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MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

New Program Preserves Supplemental Hospital Payments

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Executive Director
MS Division of Medicaid

Last December, the Mississippi Division of Medicaid (DOM) transitioned inpatient hospital services into our managed-care program, the Mississippi Coordinated Access Network (MississippiCAN), capping a major implementation effort and fulfilling a key priority for the agency.

This is just one of the moves helping to position Medicaid as a leading driver of health policy in this state. Specifically, the intent of making inpatient hospital services part of managed care is to improve follow-up care after a beneficiary is discharged from a hospital setting, keep the beneficiary active in their personal health, provide follow-up care with a case manager and prevent possible readmissions for the same condition. Prior to this transition, we were one of the few states with a managed-care program that did not include inpatient services.

The state Legislature authorized this inpatient roll-in during the 2015 session and also mandated the development and implementation of the Mississippi Hospital Access Program (MHAP). MHAP is a critical part of the inpatient transition because without it, hospitals would lose upper payment limit (UPL) funding.

As many in the provider community are aware, UPL funds are supplemental Medicaid payments designed to provide additional funds to hospitals up to the level that Medicare would have allowed for similar inpatient services. Hospitals rely heavily on this supplement, but they typically are not allowed in a managed-care environment because UPL funding is based on a fee-for-service reimbursement model. The loss of UPL, which totaled $533 million in 2015, would be devastating to hospitals, so we needed to create a new inpatient supplemental payment structure to maintain that funding for Mississippi hospitals.

Using this model, DOM makes payments to our managed care organizations, who then distribute the full amount of MHAP funds to the hospitals that participated in the UPL program. Ultimately, MHAP aims to protect patient access to hospital care by maintaining supplemental hospital reimbursement at the fiscal year 2015 level.

The Centers for Medicare and Medicaid Services (CMS) approved MHAP and in May, CMS issued new regulations known as a final rule, impacting all Medicaid managed care programs. One important component of the new regulations is a requirement that pass-through payments, such as MHAP, are fully phased out or that the payments transition to accountability-based models by July 1, 2027. Consequently, CMS required DOM to put together a corrective action plan (CAP) explaining how we plan to modify MHAP.

IN THIS ISSUE

According to the regulations, at least 10 percent of pass-through payments must be phased out or transitioned each year beginning with state fiscal year 2019, which begins July 2018.

The fact is managed care is becoming an indispensable component to administering a Medicaid program, but managed care will not thrive without including inpatient services. Hospitals would be greatly affected by the loss of supplemental payments they depend on. This is a very contentious subject in this state, and my goal is to clearly communicate that this is a necessary step and one that is backed by state and federal law.

Ultimately, this means we will have to devise a way to link MHAP payments to utilization, quality, or outcomes, and according to the final rule we have ten years to complete the transition. This accountability-based model is nothing new; Medicare does the same thing, and so do many private insurers. We do not yet know what our model is going to look like, but I am committed to actively involving hospitals to be a part of the planning. Planning is underway to bring hospital representatives and other stakeholders together for the first in a series of informational meetings beginning this fall.

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.

PROVIDER COMPLIANCE

Attention All Elderly and Disabled (E&D) Waiver Adult Day Care (ADC) Providers

RATE CHANGE!

For dates of service on or after July 1, 2016, the ADC rate is $61.82 per day. This is the maximum rate allowed under the current CMS approved Elderly and Disabled Waiver. The procedure code for ADC is S5102 and must be billed with a U1 modifier for services provided under the Elderly and Disabled Waiver.

Third Party Billing

Did you know most third party billing questions or problems can be resolved by simply referring to the MS Administrative Code or the Provider Billing Handbook? This information is available on the Division of Medicaid's website at https://medicaid.ms.gov/providers/. The support staff in the Office of Recovery is available to assist providers with any additional third party billing issues and can be reached at 1-800-421-2408.

Providers can also report third party insurance updates directly to the Third Party Recovery File Maintenance Unit via email at tplpolicyupdate@medicaid.ms.gov. Your email will be promptly handled within three to four business days.

