Volume 22, Issue 2 June 2016

MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

DOM's Budget at a Glance

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The ink has dried on the Division of Medicaid's (DOM) budget bill for fiscal year (FY) 2017. We asked the Legislature for $1.03 billion in our budget proposal and they approved $948 million, which is roughly $82 million below DOM's FY 2017 request.

Unfortunately, this comes as no surprise. At the same time, lawmakers passed a deficit appropriations bill of $52 million to cover a funding gap for FY 2016. This has been the trend since I became executive director of Medicaid in 2012: We accurately predict our budget needs based on various fluctuating parameters only to be underfunded and later the Legislature has to scrounge up the difference, which we knew we would need in the first place.

There is no getting around the fact that Medicaid comes with a big price tag, one that would give any lawmaker sticker shock. However, as state agencies go, DOM arguably has the best return on investment thanks to the amount of federal matching dollars it can draw down. More importantly, it provides health coverage for almost 800,000 Mississippians who otherwise would go without it.

Hands Tied

The reality is that DOM has little control over how much funding it requires to be sustainable and fulfill its mission. The largest expenditure to the agency (and state) is medical services costs for taking care of beneficiaries.

Medicaid is a jointly funded state and federal government program providing health coverage for eligible, low-income populations. States are not required to have a Medicaid program, yet all 50 states, five territories and the District of Columbia participate in it.

Although each state runs its own Medicaid program, the eligibility of beneficiaries is determined by household income based on the Federal Poverty Level (FPL) and family size, and Supplemental Security Income (SSI) status. As its name suggests, the FPL is set by the Department of Health and Human Services, and DOM is obliged to adhere to this indicator.

In short, if Mississippi wants to keep a Medicaid program, it must receive enough funds to cover all qualified residents based on federal eligibility guidelines. As of the end of May, 778,894 beneficiaries were enrolled in Medicaid and the Children's Health Insurance Program (CHIP).

The good news is the federal government, through the Centers for Medicare & Medicaid Services (CMS), supports state programs by matching their Medicaid costs at varying levels. This is called the Federal Medical Assistance Percentage (FMAP), and Mississippi currently has the highest FMAP in the country.

Our current FMAP is 74.17 percent, which is for medical services. It is re-determined each year and fluctuates up and down because it is based on several economic indicators each state has relative to each other, such as household income and level of poverty. Since we have the highest poverty indicators and low household income, we have the highest FMAP.

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To put it into perspective, DOM's total budget in FY2015 was $5.9 billion and $4.10 billion of that came from the federal government.

Cost Predictability

Each fall DOM presents its budget request to the Legislative Budget Committee. The governor also submits his budget proposal, the Executive Budget Request, and during the session the two legislative chambers debate, amend and pass an appropriations bill, which they did this year on April 18.

Because DOM knows exactly how many beneficiaries are enrolled at any one time and can estimate the growing costs of medical services, the agency's financial team can make very accurate budget projections for the next fiscal year. In fact, over the last two years, we have only been off by 0.2 and 0.3 percent in our projections, even though we have many factors influencing our needs. However, the agency is continually underfunded. That is the reason why the agency had a deficit of about $52 million for FY2016 (which the Legislature just patched up).

Administrative Costs

The agency's administrative costs are among the lowest in the country. The vast majority of DOM's annual budget goes toward reimbursing health-care providers for treating the health-care needs of our beneficiaries. Specifically, only 3.82 percent went toward administrative costs the last fiscal year.

Out of a state budget of nearly $1 billion, we run the entire agency on about $79 million of state dollars. The rest of that money goes to reimbursing providers for the care of our beneficiaries. We are doing the best we can on a very limited budget and we turn our nearly $1 billion into almost $6 billion, most of which goes to providers.

Generating Money

Since DOM's managed-care program, MississippiCAN was launched in 2011, it has grown to the point where it now covers 65 percent of Medicaid beneficiaries, including children and inpatient services. It has been estimated that MississippiCAN has saved the state about $211 million, according to the actuarial firm Milliman, which analyzed coverage costs of beneficiaries before implementation and enrollment in MississippiCAN and after. About 60 percent of that figure is due to the premium tax.

The Department of Insurance views the managed care organizations (MCO) as insurance providers, and as such they charge them a 3 percent tax on their revenue. Medicaid has two MCOs, Magnolia Health and UnitedHealthcare Plan. The MCOs do not pay that tax by themselves; we include that three percent into rates DOM pay them to manage our beneficiaries. Because our footprint for managed care has increased dramatically and we have transitioned the upper payment limit (UPL) payments into the Mississippi Hospital Access Payments (MHAP) program the premium tax has increased.

This premium tax is paid by the MCOs and deposited into the state general fund. Next year, the premium tax for managed care is estimated to be $89 million. Because the premium tax is included in the rates we pay the MCOs, we are able to leverage the FMAP and generate funds for the state through this process. The aggregate amount in state dollars paid to the MCO to cover the premium tax is about $23 million, but this generates the $89 million for the general fund, which is a net increase of $66 million.

Not only does managed care save the state money, it actually generates money for the state. Ultimately, another budget battle has been settled for one more year, and DOM will continue to stretch every dollar we receive to make sure our beneficiaries are covered.

