 18, 2017
May 14 – 20	(Sunday – Saturday)	January 1, 2018
May 21 – 27	(Sunday – Saturday)	January 15, 2018
May 28 – June 3	(Sunday – Saturday)	January 29, 2018
June 4 – 10	(Sunday – Saturday)	February 12, 2018
June 11 – 17	(Sunday – Saturday)	February 26, 2018
June 18 – 24	(Sunday – Saturday)	March 12, 2018
June 25 – July 1	(Sunday – Saturday)	March 26, 2018
July 2 – 8	(Sunday – Saturday)	April 9, 2018
July 9 – 15	(Sunday – Saturday)	April 23, 2018
July 16 – 22	(Sunday – Saturday)	May 7, 2018
July 23 – 29	(Sunday – Saturday)	May 21, 2018
July 30 – August 5	(Sunday – Saturday)	June 4, 2018
August 6 – 12	(Sunday – Saturday)	June 18, 2018
August 13 – 19	(Sunday – Saturday)	July 2, 2018
August 20 – 26	(Sunday – Saturday)	July 16, 2018
August 27 – 31	(Sunday – Thursday)	July 30, 2018



In an effort to support providers during this adjustment period, DOM has made an estimated financial impact, based on reprocessing fee-for-service and MississippiCAN pharmacy point-of-sale claims filed in the month of April 2017, available to pharmacy providers. Mercer will have estimated financial impacts for May through June available no later than September 18, 2017.

Providers can contact the Mercer Call Center to obtain their estimated financial impact total for April 2017 by phone at 855-612-6863. To receive this information through secure email or when inquiring for more than 10 pharmacies, email your request to [MSMedicaidRx@mercer.com](mailto:MSMedicaidRx@mercer.com) and include your pharmacy name, address, Medicaid ID number and phone number.

For other questions, contact DOM's Office of Pharmacy by phone at 601-359-5253 (select option #4) or refer to the Frequently Asked Questions on the DOM Pharmacy web page at <https://medicaid.ms.gov/providers/pharmacy/>.

## Pharmacy Reimbursement Questions

Providers with questions concerning Pharmacy reimbursement may visit the Pharmacy reimbursement webpage located at <https://medicaid.ms.gov/providers/pharmacy/pharmacy-reimbursement/>. The National Average Drug Acquisition Cost (NADAC) Help Desk information link has been added in addition to the pharmacy rate setting vendor's contact information and website link.

Please contact the NADAC Help Desk for support of the NADAC survey or to provide notification of recent drug price changes that are not reflected in posted NADAC files.

### NADAC Help Desk Contact Information:

Toll free phone: (855) 457-5264

E-mail: [info@mslcrps.com](mailto:info@mslcrps.com)

Fax: (844) 860-0236

Please note that the Help Desk will not address pharmacy inquiries related to specific state claim reimbursement questions or concerns.