Attention Maternity Providers

The Division of Medicaid (DOM) covers inductions of labor or cesarean sections prior to one (1) week before the treating physician's expected date of delivery when medically necessary in accordance with Part 222, Chapter 1, Rule 1.1 B.

DOM does not cover non-medically necessary early elective deliveries. DOM defines an early elective delivery as delivery one (1) week prior to the treating physician's expected date of delivery. An elective delivery performed after one (1) week prior to the treating physician's expected date of delivery, is considered a covered service.

If you have any questions, please contact your Provider Representative or the Office of Medical Services at 601-359-6150

Billing Updates for Mental Health Providers

2016 ANNUAL RATE UPDATES

Effective July 1, 2016, the 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://www.medicaid.ms.gov/wp-content/uploads/2014/03/CommunityMentalHealthCenter.pdf

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

Therapeutic and Evaluative Services for Expanded EPSDT (T&E):
http://www.medicaid.ms.gov/wp-content/uploads/2016/03/TherapeuticEvaluativeMentalHealthChildren.pdf

Please refer to the most current CPT Code Book for the appropriate procedure code(s) for services provided.

You may contact Kimberly Evans or Felita Bell at 601-359-9545, with questions.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

Effective November 1, 2015, Mississippi Division of Medicaid (DOM) received Centers for Medicare and Medicaid Services (CMS) approval of State Plan Amendment (SPA) 15-017 Early and Periodic Screening, Diagnosis and Treatment (EPSDT). SPA 15-017 requires that DOM EPDST providers adhere to the American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule for physical, mental, psychosocial and/or behavioral health, vision, hearing, adolescent, and developmental screening services. SPA 15-017 also requires DOM EPSDT providers adhere to the requirements of the American Academy of Pediatric Dentistry (AAPD) for dental screening services.

EPSDT screenings must be provided by currently enrolled DOM EPSDT providers who have signed an EPSDT specific provider agreement. EPSDT providers may seek reimbursement for services rendered in accordance with the AAP Bright Futures Periodicity Schedule for dates of service on and after November 1, 2015.

EPSDT screenings must include:

1. An initial or established age appropriate medical screening which must include, at a minimum:

- ✓ A comprehensive health and developmental history including assessment of both physical and mental health development.
- ✓ A comprehensive unclothed physical exam (which may be accomplished by examining each unclothed body system individually).
- ✓ Appropriate immunizations according to the Advisory Committee for Immunization Practices (ACIP) and specific to age and health history.*
- ✓ Laboratory tests adhering to the AAP Bright Futures Periodicity Schedule.
- ✓ Sexual development and sexuality screening adhering to the AAP Bright Futures Periodicity Schedule, and

- ✓ Health education, including anticipatory guidance.

2. Adolescent counseling and risk factor reduction intervention to include diagnosis with referral to a Mississippi Medicaid enrolled provider for diagnosis and treatment for defects discovered.

3. Developmental screening or surveillance to include diagnosis with referral to a Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

4. Psychosocial/behavioral assessment to include referral to a Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

5. Vision screening at a minimum to include diagnosis with referral to a Mississippi Medicaid optometry or ophthalmology provider for diagnosis and treatment for defects in vision, including eyeglasses.

6. Hearing screening at a minimum to include diagnosis with referral to a Mississippi Medicaid audiologist, otologist, otolaryngologist or other physician hearing specialists for diagnosis and treatment for defects in hearing including hearing aids.

7. Dental screening at a minimum to include diagnosis with referral to a Mississippi Medicaid dental provider for beneficiaries at or the eruption of the first tooth or by twelve (12) months of age for diagnosis and referral to a dentist for treatment and relief of pain and infections, restoration of teeth and maintenance of dental health.

DOM EPSDT providers must schedule and perform all age appropriate screenings and assessments in accordance with Mississippi Administrative Code Title 23, Part 223 Early and Periodic Screening, Diagnosis, and Treatment, which is currently under revision to align with the AAP Bright Futures.