Medicaid 101: What it costs to run the agency

On an annual basis the Division of Medicaid makes multiple presentations to specific groups and legislative committees regarding our budget needs. This past year, when DOM presented its fiscal year (FY) 2017 budget request to the Legislative Budget Office, the total administrative expenses were broken down by category as follows:

- **$49.4 million – contractual:** the majority goes to our fiscal agent, Xerox, to process and pay provider claims
- **$26.5 million – personnel, salaries**
- **$2.2 million – equipment**
- **$434,386 – commodities**
- **$412,536 – travel**: mostly in-state travel to audit our providers, clinics and nursing homes as required by the federal government
- **$35,000 – vehicles**

The total amounts to $79 million in state appropriations for administrative expenses. We also receive a 50/50 federal match for administrative costs and a 90/10 federal match for information technology (IT) expenses. The remainder of our budget is used to pay claims for reimbursement. If you do not count our contractual expenses, our operating budget is only $29.6 million or 2.9 percent. That does not include the $2.2 million that goes toward our total rent for one central office and 30 regional offices, as well as utilities.

For FY2017, the Legislature underfunded DOM by $82 million, even though we have predicted our budget needs within an amazing degree of accuracy (under 0.2 and 0.3 percent for the past two years). As with FY2016, we anticipate lawmakers to pass a deficit appropriation in the next session to help fill the gap, but this illustrates the unique challenge DOM faces when the state experiences a budget shortfall and asks all state agencies to cut their operating budgets.

There is very little we can cut because we already run a very lean operation and serve almost 800,000 Mississippians. No one wants to cut provider payments. All that is to say, we can not do enough to educate stakeholders and decision-makers about what it takes to maintain a viable Medicaid program in this state, and continue to serve more, with less.

DOM reimbursing for lead-level testing

In February, the City of Jackson issued a press release regarding elevated levels of lead in some home water samples serviced by the city water system. The detection of lead in municipal drinking water has attracted media attention in the local Jackson area, as well as nationally in recent months. After consulting with the Centers for Disease Control and the Environmental Protection Agency, the Mississippi State Department of Health (MSDH) has advised Jackson residents to take precautions related to the use and consumption of the city's drinking water.

Due to this elevated concern, the Division of Medicaid (DOM) has entered into an agreement with MSDH to make testing blood lead levels simple and efficient for Medicaid beneficiaries who live in Jackson and are exposed to Jackson city water. Specifically, the interagency agreement allows for the blood draw and lead testing to be reimbursed outside of the usual MSDH clinic encounter rate methodology, effective March 1, 2016. Medicaid beneficiaries who use Jackson city water can go to a local MSDH clinic and get their blood lead levels tested.

With the help of providers, DOM and MSDH hope this will be the most effective and fiscally responsible way to address an important public health issue.

To make it easier for providers who serve our beneficiaries, DOM has developed specific instructions about billing and reimbursement related to lead testing and treatment. These instructions can also be found on our website at http://medicaid.ms.gov.

DOM covers CPT code 83655 (lead testing) outside of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) or wellness benefit for all beneficiaries when billed with a QW modifier. The ICD-10 code for contact with and (suspected) exposure to lead is Z77.011.

Claims for beneficiaries impacted by the recent MSDH announcement related to City of Jackson Public Water System should include ICD-10 code Z77.011, CPT code 83655 (with QW modifier) and an appropriate Evaluation and Management code, when lead testing is performed outside of the EPSDT or wellness benefit. All applicable Administrative Code, State Plan and provider policies apply.

Please direct any questions related to DOM's lead level testing coverage to the Office of Medical Services at 601-359-6150.

DOM medical director helps to address provider concerns

Communicating with Medicaid providers and fixing problems: Those are the key functions Dr. Tami Brooks performs on a weekly basis, one year into her role as medical director for the Mississippi Division of Medicaid (DOM).

As an actively practicing pediatrician at the University of Mississippi Medical Center (UMMC), Brooks says she is ideally positioned to serve as a liaison between the provider community and DOM and is even more accessible. While her role at DOM is part time, there is now a toll-free 800 number practitioners can call to reach Brooks with questions or concerns about DOM policy or patient coverage (844-301-7004).

"We thought it would be a good idea for providers to be able to contact me when I'm not at the Medicaid central office," she said. "Luckily we were able to get this line established so providers can pick up the phone and talk about issues that they might have regarding their patients who are DOM beneficiaries."

DOM has been providing healthcare coverage for eligible Mississippians since its inception in 1969. But the complex and ever-changing federal and state laws governing Medicaid have always created a communications challenge between the agency and healthcare providers. That's where Brooks comes in.

With one foot in Medicaid and one foot in the provider community, Brooks has the ability to bridge the two worlds, address concerns and help the places where they intersect function more smoothly – whether it is the business operations of a small-town health clinic or the fine details of agency coding specifications.

"I have learned that there are many knowledgeable and caring people here (at DOM) who want to do the right thing," Brooks said. "And I think that perception is not always received by some providers because of their frustrations with certain things."

"On the flip side of that coin, DOM employees typically don't have the perspective of clinicians, but they are eager to try and understand that point of view", she added.

Brooks has served as an associate professor of pediatrics at UMMC since completing her residency there in 1996. In addition to training medical students, she is also the medical director of UMMC's Pediatric North Clinic, which means she is familiar with the administrative aspect of health care.

Brooks also serves as legislative chair of the Mississippi Chapter of the American Association of Pediatrics (AAP). A practitioner, an advocate and now a champion for Medicaid, Brooks has a passion for the health of Mississippians.

She joined DOM in December of 2014.

