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MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

Medicaid Innovates with Big Picture in Mind

DR. DAVID DZIELAK
Executive Director
MS Division of Medicaid

Thirteen years ago (in 2003), some foresighted innovators at the University of Mississippi Medical Center (UMMC) began developing a "telemergency" program using telecommunications to enhance access to emergency medicine specialists throughout the state.

Over the following decade, the program gradually expanded its scope to include a host of different telehealth services, from psychiatry to radiology to diabetes monitoring and more. Now other hospitals and providers have adopted the concept as well, and telehealth (or sometimes referred to as telemedicine) is quickly becoming a popular health-care topic across the nation

UMMC did not invent the concept; they were not the first to try it. They did recognize early on the tremendous utility technology presented as a way to stretch and spread the Medical Center's impressive medical expertise across Mississippi, a very rural state, and a state with chronic health disparities and dire access-to-care issues.

As it happens, UMMC is the single largest health-care provider in the state for the Mississippi Division of Medicaid (DOM). Roughly half of the patients served by UMMC are Medicaid beneficiaries. It only makes sense that DOM maintains a close and mutually beneficial relationship with the Medical Center, and it is that relationship – and others like it – that have helped position DOM as more than simply a payer of claims, but also an innovative driver of health policy dedicated to improving the health of Mississippians.

Telehealth, which DOM defines as a component of the umbrella term telemedicine, uses an audio/visual connection to allow a provider in one part of the state (or country) to consult on a patient's case in another location. Because of our rural nature, Mississippi is the perfect incubator for such a program. Telehealth allows patients to benefit from medical expertise in real time and without unnecessary travel.

Last year, DOM began to reimburse health-care providers for telehealth and became the first Medicaid program in the country to have a separately reimbursable State Plan for telehealth services, giving DOM the ability to reimburse both the rural hospital caregiver, as well as the provider on the other end.

Not only does this enhance the access our beneficiaries have to specialties they need, but our reimbursement model incentivizes providers, such as UMMC, to keep expanding their services. It saves costs and paves the way for partnerships to analyze and hopefully improve health outcomes.

Earlier in 2016, DOM entered into a different kind of partnership with UMMC and became the first agency of its kind to exchange beneficiary claims data with a health system. DOM's health-care

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data analysis vendor MedeAnalytics, created a portal which UMMC's Electronic Health Record (EHR) system, Epic, can access for clinical information such as a patient's medications and allergies. Having that information at their fingertips will help providers make better treatment decisions faster, preventing unnecessary tests and ultimately saving money for the state.

The creation of that portal, which can be applied to almost any electronic medical records system used in the state, represents a fundamental information exchange that we want to replicate on a larger scale.

The opportunities for Mississippi to see widespread benefits through the concept of population health are unlike any other state in the country. Simply put, we have perhaps the most unique population in terms of health, education, poverty and demographics.

In order to have a real impact on the health of our beneficiaries, we have to know their baseline conditions. Up until now, the only information we had access to is our beneficiaries' claims data, which is essentially the billable services a provider renders and then files for reimbursement. That information does not tell much about the history and health conditions of the patients apart from what one can infer.

If we can use the model built by MedeAnalytics and partner with more health-care providers in Mississippi to safely match claims data with electronic health records data, we can get a very accurate picture of the health status of an individual. Analyzing that data can reveal long-term trends, disease states, treatments and outcomes for different populations around the state, which can then be used to customize the care for our beneficiaries.

This population health project is very early in the works, but it's a priority I am committed to. DOM has a version of this concept already in place with the Delta Health Alliance (DHA).

The Mississippi Delta Medicaid Population Health Demonstration Project plans to use claims data to identify beneficiaries who may be pre-diabetic or at risk for pre-term birth and enlist them in the project.

That data, which has been carefully edited to remove any sensitive data codes within set parameters, will be analyzed and used to introduce clinical interventions to reduce pre-term births and pre-diabetics from developing Type 2 Diabetes. The goal is to reduce both by five percent.

This approach to data-driven treatment and care management not only presents clear benefits for Medicaid beneficiaries, but also advantages for providers and the state as a whole. Applying innovative strategies and maximizing resources prevents unnecessary hospitalizations, manages diseases earlier before they require more intensive treatments, keeps people healthy and contributing to their communities and the economy.