DOM EPSDT providers must refer beneficiaries to other Mississippi Medicaid enrolled licensed practitioners for services necessary to correct or ameliorate physical, mental, psychosocial and/or behavioral health conditions discovered by the screening services, whether or not such services are covered under the Mississippi State Plan.

For more information regarding SPA 15-017, please refer to the DOM website at https://medicaid.ms.gov/about/state-plan/approved-state-plan-amendments/ or contact the Office of Medical Services at (601) 359-6150.

*DOM does not enroll providers in the Vaccines For Children (VFC) Program. To enroll in the VFC program, please contact the Mississippi Department of Health Immunizations at 601-576-7751.

Provider Information regarding the Zika Virus

On June 1, 2016 the Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin informing Medicaid Agencies how Medicaid services can help states and territories prevent, detect, and respond to the Zika virus, including efforts to prevent the transmission and address health risks to beneficiaries. The Informational Bulletin may be found at https://www.medicaid.gov/federal-policy-guidance/downloads/cib060116.pdf

The Mississippi Division of Medicaid's (DOM) Zika coverage related to the June 1,2016 CMS informational bulletin is as follows:

➢ **Prevention**

- Vaccine – The Food and Drug Administration (FDA) has

not approved a vaccine for Zika at this time. Should one become available and be FDA approved, DOM will cover the vaccine through State Plan benefits available to all beneficiaries.

- Insect Repellents – Mosquito repellents applied to the skin can aid in preventing Zika virus infection. The Centers for Disease Control (CDC) recommends people use Environmental Protection Agency (EPA)-registered insect repellents with one of the following active ingredients: DEET, picaridin, IR3535, oil of lemon eucalyptus, or para-menthane-diol.

  Effective August 1, 2016, ***DOM will cover mosquito repellents when prescribed by an enrolled Medicaid provider and billed by a Medicaid pharmacy provider.*** DOM will maintain a list of covered insect repellents which have been assigned National Drug Code (NDC) numbers by national drug databases such as First Databank and Medispan. Please refer to DOM's website at https://medicaid.ms.gov/providers/pharmacy/.

  Prescription claims for insect repellents ***will not count toward the five (5) prescription monthly service limit.***

  A maximum of ***two (2) cans/bottles per month per beneficiary*** will be allowed for ***all beneficiaries age 13 and over.***

➢ **Coverage** – Family Planning service for men and women of child bearing age or women who are pregnant.

- Family Planning Counseling – DOM currently covers this service for all beneficiaries through the Family Planning Waiver, Annual Wellness Exams and in accordance with the EPSDT Bright Futures Wellness periodicity guidelines.

- Contraception – DOM covers all forms of contraceptives included in the bulletin (oral contraceptives, condoms, diaphragms, foams, gels, patches, rings, injections, tablets, emergency contraceptives and long-acting reversible contraceptives) through the Family Planning Waiver (FPW). DOM covers all forms of contraceptives included in the FPW, except for condoms, for all beneficiaries regardless of category of eligibility (COE).

➢ **Detection of Zika Infection**

- Diagnostic Services – DOM covers all forms of diagnostic testing included in the bulletin (CT scans, MRIs, ultrasounds, blood tests, urine tests and genetic testing) for all beneficiaries, as medically necessary.

➢ **Treatment**

- Targeted Case Management Services – DOM covers targeted case management services for beneficiaries enrolled in certain waivers, the Perinatal High Risk Management/Infant Services System (PHRM/ISS) program, the Early Intervention (EI) Program and through certain MississippiCAN programs.

- Physical Therapy and Related Services – DOM covers medically necessary physical, speech and occupational therapy services for all beneficiaries.

- Prescribed Drugs – DOM covers the drugs specifically mentioned in the bulletin, for all beneficiaries.

- Long-Term Services and Supports – DOM covers medically necessary long-term rehabilitative services for all beneficiaries in institutional care and covers additional home and community-based services (HCBS) through EPSDT benefits and the five HCBS waivers, Assisted Living (AL), Elderly and Disabled (E&D), Intellectual Disabilities/Developmental Disabilities (ID/DD), Independent Living (IL), Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI).