"My role at Medicaid has been primarily to communicate issues that providers have to the division and then educate them with the answers," she said. "I have been able to review policy changes, and I've also been very involved more recently with quality improvement. Hopefully as we move forward I'll start hearing less provider complaints because we're addressing their problems, and we can spend more effort improving the quality of care."

In addition to the phone line, Brooks says she responds to emails from providers on a regular basis. Often times, they are issues she passes along to the Office of Eligibility, Pharmacy

or other areas, but providers are becoming more aware that Brooks is a point of entry for DOM answers.

"I get the sense that providers have never felt like they had that before," she said.

Dr. Dorthy Young, deputy administrator for Health Services, says having Brooks' point of view is a great advantage for DOM.

"Dr. Brooks provides DOM clinical staff with a valuable pediatric provider perspective and has collaborated with multiple areas of the agency on the development of policy," Young said. "She also assists in provider outreach. We are excited about the new dedicated phone line for medical providers to call Dr. Brooks directly. It will be an additional avenue for our medical community to interact with our medical director."

Brooks says UMMC has been very supportive of her role at DOM and she has been able to share what she's learned with a wider audience.

"I have spoken to family medicine practitioners, the Mississippi State Medical Association and also medical students," she said. "So I've also been able to go out and tell people about what we do here."

Providers are encouraged to contact Dr. Brooks with any questions or concerns by calling toll-free at 844-301-7004 or 601-359-6138.

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.

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Swing-Bed Hospital Services

In accordance with its State Plan, DOM provides payment for routine nursing facility services furnished by a swing-bed hospital. Provision of swing- bed services is authorized by Section 1913, Title XIX of the Social Security Act, as enacted by Congress through Section 904 of Public Law 96-499 and implemented by the Department of Health and Human Services through regulations 42 CFR Parts 405, 435, 440, 442, and 447. By definition, swing-bed services are extended care services provided in a hospital bed that has been designated as such and consists of one or more of the following:

- Skilled nursing care and related services for patients requiring medical or nursing care;
- Rehabilitation services for persons who are injured, disabled, or sick; and/or
- On a regular basis, health related care and services to individuals who, because of their medical status, require care and services above the level of room and board, which can be made available to them only through institutional facilities.

DOM has determined that swing-bed hospital services should not have been included in the inpatient hospital roll-in effective December 1, 2015. DOM maintains responsibility for authorization and reimbursement of swing-bed hospital services rendered to both Medicaid beneficiaries and MississippiCAN members.

As a result of the Coordinated Care Organizations (CCOs) will proceed as follows:

- The CCOs should recoup payments incorrectly made to providers for swing-bed hospital services for such services rendered on or after December 1, 2015.
- The CCOs should notify providers to contact the DOM Utilization Management/Quality Improvement Organization (UM/QIO) vendor, eQHealthSolutions, for authorization.
- The CCOs should notify providers to submit swing-bed claims to DOM's fiscal agent Xerox to process payments of all payments recouped by the CCOs in response to the memorandum of April 21, 2016 and future swing-bed hospital services rendered to MississippiCAN members.
- The CCOs should deny all swing-bed authorizations and claims submitted to CCO on or after December 1, 2015.
- DOM requests immediate provider outreach by the CCOs to educate providers of this policy.

Long-Term Acute Care (LTAC) Hospital Services

Long-Term Acute Care (LTAC) hospital services are reimbursed by DOM for inpatient services using the All Patients Refined Diagnosis Related Groups (APR-DRG) payment methodology. When services constitute inpatient setting in a LTAC, these services are paid for by DOM as an inpatient stay. However, the services are limited to eligible persons under twenty-one (21)

years of age per Miss. Code Ann. §43-13-117 as noted below: "(48) Pediatric long-term acute care hospital services.

A. Pediatric long-term acute care hospital services means services provided to eligible persons under twenty-one (21) years of age by a freestanding Medicare- certified hospital that has an average length of inpatient stay greater than twenty-five (25) days and that is primarily engaged in providing chronic or long-term medical care to persons under twenty-one (21) years of age.

B. The services under this paragraph (48) shall be reimbursed as a separate category of hospital services."

DOM has determined that LTAC hospital services should have been included in the inpatient hospital roll-in effective December 1, 2015. The CCOs are responsible for coverage of LTAC hospital services for MississippiCAN members when the above-described conditions are met.

As a result, the CCOs will proceed as follows:

- The CCOs should allow providers to submit or resubmit claims for LTAC services rendered to MississippiCAN members on or after December 1, 2015.
- Timely filing for LTAC claims not paid by the CCOs from and after December 1, 2015, should be considered six (6) months from the effective date of the memorandum of April 21, 2016 and the CCOs shall not deny on the sole basis of timely filing any LTAC claim with a date of service December 1, 2015 through the effective date of the memorandum.
- The CCOs should notify providers to submit LTAC claims to the CCOs from December 1, 2015 through the present and for all future LTAC claims for MississippiCAN members.
- DOM requires immediate provider outreach by the CCOs to educate providers of this policy and the appropriate method for obtaining authorization and payment for LTAC services.

PROVIDER COMPLIANCE

Attention Obstetricians: Billing Tips for Multiple Births

There has been an increasing number of multiple birth claims with denials for the second or subsequent births. The information below will help when billing these claims to DOM or the MississippiCAN coordinated care organizations.

- All maternity related services billed must include the TH modifier on the claim line. This modifier is used to track data and to bypass the physician visit limits for antepartum office visits.