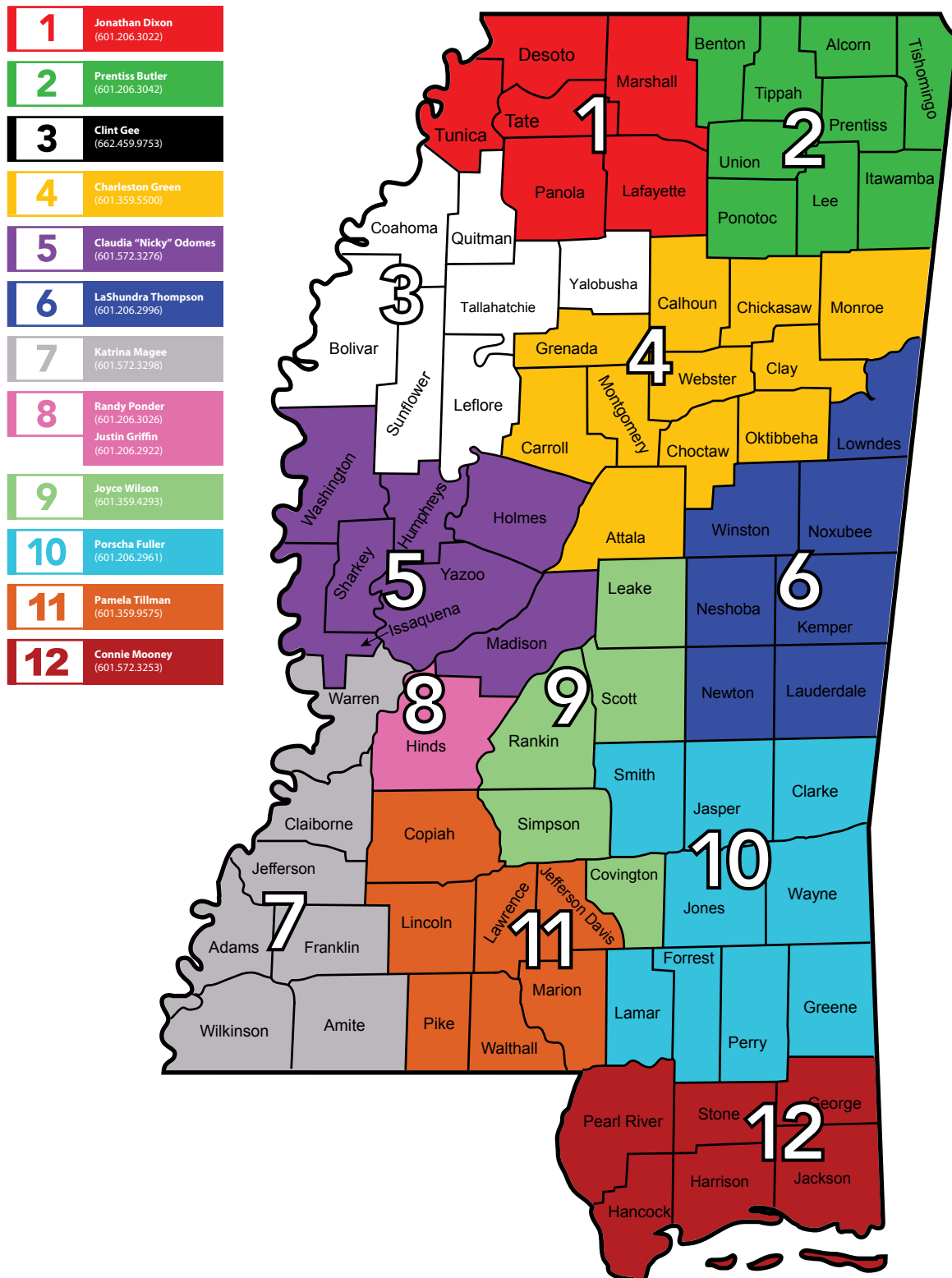


# PROVIDER FIELD REPRESENTATIVES

## PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY

PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY		
<b>AREA 1</b> <b>Jonathan Dixon (601.206.3022)</b> <a href="mailto:jonathan.dixon@conduent.com">jonathan.dixon@conduent.com</a>	<b>AREA 2</b> <b>Prentiss Butler (601.206.3042)</b> <a href="mailto:prentiss.butler@conduent.com">prentiss.butler@conduent.com</a>	<b>AREA 3</b> <b>Clint Gee (662.459.9753)</b> <a href="mailto:clinton.gee@medicaid.ms.gov">clinton.gee@medicaid.ms.gov</a>
<b>County</b>	<b>County</b>	<b>County</b>
Desoto	Alcorn	Bolivar
Lafayette	Benton	Coahoma
Marshall	Itawamba	Leflore
Panola	Lee	Quitman
Tate	Pontotoc	Sunflower
Tunica	Prentiss	Tallahatchie
	Tippah	Yalobusha
	Tishomingo	
<b>*Memphis</b>	Union	
<b>AREA 4</b> <b>Charleston Green (601.359.5500)</b> <a href="mailto:charleston.green@medicaid.ms.gov">charleston.green@medicaid.ms.gov</a>	<b>AREA 5</b> <b>Claudia "Nicky" Odomes (601.572.3276)</b> <a href="mailto:claudia.odomes@conduent.com">claudia.odomes@conduent.com</a>	<b>AREA 6</b> <b>LaShundra Thompson (601.206.2996)</b> <a href="mailto:lashundra.othello@conduent.com">lashundra.othello@conduent.com</a>
<b>County</b>	<b>County</b>	<b>County</b>
Attala	Holmes	Kemper
Calhoun	Humphreys	Lauderdale
Carroll	Issaquena	Lowndes
Chickasaw	Madison	Neshoba
Choctaw	Sharkey	Newton
Clay	Washington	Noxubee
Grenada	Yazoo	Winston
Monroe		
Montgomery		
Oktibbeha		
Webster		
<b>AREA 7</b> <b>Katrina Magee (601.572.3298)</b> <a href="mailto:katrina.magee@conduent.com">katrina.magee@conduent.com</a>	<b>AREA 8</b> <b>Justin Griffin (601.206.2922)</b> Zip Codes (39041-39215) <a href="mailto:justin.griffin@conduent.com">justin.griffin@conduent.com</a> <b>Randy Ponder (601.206.3026)</b> Zip Codes (39216-39296) <a href="mailto:randy.ponder@conduent.com">randy.ponder@conduent.com</a>	<b>AREA 9</b> <b>Joyce Wilson (601.359.4293)</b> <a href="mailto:joyce.wilson@medicaid.ms.gov">joyce.wilson@medicaid.ms.gov</a>
<b>County</b>	<b>County</b>	<b>County</b>
Adams	Hinds	Covington
Amite		Leake
Claiborne		Rankin
Franklin		Scott
Jefferson		Simpson
Warren		
Wilkinson		
<b>AREA 10</b> <b>Porscha Fuller (601.206.2961)</b> <a href="mailto:porscha.fuller@conduent.com">porscha.fuller@conduent.com</a>	<b>AREA 11</b> <b>Pamela Tillman (601.359.9575)</b> <a href="mailto:pamela.tillman@medicaid.ms.gov">pamela.tillman@medicaid.ms.gov</a>	<b>AREA 12</b> <b>Connie Mooney (601.572.3253)</b> <a href="mailto:connie.mooney@conduent.com">connie.mooney@conduent.com</a>
<b>County</b>	<b>County</b>	<b>County</b>
Clarke	Copiah	George
Forrest	Jefferson-Davis	Hancock
Greene	Lawrence	Harrison
Jasper	Lincoln	Jackson
Jones	Marion	Pearl River
Lamar	Pike	Stone
Perry	Walthall	
Smith		
Wayne		
<b>OUT OF STATE PROVIDERS</b>		<b>Mobile, AL</b>
<b>Tora Monroe (601.206.2929)</b> <a href="mailto:tora.monroe@conduent.com">tora.monroe@conduent.com</a>		