Mississippi Division of Medicaid Diabetes Self-Management Training (DSMT)

Effective April 1, 2015, the Division of Medicaid (DOM) began reimbursing for Diabetes Self-Management Training (DSMT). DOM defines DSMT as an interactive and collaborative process through which beneficiaries with diabetes gain the knowledge and skills needed to modify their behavior and self-manage the disease and its related conditions.

DOM does not enroll a provider for the sole purpose of performing DSMT because DSMT is not a separately recognized provider type. Providers seeking reimbursement for DSMT must meet all of the required criteria set forth in Miss. Admin. Code Part 200, Rule 4.8 in addition to being:

- A current Mississippi Medicaid provider,
- Located in the state of Mississippi, and
- Accredited by the American Diabetes Association (ADA) or the American Association of Diabetes Educators (AADE).

DOM covers DSMT when medically necessary, ordered by a physician, physician assistant, or nurse practitioner who is actively managing the beneficiary's diabetes who has received prior authorization by the Utilization Management/ Quality Improvement Organization (UM/QIO), DOM or a designated entity when all the following criteria are met:

- The beneficiary has been diagnosed with diabetes by a physician,
- The services are provided under the direct supervision of a physician, physician assistant, nurse practitioner, pharmacist or a registered nurse certified as a diabetes educator, and
- The program meets the current ADA training standards.

A Plan of Care is required for DSMT and must include, but is not limited to:

- An assessment of the beneficiary's specific needs for training,
- Identification of the beneficiary's specific diabetes self-management goals,
- Behavioral interventions directed toward helping the beneficiary achieve identified self- management goals, and
- Evaluation of the beneficiary's progress toward identified self-management goals.

DOM covers a total of seven (7) hours of DSMT. One (1) hour is covered for an individual session to assess the beneficiary's training needs and six (6) hours are covered for group sessions consisting of two (2) or more individuals (not all of whom have to be Medicaid beneficiaries) unless the ordering physician determines a beneficiary would benefit from individual sessions instead of group sessions. The physician's order must include a statement specifying DSMT training in individual sessions along with an explanation.

The training must be furnished in increments of no less than one-half hour and be completed within a continuous six-month period which begins with the initial assessment session. DSMT initial training is a one-time benefit for beneficiaries. Providers are encouraged to verify that the beneficiary has not received DSMT at another facility. Two (2) hours of follow-up training is covered each year when ordered by the physician actively managing the beneficiary's diabetes. The follow-up training must not be initiated until at least 12 months following the completion of the initial training and must be prior authorized. The provider must document the specific medical condition that the follow up training is to address in both the referral for training and in the beneficiary's medical record.

Beneficiaries under the age of eighteen (18) must be accompanied by a parent/guardian/legal representative.

Individual sessions should be billed with HCPCS code G0108 and the group sessions should be billed with G0109. DOM's current reimbursement for G0108 is $45.05/unit and $12.13/ unit for G0109. For Rural Health Clinic (RHC), Federally Qualified Health Center (FQHC), and the Mississippi State Department of Health (MSDH) providers, Diabetes Self-Management Training is included in the encounter rate for the core service. An encounter cannot be paid solely for DSMT.

If your program is not currently Diabetes Self-Management Education (DSME) certified you may obtain additional help and information through the MSDH Diabetes Prevention and Control Program. Additional questions may be addressed by reviewing the various resources listed below or by calling the numbers are the bottom of this page.

Link to DSMT accredited Mississippi programs: http://diabetescoalition-ms.org/accredited-dsmt-programs/

Link to the MS Division of Medicaid Administrative Code Title 23: Part 200, Chapter 5, Rule 5.6: https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-200.pdf

Link to the MS Division of Medicaid Fee Schedule: ms-medicaid.com/msenvision/AMA_ADA_licenseAgreement.do?strUrl=downloadableFeeSchedule

Link to Mississippi Division of Medicaid coverage sheet: http://diabetescoalition-ms.org/wp-content/uploads/sites/31/2015/05/DSMT-Medicaid-Coverage-fact-sheet-pdf.pdf

Fee for Service	
Prior Authorization:	(866) 740-2221 (601) 352-6353
Questions:	(800) 421-2408
DSMT Provider Manual	**http://ms.eqhs.org/Portals/10/DSMT%20Provider%20Manual%20Final%2025.18.16.pdf**
MississippiCAN	
UnitedHealthcare Community Plan:	(877) 743-8731
Magnolia Health:	(866) 912-6285 (601) 863-0700
http://www.magnoliahealthplan.com/for-providers/important-notifications/	

Submission of Medicare Part C Claims on the Mississippi Envision Web Portal is Now Available!