One thing is certain: We cannot maintain the status quo. Maintaining the status quo only gets us further behind. DOM wants to do its part to move the state forward, and with innovations such as these, we hope that our current and future partnerships will help to achieve this goal.

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

CMS Civil Money Pentalty Grants for Nursing Facilities

The Division of Medicaid (DOM) is accepting applications for CMS Civil Money Penalty Grants. There is no longer a deadline for submitting an application. The grant committee meets quarterly to analyze and approve applications for submission to CMS. DOM encourages nursing home providers and other local organizations in our State to submit grant applications that will benefit our nursing facility residents.

To obtain a CMP application with instructions, visit our website at https://medicaid.ms.gov/programs/civil-money-penalty-cmp-grant-awards-program/

Applications must be submitted electronically to CMPGrants@medicaid.ms.gov.

If you have any questions, please contact Phyllis Caudill, Medicaid Program Nurse @ 601-359-9529.

Coming Soon: Provider Re-Validation

42 CFR §455.414 of the Final Rule of the Affordable Care Act (ACA) requires that state Medicaid agencies revalidate the enrollment of all providers at least every five years. The Division of Medicaid is in the process of implementing this requirement.

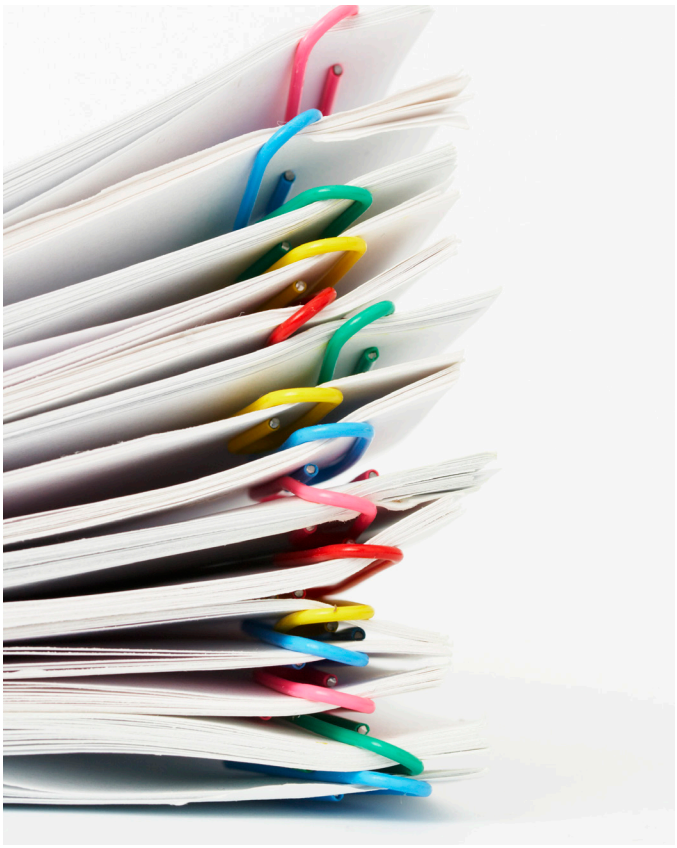
Please watch for upcoming communications on the DOM website and the Envision Web Portal concerning implementation of processes and policies relating to these guidelines. For in-depth details on this CMS Final Rule, please refer to the CMS website at www.cms.hhs.gov.

Allowable Board of Directors Fees for Nursing Facilities, ICF-IID's and PRTF's 2016 Cost Reports

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2016 cost reports filed by nursing facilities (NF's), intermediate care facilities for individuals with intellectual disabilities (ICF-IID's), and psychiatric residential treatment facilities (PRTF's) 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 2016 are as follows:

Category	Maximum Allowable **Cost for 2016**
0 – 99 Beds	$ 4,055
100 – 199 Beds	$ 6,083
200 – 299 Beds	$ 8,110
300 – 499 Beds	$10,138
500 Beds or More	$12,165



Trainings to help providers bill properly for date-bundling services

When the second phase of a new claims processing system took effect in 2015 at the Mississippi Division of Medicaid (DOM), like any complex computer program it had some bugs that needed to be worked out. In this case, the error in the system related to reimbursable outpatient services that qualify for date bundling – grouping together multiple visits to a health-care provider for what is considered a single service, like physical therapy.