- The first birth should be billed with the appropriate delivery code (with or without postpartum care) based on the delivery services provided. A delivery code with postpartum care can only be billed once per delivery. When no postpartum care is provided, the first delivery will be billed for delivery only.

- The additional births must be billed on a single line as deliveries only. Multiple surgery rules will apply to this line so it must be billed with the modifier 51.

- National Correct Coding Initiative (NCCI) in Medicaid procedure-to-procedure rules apply when certain maternity codes billed are repeated on another claim line. These additional lines will require the NCCI associated modifier 59 on the line to identify the service as separate and distinct from the previous line.

- When there are multiple delivering physicians, each surgical line of the assistant surgeon claim must be identified with the modifier 80. An assistant surgeon is a licensed physician who actively assists the physician in charge of a case in performing a surgical procedure.

- Team or co-surgeons must be identified by the appropriate modifier and must be a different specialty than the physician in charge of the case.

Information on NCCI in Medicaid can be located at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html

If you have any questions, please contact Xerox Provider and Beneficiary Services at 800-884-3222.

Fee-For-Service Advanced Imaging Changes

Effective March 1, 2016, eQHealth Solutions (eQHS) began performing prior authorization reviews for advanced imaging services for fee-for-service enrolled beneficiaries, in accordance with Mississippi Administrative Code Title 23, Part 220 Radiology Services. Prior to March 1, 2016 advanced imaging services were prior authorized through MedSolutions (eviCore). Mississippi Division of Medicaid (DOM) will honor MedSolutions (eviCore) treatment authorization numbers issued to rendering providers for dates of services on or before March 30, 2016.

For additional information, please contact eQHS at 601-360-4833 or by e-mail at education@eqhs.org. Providers may also contact DOM Office of Medical Services at 601-359-6150.

This change does not impact Medicaid beneficiaries enrolled in MississippiCAN.

Attention Nursing Facilities

Effective June 1, 2016, DOM will accept Civil Money Penalty (CMP) grant applications.

Nursing home providers and stakeholders are encouraged to submit CMP grant applications for the development and implementation of quality improvement initiatives that directly or indirectly benefit nursing facility residents.

- CMP applications will be accepted from dually certified providers (SNF/NF) and nursing facilities (NF) and other organizations.

CMP applications shall be submitted electronically to DOM utilizing the Region IV: CMP Grant Request form. The form can be downloaded from the DOM website on the Civil Money Penalty Grant Awards Program webpage at https://medicaid.ms.gov/programs/civil-money-penalty-cmp-grant-awards-program/.

The completed grant application and the grant proposal information should be attached and emailed to the CMP Grants mailbox: CMPGrants@medicaid.ms.gov

- Enhancement or educational grants should demonstrate current and sound evidence-based practices that promote quality of care and quality of life for nursing facility residents.

Collaboratively, representatives from DOM and Mississippi State Department of Health (MSDH), Division of Licensure and Certification shall first assess the merit of each proposed project and the ability of the project to improve resident outcomes and advance the care and services provided in certified long term care facilities. Following this collaborative review, the CMP application shall be forwarded to the CMS electronic mailbox for a decision.

Additional guidance and specific instructions for completing the CMP grant proposal are also included in the grant application request form. Failure to complete all sections of the application may result in denial of the grant request.

Assistance for Providers

Provider and Beneficiary support staff is available to assist providers in various ways and can be reached at 1-800-884-3222. Questions regarding claims status, explanations of denials, provider enrollment inquiries, and assistance from EDI can be addressed immediately Monday through Friday 8 a.m. to 5 p.m. Inquiries can also be sent 24 hours a day, 7 days a week, and 365 days a year via the Envision Web portal at http://ms-medicaid.com by logging on and selecting "Ask Provider Relations."

Provider Field Representatives are available to assist providers with large complex issues and are also available to conduct policy, program, and software training. Should you experience complex issues or need training, please call or email the appropriate representative. Provider Representatives work in the field two (2) to three (3) days each week and are not always available immediately, but they return calls and email within 24 to 48 hours.

In an effort to safeguard Protected Health Information (PHI), claims should not be mailed to provider representatives. All claims should be mailed to:

Xerox State Healthcare, LLC
P.O. Box 23076
Jackson, MS 39255

Provider Access integrates Real Time Clinical Data, Don't Miss Out

As some of you may have seen, DOM made headlines in March after announcing that it became the nation's first Medicaid agency to send and receive clinical data in real-time using the C-CDA format. The agency worked with technology partners MedeAnalytics and Epic to share Medicaid data with the state's largest provider of care to Medicaid patients, the University of Mississippi Medical Center (UMMC). Providers across the state now have access to the DOM provider portal, Provider Access, to improve care coordination across their practices. Providers can request real-time summaries of Medicaid patients from DOM, including medication lists, allergies, diagnoses and procedures. These patient summaries are then presented to the physician via the electronic health record (EHR) system, in real-time. Upon patient discharge, updated C-CDA clinical summaries are then automatically sent back to DOM, where they are integrated into the DOM Clinical Data Repository (CDR).

Provider Access is complimentary to all Mississippi Medicaid providers, and allows you to:

- View three (3) years of claims-based, clinical information—on your PC or iPad
- Access patients' medication histories and monitor their filling habits
- Conduct unofficial claims pre-authorizations by reviewing paid and denied claims
- Reduce duplicative therapies with insight into immunizations and acute episodes of care
- Perform reconciliations for proactive fraud detection and billing practices
- Download patient histories to your EMR or display and print PDF files
- Educate, coach and motivate patients on allergies, smoking and other ways to improve their health

Here is what others have said about their experience using Provider Access.