The Mississippi Envision Web Portal has now been updated to allow providers to submit Part C claims electronically. When entering claims via the Web Portal, providers will not only have the options to submit CMS 1500 and UB-04 claims, but will also have the option to submit "Medicare Part C Institutional" or "Medicare Part C Professional" claims. If entered correctly, these claims should suspend for review of the Explanation of Medicare Benefits (EOMB), edit 0610. ***NOTE: The EOMB must be uploaded and attached to the claim during the submission process***. Please allow up to 30 days to have the claim reviewed and released for payment or denial.

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

Hospice Providers Update

DOM's fiscal Agent, Xerox, has successfully updated the Medicaid MMIS claims processing system to process payment for Routine Home Care (Revenue 0651) level of Hospice services, as required by CMS's methodology change. As of July 1, 2016, current Hospice claim payments should reflect the Tier-1 (T1) and Tier-2 (T2) Routine Home Care Rates. The (T1) higher rate is for the first 60 days of services and the lower rate (T2) is for days 61 and thereafter. Payment of the Service Intensity Add-on (SIA) rate for the last seven (7) days of life, which meet the registered nurse or social worker requirements, will not be paid until the following additional information is provided.

Reimbursement for the SIA component will require providers to identify on their claim when Registered Nurse (RN) or Social Worker (SW) services are provided. For RN services, providers will use 0559 Revenue Code and G0299 Procedure Code, along with the number of units provided. For this combination, one (1) unit is fifteen (15) minutes. For SW services, providers will use 0561 Revenue Code and G0155 Procedure Code for clinical social work services. For non-clinical social work services, Providers will use 0569 Revenue Code and G0155 Procedure Code, along with the number of units provided. These combinations will also be calculated as one (1) unit per fifteen (15) minutes.

In August, DOM anticipates a mass adjustment to re-process prior claims for dates of service January 1, 2016, through June 30, 2016 (start of the new methodology processing). The mass adjustment will correctly adjust those claims that were incorrectly paid at the higher "T1" rate for day 61 and after instead of the lower "T2" rate. In most cases, this will result in a recoupment of funds due Medicaid ranging from $34.55 to $37.28, per day, per beneficiary, depending on the county in which services were provided. Providers will need to resubmit SIA claims with the required additional coding in order to be reimbursed the SIA rate for beneficiaries that expired and had the pre-requisite services during the last seven (7) days of life.

DOM appreciates your patience during this process, and we apologize for the inconvenience.

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

Long Acting Reversible Contraceptives Inpatient Reimbursement

Effective July 1, 2016, Mississippi Division of Medicaid will begin reimbursing hospitals outside of the All Patient Refined-Diagnosis Related Groups methodology (APR-DRG), for insertion of Long Acting Reversible Contraceptive (LARC) devices when the device is placed prior to discharge from a postpartum inpatient stay. To receive reimbursement, the hospital may submit a separate outpatient claim for the device and insertion listing only the correct Current Procedural Terminology (CPT) and/or Healthcare Common Procedural Coding System (HCPCS) code and National Drug Code (NDC). Reimbursement will be at the current outpatient prospective payment system (OPPS) rates for the date of service. All other services provided by the hospital must be billed on the inpatient claim and reimbursed at the appropriate APR-DRG rate.

LARCs inserted in an outpatient hospital or physician setting, will continue to receive reimbursement under applicable reimbursement methodologies, when billed using the correct CPT and/or HCPCS code and NDC.