However, fixing that glitch in the system is only part of the problem. The other challenge is teaching providers about DOM's policy regarding date bundling to bill their claims correctly, which is why Zeddie Parker, director of Hospital Programs and Services at DOM, and her team aims to provide outreach and training.

On Sept. 1, 2012, DOM changed its payment methodology for outpatient services from a cost-to-charge ratio payment to an Outpatient Prospective Payment System (OPPS) where each claim must be billed with a procedure code associated with it. Under the prior system, a procedure code did not always have to be present in order to receive a payment. OPPS is designed to be a more accurate representation of what specific services are being billed for and paid.

On July 1, 2015, phase two of OPPS implementation went into effect, which included date bundling. Typically, all outpatient services provided by the same hospital to the same beneficiary on the same date, should be billed on the same claim.

"However we are going to allow multiple days for certain things like therapy, because we know that it is going to continue for a span of dates," Parker said. "Physical therapy is an outpatient service, but it is something you would do continuously until you're better, so we allow providers to bill up to 31 days for those types of services that are eligible for date bundling."

After going live last year, it was determined that the system has been denying against single-day claims, which it is not supposed to do. It should deny against span-date claims, which are multiple dates.

Working with the agency's fiscal agent, Xerox, the system has been fixed and the process for a mass adjustment began August 22. Parker has requested that Xerox provide DOM a list of all claims affected by the system between July 1, 2015, and August 22, 2016, for review and approval to proceed with reprocessing these claims. Claims with dates of service beginning August 22 forward are being processed correctly.

Some of those claims that are reprocessed may still be denied, Parker pointed out, because they were not billed correctly by the provider, hence the need for training. Parker worked with the Office of Provider Beneficiary Relations to coordinate training seminars throughout the fall in three regions of the state: Southaven, Gulfport and Jackson.

"I wanted to give providers as much information as possible," she said. "I wanted to define what date bundling is, identify services DOM considers date bundling and how they are recognized. I also wanted to explain how many days you can date bundle these services.

"For instance Medicare allows certain services for date bundling that DOM does not recognize, so we want to make that distinction very clear."

Information, reference guides, and the training presentation are available on the DOM website at https://medicaid.ms.gov/providers/finance/.

2016 Owner Salary Limits for Long-Term Care Facilities

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities as owner's salaries for 2016 are based on 150% of the average salaries paid to non-owner/ administrators that receive payment for services related to patient care. The limits apply to all salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2016 are as follows:

Small Nursing Facilities (1-60 Beds)	$131,882
Large Nursing Facilities (61 + Beds)	$155,873
Intermediate Care Facilities for individuals with intellectual disabilities (ICF-IID)	$155,727
Psychiatric Residential Treatment Facilities (PRTF)	$135,467

Billing Reminders for Nursing Facility and ICF/IID residents

1. Disposable diapers and blue pads were listed as medical supplies to be included in the nursing facility and ICF/IID per diem as of January 2, 2015.

Reference: Administrative Code, Part 207, Chapter 2, Rule 2.6, C.10. for Nursing Facility; Administrative Code, Part 207, Chapter 3, Rule 3.4: C.11. for ICF/IID

2. Individuals residing in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) are exempt from payment of a co-payment. The co-payment exception code of "N" must be indicated on the claim. This exception code applies to facility charges, professional fees, and pharmaceuticals.

Reference: Administrative Code, Part 200, Chapter 3: Beneficiary Information, Rule 3.7: Beneficiary Cost Sharing, C.4. Nursing Facility

If additional information is required, contact the Office of Long Term Care Institutional Division at 601-359-4161.

Submission of Consent Forms for Beneficiaries

As of December 1, 2015, MississippiCAN, Medicaid's Managed Care Program is responsible for both, inpatient and professional service payments. It is imperative that providers verify the beneficiary's eligibility before submitting consent forms to verify whether the beneficiary is enrolled in MississippiCAN or Fee-for-Service Medicaid.

If the beneficiary is enrolled in one of the MississippiCAN Coordinated Care Organizations (CCO), United Healthcare Community Plan or Magnolia Health, providers should follow the guidelines of the CCO for submitting consent forms as they will be responsible for payment of the services. No consent form should be sent to Xerox for beneficiaries that are enrolled in the MississippiCAN.