Samikea Hudson, MD, with Jackson Pediatrics, received an iPad mini for having the most beneficiary lookups between October and December, and reported that she uses the Provider Access Medications Tab most frequently. "The portal is a valuable resource for our staff," says. Dr. Hudson. For new patient consults, her staff uses the portal to search diagnosis and procedures to gain insight into that patient's overall care.

John Blythe, MD, with Queen City Medical Equipment, uses Provider Access to research diagnosis code history and verify that they are not duplicating durable medical equipment (DME) services already rendered by another provider. It has also helped him and his staff locate patients when they moved. Dr. Blythe says the portal has really been an asset to his company and utilizes this site almost daily.

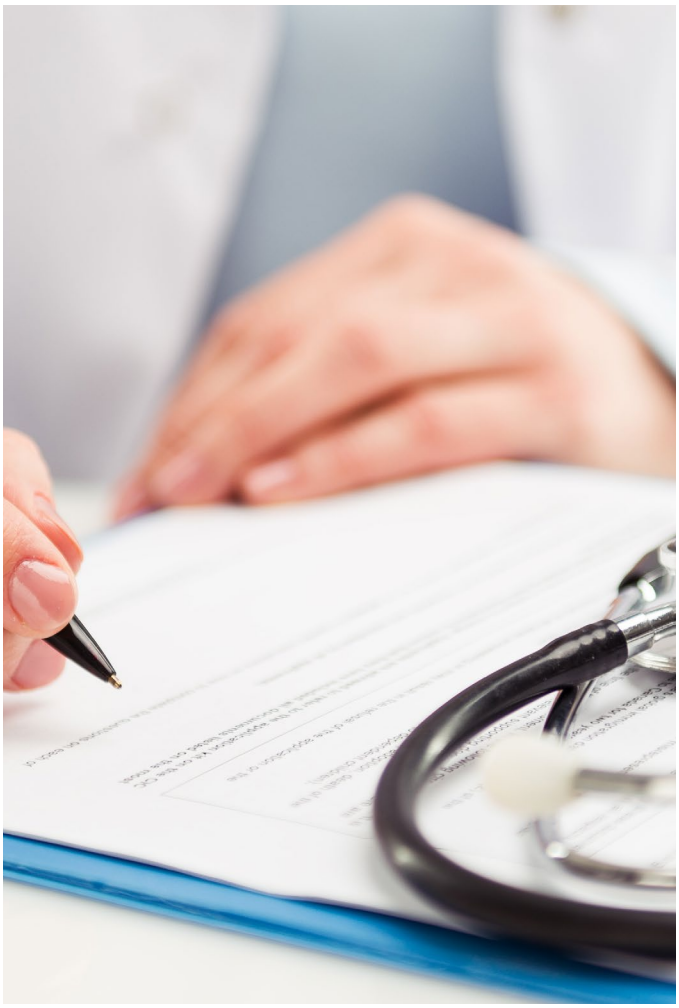
New Enhancements are coming soon!

Addressing numerous provider requests, we will soon introduce a new patient face-sheet to display the most relevant claims and clinical information on one page, in real-time, with a clinical interface to Epic. The sheet will also display detailed clinical information in existing categories, as well as new categories – imaging, laboratory results and vital signs.

How to Sign Up.

To register for Provider Access, contact Mississippi Division of Medicaid Clinical Advocate Nancy-Barton Marini:

Email: nancy.bartonmarini@medicaid.ms.gov
Phone: 662-231-7715



Hospital Inpatient APR-DRG Alert – July 1, 2016 Updates

DOM will adopt V.33 of the 3M Health Information System APR-DRG Grouper and V.33 of the Health Care Acquired Conditions (HCAC) utility for payment of hospital inpatient claims for discharges on and after July 1, 2016. APR-DRG parameters will not change for hospital inpatient discharges on and after July 1, 2016.

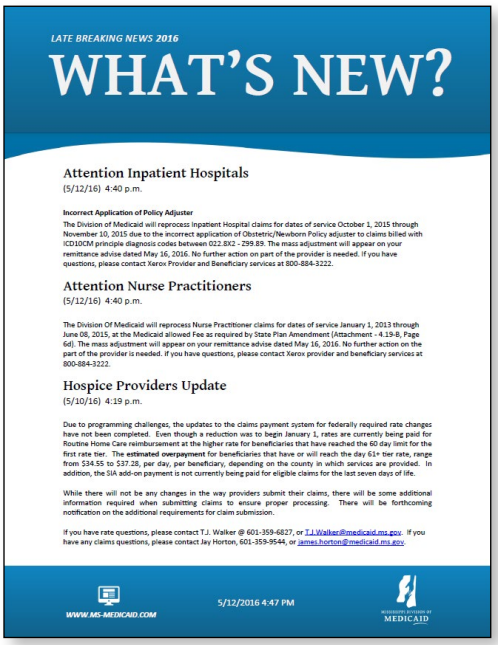
Hospitals are not required to purchase 3M software for payment of claims; however, all hospitals that have purchased the 3M software should ensure their internal systems are updated to reflect all changes that occur for hospital discharges beginning on and after July 1, 2016.