Inpatient LARC placement postpartum (supplied by HOSPITAL and prior to discharge)

- The hospital may submit an outpatient claim for LARC devices placed during the postpartum inpatient stay, listing only the date of the insertion as the date of service.
- The claim should include only the LARC device and insertion billed under the applicable Revenue code(s) with the appropriate device CPT and/or HCPCS code and the NDC for the product supplied.
- Reimbursement for LARCs will be at the current outpatient prospective payment system (OPPS) rates for the date of service.
- All other services provided by the hospital must be billed on the inpatient claim and reimbursed at the appropriate APR-DRG rate.
- Any professional claims submitted should not duplicatively include a LARC device.
- Inpatient LARC placement postpartum (supplied by PHYSICIAN and prior to discharge)
- The hospital will not be reimbursed for the LARC device when it is provided by the physician during the postpartum inpatient stay.
- All other services provided by the hospital must be billed on the inpatient hospital claim and reimbursement will be calculated at the appropriate APR-DRG rate.
- The physician will submit a CMS1500 professional claim for services provided and include the appropriate device HCPCS code, and the NDC for the product supplied.
- Reimbursement for the LARC will be the physician fee for the date of service billed.

Outpatient LARC placement (supplied by the HOSPITAL)

- The hospital may submit an outpatient claim for all services provided and include the LARC device billed under the appropriate Revenue code(s) with the appropriate device CPT and/or HCPCS code and the NDC for the product supplied.
- Reimbursement for LARCs will be at the current outpatient prospective payment system (OPPS) rates for the date of service.
- Any professional claims submitted should not duplicatively include a LARC device.
- Outpatient LARC placement (supplied by the PHYSICIAN)
- The hospital will not be reimbursed for the LARC device when it is provided by the physician.
- All other services provided by the hospital must be billed on the outpatient hospital claim and will be reimbursed at the outpatient hospital rate for the date of service billed.
- The physician will submit a CMS-1500 professional claim for services provided and include the appropriate device HCPCS code and the NDC for the product supplied.
- Reimbursement for the LARC will be the physician fee for the date of service billed.