If the beneficiary is enrolled in Fee-for-Service (traditional) Medicaid, providers should continue to fax all consent forms to Xerox Medical Review at 1-888-495-8169.

Certain physicians must self-attest to continue to receive higher reimbursement rates

Primary care physicians (PCP), obstetricians and gynecologists enrolled as Mississippi Medicaid providers are eligible for higher payments for certain services. In order for Providers to receive those enhanced reimbursements they must complete the required forms attesting that they qualify as specialists in those fields.

The Mississippi Division of Medicaid (DOM) will continue to reimburse at 100 percent of the Medicare Physician Fee Schedule for certain services provided by physicians who self-attest as having a primary specialty designation of family medicine, pediatric medicine or internal medicine as long as authorized by state law, formerly authorized by 42 C.F.R. § 447.400(a).

In addition to primary care physicians, effective July 1, 2016, and as long as authorized by state law, DOM will reimburse at 100 percent of the Medicare Physician Fee Schedule for certain services provided by obstetricians and gynecologists (OB/GYNs) with a primary specialty/subspecialty designation in obstetric/gynecologic medicine who attest to one of the following:

1. Physician is board certified by the American Congress of Obstetricians and Gynecologists (ACOG) as a specialist or subspecialist in obstetric/gynecologic medicine, or

2. Physician with a primary specialty/subspecialty designation in obstetric/gynecologic medicine and has furnished the evaluation and management services and vaccines administration services listed below that equal at least 60 percent of the Medicaid codes they have billed during the most recently completed calendar year but does not have an ACOG certification, or

3. Physician, newly enrolled as a Medicaid provider, with a primary specialty/subspecialty designation in obstetric/gynecologic medicine and attests that the evaluation and management services and vaccines administration services listed below will equal at least 60 percent of the Medicaid codes they will bill during the attestation period, or

4. Non-physician practitioner providing primary care services in a Practice Agreement with a qualified physician enrolled for increased primary care services.

To receive the increased payment, eligible providers must send a completed and signed PCP Self-Attestation or OB/GYN PCP Self-Attestation form to Xerox Provider Enrollment through one of the following means:

Email: msinquiries@xerox.com
Fax: 888-495-8169
Postal mail: Xerox Provider Enrollment, P. O. Box 23078, Jackson, MS 39225

Providers will be eligible to receive the increased payment effective the day the form is processed by Xerox.

The PCP Self-Attestation Statement forms are located on the DOM website at http://medicaid.ms.gov and the Envision Web Portal at http://ms-medicaid.com. The form can also be requested by calling the Xerox Call Center toll-free at 800-884-3222.

For additional information regarding the increased payment opportunity, please contact the Office of Medical Services by phone at 601-359-6150.

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 DOM EPDST providers adhere to the American Academy of Pediatrics 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 Bright Futures periodicity schedule for dates of service on and after November 01, 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 Early and Periodic Screening, Diagnosis and Treatment (EPSDT), 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 (601) 359-6150.

DOM does not enroll providers in the VFC Program. To enroll in the VFC program, please contact the Mississippi Department of Health Immunizations at 1-601-576-7751.

Xerox Business Process Services to become Conduent

Xerox, the current fiscal agent of the Mississippi Division of Medicaid (DOM), earlier this year announced its plan to separate into two independent, publicly-traded companies. Once separated, Xerox will focus exclusively on its Document Technology and Document Outsourcing businesses, and the company will retain the brand name Xerox. The operations related to DOM and its current business process outsourcing component will be launched under the brand name Conduent Inc. in early 2017.

DOM contracts with a fiscal agent to provide the technical infrastructure for agency business operations that are too complex to be maintained in-house, such as processing provider claims, claims reimbursement, provider credentialing and enrollment. DOM's contractual relationship with Xerox began in 2005, and its current five-year contract with Xerox is set to expire in 2020.

If confirmed, DOM's contractual relationship will shift to Conduent in January 2017. While Xerox has assured DOM of a seamless transition which will not impact business operations, Medicaid beneficiaries, and especially enrolled providers, need to be aware of this important change.