Hospitals will be notified of all information related to these updates via e-mail, the DOM website http://medicaid.ms.gov, Late Breaking News, and RA Banner Messages.

Summer and Fall 2016 Provider Workshops

The Division of Medicaid and Xerox State Healthcare Solutions are planning the Summer and Fall 2016 Provider Workshops. The workshops will be designed to address issues and topics that are of most importance to the Medicaid provider community.

More specific information, including dates and locations, will be posted on the Mississippi Medicaid web portal at https://www.ms-medicaid.com/msenvision/index.do when it comes available.


LATE BREAKING NEWS 2016

WHAT'S NEW?

Attention Inpatient Hospitals

(5/12/16) 4:40 p.m.

Incorrect Application of Policy Adjuster

The Division of Medicaid will reprocess Inpatient Hospital claims for dates of service October 1, 2015 through November 10, 2015 due to the incorrect application of Obstetric/Newborn Policy adjuster to claims billed with ICD10CM principle diagnosis codes between 022.8X2 - 299.89. The mass adjustment will appear on your remittance advise dated May 16, 2016. No further action on part of the provider is needed. If you have questions, please contact Xerox Provider and Beneficiary services at 800-884-3222.

Attention Nurse Practitioners

(5/12/16) 4:40 p.m.

The Division Of Medicaid will reprocess Nurse Practitioner claims for dates of service January 1, 2013 through June 08, 2015, at the Medicaid allowed Fee as required by State Plan Amendment (Attachment - 4.19-B, Page 6d). The mass adjustment will appear on your remittance advise dated May 16, 2016. No further action on the part of the provider is needed. If you have questions, please contact Xerox provider and beneficiary services at 800-884-3222.

Hospice Providers Update

(5/10/16) 4:19 p.m.

Due to programming challenges, the updates to the claims payment system for federally required rate changes have not been completed. Even though a reduction was to begin January 1, rates are currently being paid for Routine Home Care reimbursement at the higher rate for beneficiaries that have reached the 60 day limit for the first rate tier. The **estimated overpayment** for beneficiaries that have or will reach the day 61+ tier rate, range from $34.55 to $37.28, per day, per beneficiary, depending on the county in which services are provided. In addition, the SIA add-on payment is not currently being paid for eligible claims for the last seven days of life.

While there will not be any changes in the way providers submit their claims, there will be some additional information required when submitting claims to ensure proper processing. There will be forthcoming notification on the additional requirements for claim submission.

If you have rate questions, please contact T.J. Walker @ 601-359-6827, or T.J.Walker@medicaid.ms.gov. If you have any claims questions, please contact Jay Horton, 601-359-9544, or james.horton@medicaid.ms.gov.

WWW.MS-MEDICAID.COM

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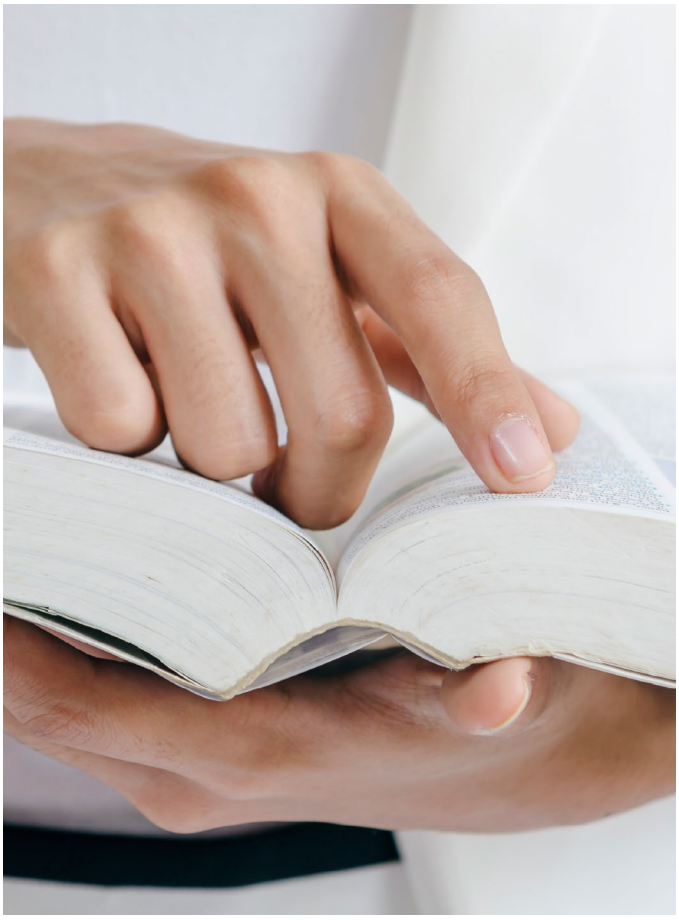
What Is Late Breaking News and Where Can I Find It?

Late Breaking News (LBN) is a valuable resource for providers to receive the most up to date information related to Medicaid claims processing. Providers are encouraged to visit the web site on a daily basis for an up-to-date list of processing changes and recommended resolutions.

LBN postings also contain information on mass adjustments of claims reprocessing as a result of associated systems enhancements, changes and policy updates.

The Late Breaking News link can be found at: http://ms-medicaid.com - located on the homepage of the Mississippi Envision Web Portal under the Late Breaking News section.



Mississippi Medicaid Provider Billing Manual

The Mississippi Medicaid Provider Billing Manual is designed to provide guidance and assistance to providers in submitting beneficiary claims to DOM. The manual provides step-by-step instructions on completing claim forms to ensure providers are reimbursed in a timely manner for services rendered.