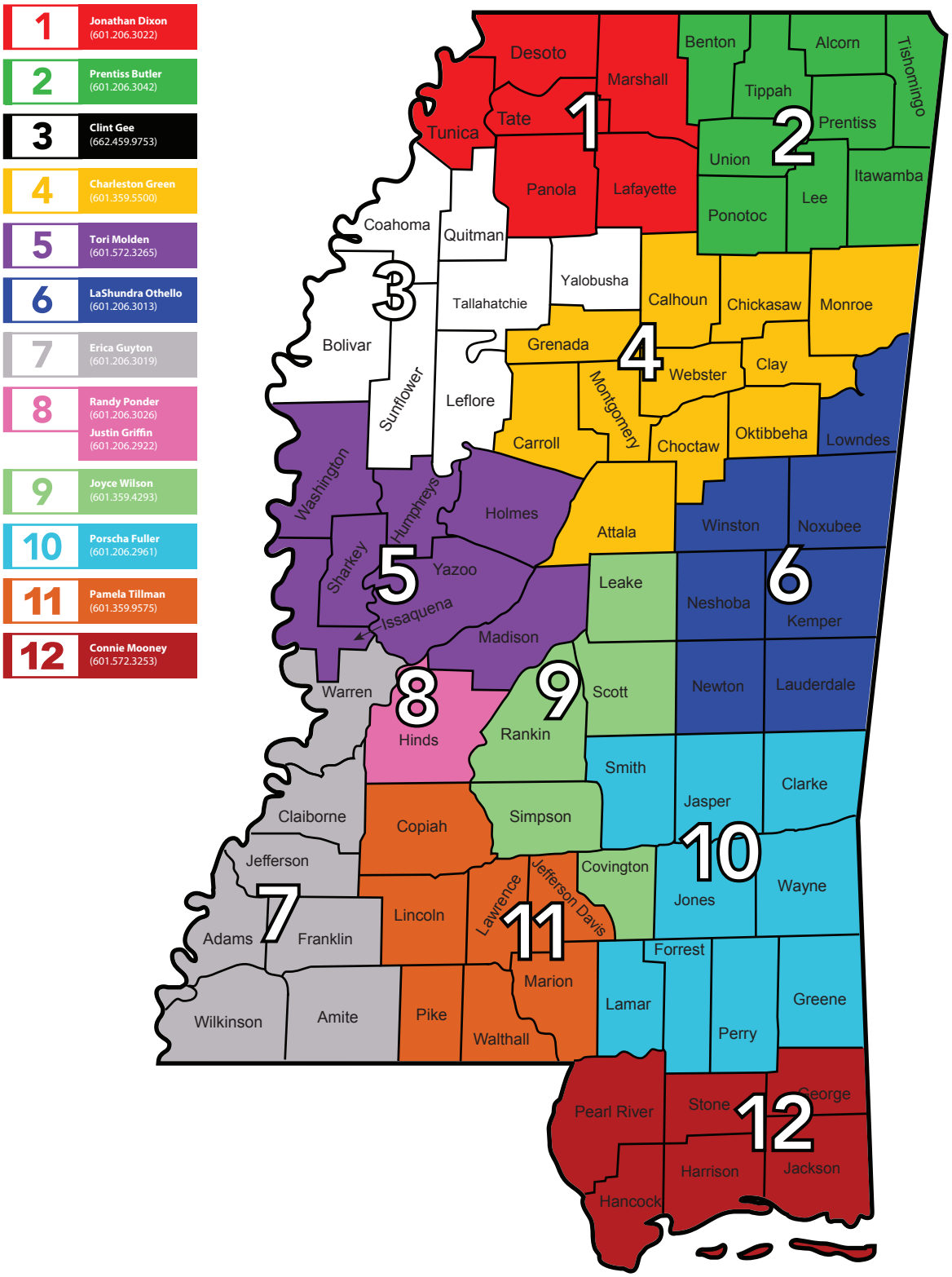
The current reimbursement rates are in the chart below:

Code	Description	Physician Fee	Outpatient Hospital
J7297	Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3 year duration	$750.00	$750.00
J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration	$972.61	$972.61
J7300	Intrauterine copper contraceptive	$886.80	$886.80
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg	$780.38	$780.38
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	$925.82	$925.82

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 Tillman (601.359.9575)** pamela.tillman@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

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SEPTEMBER 2016

THURS, SEP. 1	EDI Cut Off – 5:00 p.m.
MON, SEP. 5	Labor Day. DOM closed. Checkwrite
THURS, SEP. 8	EDI Cut Off - 5:00 p.m
MON, SEP. 12	Checkwrite;
THURS, SEP. 15	EDI Cut Off - 5:00 p.m.
MON, SEP. 19	Checkwrite
THURS, SEP. 22	EDI Cut Off - 5:00 p.m.
MON, SEP. 26	Checkwrite
THURS, SEP. 29	EDI Cut Off - 5:00 p.m.

OCTOBER 2016

MON, OCT. 3	Checkwrite
THURS, OCT. 6	EDI Cut Off – 5:00 p.m.
MON, OCT. 10	Checkwrite
THURS, OCT. 13	EDI Cut Off – 5:00 p.m.
MON, OCT. 17	Checkwrite
THURS, OCT. 20	EDI Cut Off – 5:00 p.m.
MON, OCT. 24	Checkwrite
THURS, OCT. 27	EDI Cut Off – 5:00 p.m.
MON, OCT. 24	Checkwrite

NOVEMBER 2016

THURS, NOV. 3	EDI Cut Off – 5:00 p.m.
MON, NOV. 7	Checkwrite
THURS, NOV. 10	EDI Cut Off – 5:00 p.m.
FRIDAY . NOV. 11	Veterans Day
MON, NOV. 14	Checkwrite
THURS, NOV. 17	EDI Cut Off – 5:00 p.m
MON, NOV. 21	Checkwrite
THURS, NOV. 24	EDI Cut Off – 5:00 p.m. Thanksgiving
MON, NOV. 28	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.