DOM's fiscal agent is also responsible for mailing important notifications to providers and beneficiaries. Consequently, it is essential for Medicaid enrolled providers, beneficiaries, and related groups to know that correspondence bearing the name Conduent may be Medicaid related effective January 1, 2017.

DOM will make every effort to inform all providers and beneficiaries before the transition takes place. In order to stay informed about Medicaid news and notices, enrolled providers and beneficiaries must open and read mail sent from DOM, Xerox or Conduent.

According to a news release issued by Xerox's corporate office, Xerox expects Conduent to be separated by the end of 2016, pending "final approval by Xerox's board of directors, among other conditions." The company says the separation is intended to simplify Xerox's organizational structure and resources, while placing Conduent in a position to grow its business process services opportunities.

CONDUENT

For more information about Conduent, visit http://conduent.com.

PHARMACY NEWS

Preferred Drug List (PDL) Update, January 1, 2017

The Division of Medicaid's (DOM) Universal Preferred Drug List (PDL) undergoes an annual review each October. The revisions brought about by this annual review will become effective the following January 1st. The Universal PDL is effective for Medicaid fee for service, MSCAN and CHIP beneficiaries. To access the current PDL, go to https://medicaid.ms.gov/providers/pharmacy/preferred-drug-list/ and select the MS Current PDL.

Pharmacies are encouraged to pay attention to changes which could impact their current inventory. Such changes occurring in January include, but are not limited to PDL brand/generic switches for:

- Diovan/valsartan
- Exforge/valsartan/amlodipine
- Lovenox/Enoxaparin
- Imitrex/sumatriptan nasal
- Colchicine/Mitigare
- Adderall XR/amphetamine salt combination ER
- Methylphenidate ER (generic Concerta; labelers 00591, 62175 & 68084 –all preferred)

Pharmacy Reimbursement

The Division of Medicaid hosted five Pharmacy Stakeholder Meetings in 2016 for the purpose of collaborating with stakeholders to revise reimbursement to comply with the CMS final rule which implements provisions of the Patient Protection and Affordable Care Act of 2010 pertaining to Medicaid reimbursement for covered outpatient drugs (CODs). This final rule also revises other requirements related to CODs, including key aspects of their Medicaid coverage and payment and the Medicaid drug rebate program. Reimbursement changes must be implemented no later than April 1, 2017.

Reminder to pharmacies

Pharmacy point of sale claims for beneficiaries enrolled in the MississippiCAN plans (Magnolia and United Healthcare) shall be paid at a rate no less than; the lower of the provider's submitted charge or the Medicaid fee-for-service allowed charge.

Use of Multiple Antipsychotics in Children

Over the last two decades, the use of antipsychotic medications among children has significantly increased nationwide, particularly for children in foster care.

The Centers for Medicare & Medicaid Services (CMS) and states are working together to ensure access to a high quality system of coverage and care for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP).

For the 2016 Child Core Set update, CMS added the following measure to help improve the appropriate utilization of antipsychotic drugs in children:

- Use of Multiple Concurrent Antipsychotics in Children and Adolescents

Providers prescribing multiple antipsychotics for periods exceeding 90 days will need to complete a prior authorization (PA) request. This PA form was developed in collaboration with input from psychiatrists, pediatricians, and pharmacists.

A copy of the manual PA form, "Multiple Antipsychotics for Patients Less Than Age 18 Years (Typical and Atypical Antipsychotics, Preferred and Non-Preferred Medications), is available on DOM's Pharmacy Prior Authorization website at https://medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/.

1. CMCS Informational Bulletin, Dec 11, 2015: 2016 Updates to the Child and Adult Core Health Care Quality Measurements Sets. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-12-11-15.pdf

New Pharmacy Prior Authorization Vendor

Effective October 1, 2016 the Office of Pharmacy's prior authorization unit for fee-for-service beneficiaries moved from the University of Mississippi Medical Center Pharmacy to Change Healthcare Pharmacy Solutions (formerly Goold Health Systems). Prescribers should continue using the same contact information to submit prior authorization requests:

Prior Authorization toll-free phone: 877-537-0722
Prior Authorization fax : 877-537-0720

Prescribers should complete the registration process at http://msmedicaidrxportal.com before submitting pharmacy prior authorization requests electronically.