# FIELD REPRESENTATIVE REGIONAL MAP



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*If you have any questions  
related to the topics in this  
bulletin, please contact  
Conduent at 800 - 884 - 3222*

Mississippi Medicaid  
Administrative Code and Billing  
Handbook are on the Web  
[www.medicaid.ms.gov](http://www.medicaid.ms.gov)

Medicaid Provider Bulletins are  
located on the Web Portal  
[www.ms-medicaid.com](http://www.ms-medicaid.com)

## DECEMBER 2017

MON, DEC. 4	Checkwrite
THURS, DEC. 7	EDI Cut Off - 5:00 p.m.
MON, DEC. 11	Checkwrite
THURS, DEC. 14	EDI Cut Off - 5:00 p.m.
MON, DEC. 18	Checkwrite
THURS, DEC. 21	EDI Cut Off - 5:00 p.m.
MON, DEC. 25	Christmas; DOM Closed; Checkwrite
MON, DEC. 26	DOM Closed
THURS, DEC. 28	EDI Cut Off - 5:00 p.m.

## JANUARY 2018

MON, JAN. 1	DOM Closed; Checkwrite
THURS, JAN. 4	EDI Cut Off - 5:00 p.m.
MON, JAN. 8	Checkwrite
THURS, JAN. 11	EDI Cut Off - 5:00 p.m.
MON, JAN. 15	DOM Closed; Dr. Martin Luther King Day; Robert E Lee Birthday; Checkwrite
THURS, JAN. 18	EDI Cut Off - 5:00 p.m.
MON, JAN. 22	Checkwrite
THURS, JAN. 25	EDI Cut Off - 5:00 p.m.
MON, JAN. 29	Checkwrite

## FEBRUARY 2018

THURS, FEB. 1	EDI Cut Off - 5:00 p.m.
MON, FEB. 5	Checkwrite
THURS, FEB. 8	EDI Cut Off - 5:00 p.m.
MON, FEB. 12	Checkwrite
THURS, FEB. 15	EDI Cut Off - 5:00 p.m.
MON, FEB. 19	DOM Closed; President's Day; Checkwrite
THURS, FEB. 22	EDI Cut Off - 5:00 p.m.
MON, FEB. 26	Checkwrite
THURS, FEB. 31	EDI Cut Off - 5:00 p.m.

Checkwrites and Remittance Advices are dated every Monday. Provider Remittance Advice is available for download each Monday morning at [www.ms-medicaid.com](http://www.ms-medicaid.com). Funds are not transferred until the following Thursday.