Providers may obtain a hard copy of the manual at a minimal cost, by contacting the fiscal agent's Provider and Beneficiary Services Unit toll-free at 1-800-884-3222, or an electronic version of the Manual may be downloaded at http://medicaid.ms.gov.

This manual 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 DOM website at http://medicaid.ms.gov.

Medicaid Program Integrity Education

The Centers for Medicare & Medicaid Services (CMS) seeks to further the program integrity education efforts by now offering continuing education (CE) courses. CMS, through its Medicaid Provider Integrity Education (MPIE) system, provides resources to educate providers, beneficiaries and other stakeholders in promoting best practices and awareness of Medicaid fraud, waste and abuse.

The MPIE system has been expanded to include accredited CE, including Continuing Medical Education (CME), Continuing Pharmacy Education (CPE), and Continuing Education Unit (CEU) credits to all Medicaid medical provider types and State Medicaid staff. CME, CPE and CEU credits provides several advantages to provider communities and are offered at no cost to the State or the provider. These courses are located at: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/continuing-ed-podcasts.html.

Improving Claims Processing

At Xerox State Healthcare, LLC we are working to improve claims processing. We would like to make sure that every provider's claim is processed correctly and expeditiously. In order to improve this process, DOM request that the Provider community:

1. Please do not staple your claims together. Providers can simply place their attachments behind the associated claim and place them in an envelope.

2. Please sign the claim in ink. The vast majority of the claims are Returned to the Provider (RTP) because they are not properly signed.

3. Please submit request for Medicaid payment on crossover claims. Providers are sending claims with Medicare Explanation of Benefits (EOB) showing that payment has been received by Medicare.

4. Please list the Third Party Liability (TPL) payment in the appropriate field. For all claims submitted with TPL payments, the payment must be shown in the prior payments (UB-04) field and the amount paid in the (CMS-1500) field on the claim.

5. Please do not send a stack of claims and one copy of the attachment that goes with each claim. If there is an attachment that is critical to the processing of the claim, copy the attachment for each claim and place it with its associated claim before submitting those claims for processing.

6. Please submit standard 8 x 11 attachments. Strips, cutouts and the like are not acceptable.

7. Please put the bill date on each claim.

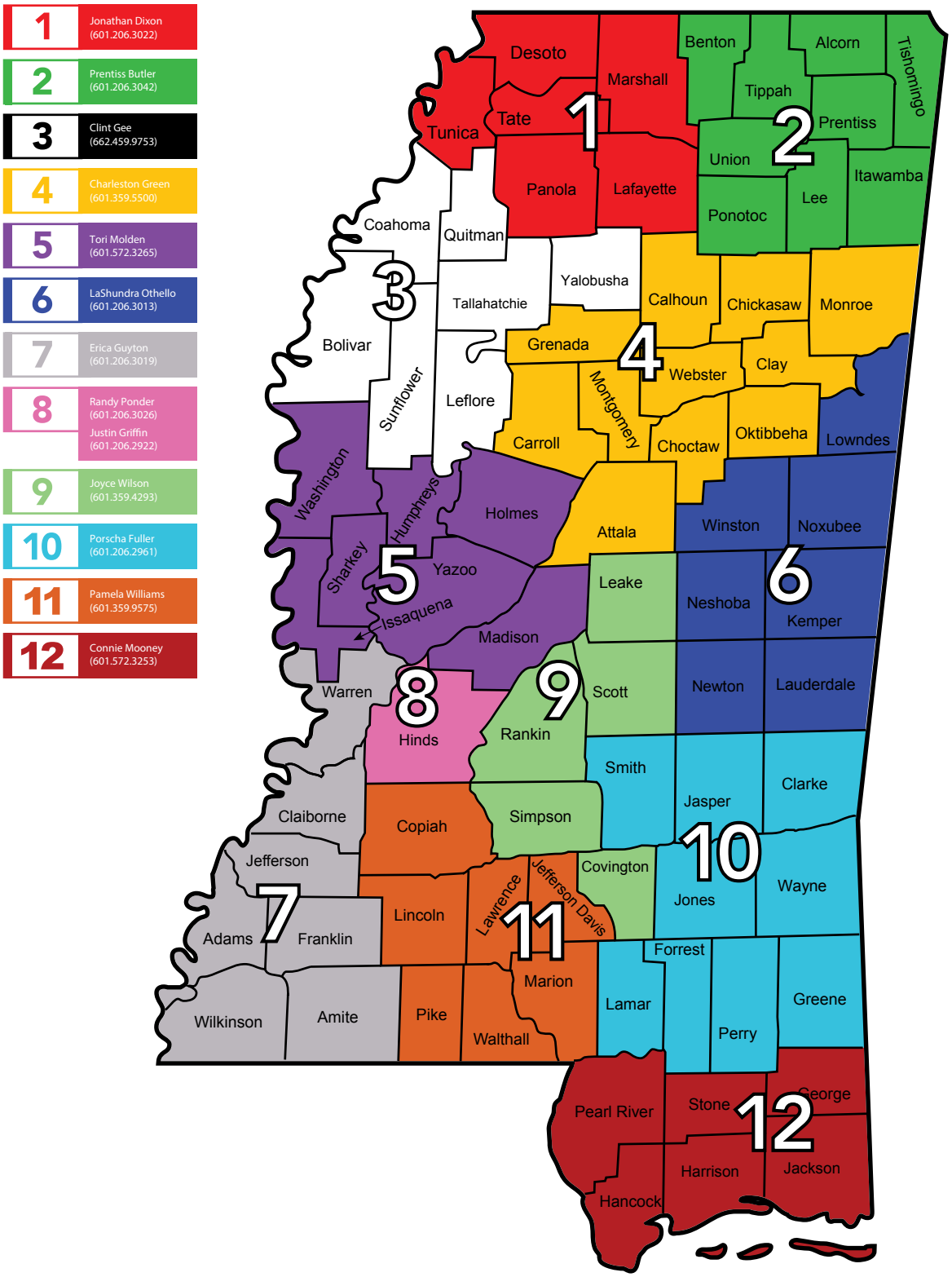
8. Please place bill types on UB-04's and Crossover A's.