CDC Guidelines and Division of Medicaid Guidance: Recommendations for opioid prescribing for chronic pain

The state of Mississippi has one of the nation's highest rates of opioid prescriptions, with 1.2 opioid prescriptions for every citizen in 2012. Hydrocodone is the most commonly prescribed opioid in Mississippi, with 145,846 prescriptions and 8,343,259 dosage units dispensed for the month of July 2016.

Nationwide, over the past two decades, a marked increase in the use of opioid pain relievers has resulted in an explosion of opioid dependency and overdose deaths, and has led to an epidemic of heroin addiction. Since 1999, opioid prescriptions have increased fourfold, and from 1999 to 2014, 165,000 Americans have died from overdoses of prescription pain-killers.1

Due to the serious consequences of long-term opioid use, in March 2016 the Centers for Diseases Control and Prevention (CDC) released their final version of their "Guideline for Prescribing Opioids for the Management of Chronic Pain."2 Several of the CDC recommendations are below:

CDC recommendation 1: When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release (IR) opioids instead of extended-release/long-acting (ER/LA) opioids.

CDC recommendation 2: When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians must use caution when prescribing opioids at any dosage, carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day.

Daily morphine milligram equivalents are used to assess comparative potency of opioid products, but not to convert a particular opioid dosage from one product to another. The terminology for daily morphine equivalency may vary depending on the resource used, and may be described as morphine equivalent daily dose (MEDD), morphine equivalent dose (MED), or morphine milligram equivalents (MME). By converting the dose of an opioid to a morphine equivalent dose, a clinician can determine whether a cumulative daily dose of opioids approaches an amount associated with increased risk.

CDC recommendation 3: Before starting, and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate strategies to mitigate risk into the management plan, including the consideration to offer naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.

CDC recommendation 4: Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids, and prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less is often sufficient; more than seven days is rarely needed.

CDC recommendation 5: Providers should avoid prescribing opioid pain medication for patients receiving benzodiazepines whenever possible. According to CDC guidelines, experts agreed that although there are circumstances when it might be appropriate to prescribe opioids to a patient receiving benzodiazepines (e.g., severe acute pain in a patient taking long-term, stable low-dose benzodiazepine therapy), clinicians should

avoid prescribing opioids and benzodiazepines concurrently whenever possible.

The Mississippi Division of Medicaid (DOM)'s Drug Utilization Review (DUR) Board, comprised of twelve Medicaid providers including physicians, nurse practitioners and pharmacists statewide, has recommended several quality improvement initiatives addressing the use of opioids for the treatment of chronic pain following many of CDC guidelines recommendations.

DUR quality improvement initiatives for opioid prescribing:

1. New narcotic prescription (first narcotic fill within 90 days) for non-cancer patients should be for immediate release (IR) /short-acting (SA) opioids.

   For non-cancer patients, individual prescriptions for opioids with a MEDD of ≥ 90 must require a manual PA with documentation that the benefits outweigh the risks.

2. The Office of Pharmacy, with approval from DOM's Pharmacy and Therapeutics committee, has added the category of "Opiate Dependence Treatments" to the Universal Preferred Drug List (PDL). Naloxone injection and Narcan (naloxone) Nasal Spray® are preferred drugs on the PDL.

3. For non-cancer patients, new starts for IR/SA opioids can be approved through an electronic PA for a maximum of two 7-day supplies. Use of IR/SA opioids for longer periods will require a manual PA.

4. New starts regarding concomitant use of opioids and benzodiazepines require a manual PA. MS-DUR will provide an educational mailing to providers prescribing concurrent use of benzodiazepines and opioids to inform them of the increased safety risks and highlight the CDC recommendation to avoid concomitant use.

<u>Recommendations for Mississippi Medicaid providers when prescribing opioids</u>

- Several non-opioid pharmacologic therapies (including acetaminophen, NSAIDs, and selected antidepressants and anticonvulsants) are effective for chronic pain and we encourage you to consider these options first. For patients being prescribed opioids, please prescribe or titrate to lowest effective doses whenever possible.

- Before prescribing opioids, check your patient's information in the Mississippi Prescription Monitoring Program to be sure the patient is not "doctor shopping", not already taking opioids prescribed by another provider, and/or currently being treated for opioid dependence.