9. Please mail or electronically submit your claims. WE DO NOT ACCEPT FAXED CLAIMS.

PROVIDER FIELD REPRESENTATIVES

PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY		
AREA 1 **Jonathan Dixon (601.206.3022)** jonathan.dixon@xerox.com	**AREA 2** **Prentiss Butler (601.206.3042)** prentiss.butler@xerox.com	**AREA 3** **Clint Gee (662.459.9753)** clinton.gee@medicaid.ms.gov
County	**County**	**County**
Desoto	Alcorn	Bolivar
Lafayette	Benton	Coahoma
Marshall	Itawamba	Leflore
Panola	Lee	Quitman
Tate	Pontotoc	Sunflower
Tunica	Prentiss	Tallahatchie
	Tippah	Yalobusha
	Tishomingo	
***Memphis**	Union	
AREA 4 **Charleston Green (601.359.5500)** charleston.green@medicaid.ms.gov	**AREA 5** **Tori Molden (601.572.3265)** tori.molden@xerox.com	**AREA 6** **LaShundra Othello (601.206.2996)** lashundra.othello@xerox.com
County	**County**	**County**
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		
AREA 7 **Erica Guyton (601.206.3019)** erica.cooper@xerox.com	**AREA 8** **Justin Griffin (601.206.2922)** Zip Codes (39041-39215) justin.griffin@xerox.com **Randy Ponder (601.206.3026)** Zip Codes (39216-39296) randy.ponder@xerox.com	**AREA 9** **Joyce Wilson (601.359.4293)** joyce.wilson@medicaid.ms.gov
County	**County**	**County**
Adams	Hinds	Covington
Amite		Leake
Claiborne		Rankin
Franklin		Scott
Jefferson		Simpson
Warren		
Wilkinson		
AREA 10 **Porscha Fuller (601.206.2961)** porscha.fuller@xerox.com	**AREA 11** **Pamela Williams (601.359.9575)** pamela.williams@medicaid.ms.gov	**AREA 12** **Connie Mooney (601.572.3253)** connie.mooney@xerox.com
County	**County**	**County**
Clarke	Copiah	George
Forrest	Jefferson-Davis	Hancock
Greene	Lawrence	Harrison
Jasper	Lincoln	Jackson
Jones	Marion	Pearl River
Lamar	Pike	Stone
Perry	Walthall	
Smith		
Wayne		**Mobile, AL**
OUT OF STATE PROVIDERS	**Katrina Magee (601.572.3298)** katrina.magee@xerox.com **Tora Monroe (601.206.2929)** tora.monroe@xerox.com	

FIELD REPRESENTATIVE REGIONAL MAP



XEROX STATE HEALTHCARE, LLC
P.O. BOX 23078
JACKSON, MS 39225

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

Mississippi Medicaid Administrative Code and Billing Handbook are on the Web
www.medicaid.ms.gov

Medicaid Provider Bulletins are located on the Web Portal
www.ms-medicaid.com

JUNE 2016

THURS, JUN. 2	EDI Cut Off – 5:00 p.m.
MON, JUN. 6	Checkwrite
THURS, JUN. 9	EDI Cut Off - 5:00 p.m
MON, JUN. 13	Checkwrite;
THURS, JUN. 16	EDI Cut Off - 5:00 p.m.
MON, JUN. 20	Checkwrite
THURS, JUN. 23	EDI Cut Off - 5:00 p.m.
MON, JUN. 27	Checkwrite
THURS, JUN. 30	EDI Cut Off - 5:00 p.m.

JULY 2016

MON, JUL. 4	DOM Closed Independence Day
THURS, JUL. 7	EDI Cut Off – 5:00 p.m.
MON, JUL. 11	Checkwrite
THURS, JUL. 14	EDI Cut Off – 5:00 p.m.
MON, JUL. 18	Checkwrite
THURS, JUL. 21	EDI Cut Off – 5:00 p.m.
MON, JUL. 25	Checkwrite
THURS, JUL. 28	EDI Cut Off – 5:00 p.m.

AUGUST 2016

MON, AUG. 1	Checkwrite
THURS, AUG. 4	EDI Cut Off – 5:00 p.m.
MON, AUG. 8	Checkwrite
THURS, AUG. 11	EDI Cut Off – 5:00 p.m
MON, AUG. 15	Checkwrite
THURS, AUG. 18	EDI Cut Off – 5:00 p.m.
MON, AUG. 22	Checkwrite
THURS, AUG. 25	EDI Cut Off – 5:00 p.m.
MON, AUG. 29	Checkwrite

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