  - Mississippi Board of Pharmacy http://www.mbp.state.ms.us/mbop/pharmacy.nsf/webpages/PMDB_PMDB?OpenDocument)

- Monitor MEDD when writing opioid prescriptions. Online calculators are available to estimate MEDD.

  - CDC Injury Prevention and Control: Opioid Overdose https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

  - The Surgeon General's Call to End the Opioid Crisis Report - http://turnthetiderx.org/#

  - Interstate Postgraduate Medical Association http://www.ipmameded.org/media/1403/cdc-mme-chart.pdf

  - Prescription Drug Monitoring Program: Training and Technical Assistance Center http://www.pdmpassist.org/pdf/bja_performance_measure_aid_mme_conversion_tool.pdf (available upon request)

  - Agency Medical Director's Group: Opioid Calculator http://www.agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm

- When an MEDD above 50 is needed, implement additional precautions, including increased frequency of follow-up and consider offering naloxone and overdose prevention education to both patients and the patients' household members.

- Maintain awareness of the risks of opioid usage for chronic pain and have an open dialogue with patients, especially in certain special populations (older adults and pregnant women), and patients with conditions posing special risks (history of substance abuse).

- Evaluate the opportunity for addiction treatment anytime a patient experiences an opioid overdose and has to be rescued.

1. Mississippi State Dept. of Health Mississippi Morbidity Report Vol 32, Number 2. Aug 2016.

2. CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016 Recommendations and Reports / MMWR March 18, 2016 / 65(1);1–49. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

DOM clinical guidelines and recommended changes for buprenorphine/naloxone therapy

Increased use of medication assisted treatment (MAT) for opioid use disorders is an integral component of addressing opioid addiction. Existing evidence shows that MAT is under-utilized.

- MAT is the use of medications in combination with counseling and behavioral therapies to provide a comprehensive patient approach to the treatment of substance use disorders, including opioid use disorders.

- Currently, there are four MAT medications approved by the FDA for the treatment of opioid dependence: methadone, buprenorphine, buprenorphine/naloxone, and naltrexone.

- Buprenorphine-based MAT is governed by the Controlled Substances Act (CSA), as amended by the Drug Addiction Treatment Act of 2000 (DATA 2000). Pursuant to DATA 2000 and recent amendments, practitioners may obtain a waiver to prescribe buprenorphine for treatment of opioid use disorder. Initially, they may treat up to 30 patients at a time. After one year, they may file a request to treat up to 100 patients at a time, and after an additional year they can request to treat up to 275 patients at a time.

- In September 2012, DOM implemented criteria through electronic prior authorization (PA) and the pharmacy point-of-sale (POS) systems for managing use of buprenorphine/naloxone. In March 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final ruling on how the Mental Health Parity and Addiction Equity Act of 2008 applied to Medicaid programs. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-03-29.html

In consideration of CMS' final ruling described above, DOM's DUR Board recommended the following criteria for use of buprenorphine/naloxone and buprenorphine in the treatment of opioid dependence. These criteria apply to DOM's regular fee-for-service beneficiaries, as well as Magnolia Health™ and UnitedHealthcare® beneficiaries requiring buprenorphine/naloxone or buprenorphine "MAT" prescriptions for the treatment of opioid dependence.

Buprenorphine/naloxone (Suboxone®) and buprenorphine (Subutex®)

Criteria for the treatment of opioid dependence

- Appropriate Diagnosis – unchanged
- Length of Coverage – the 24-month maximum length of coverage and limits on restarts should be removed.
- Step Therapy With Maximum Daily Doses – change to:
  - Induction and stabilization phase – maximum daily dose of 24 mg/day for up to 2 months
  - Maintenance phase -- maximum daily dose of 16 mg/day
- Opioid Use Restriction – unchanged

A summary of details for DOM's coverage of buprenorphine/naloxone and buprenorphine therapy and other background information can be accessed at:

- Mississippi Division of Medicaid Pharmacy Resources Page– https://medicaid.ms.gov/providers/pharmacy/pharmacy-resources/select Specific Drugs - Buprenorphine/Naloxone and Buprenorphine coverage summary for providers

- ASPE Issue Brief: Opioid Abuse in the U.S. and HHS Actions to Address Opioid-Drug Related Overdoses and Deaths https://aspe.hhs.gov/sites/default/files/pdf/107956/ib_OpioidInitiative.pdf

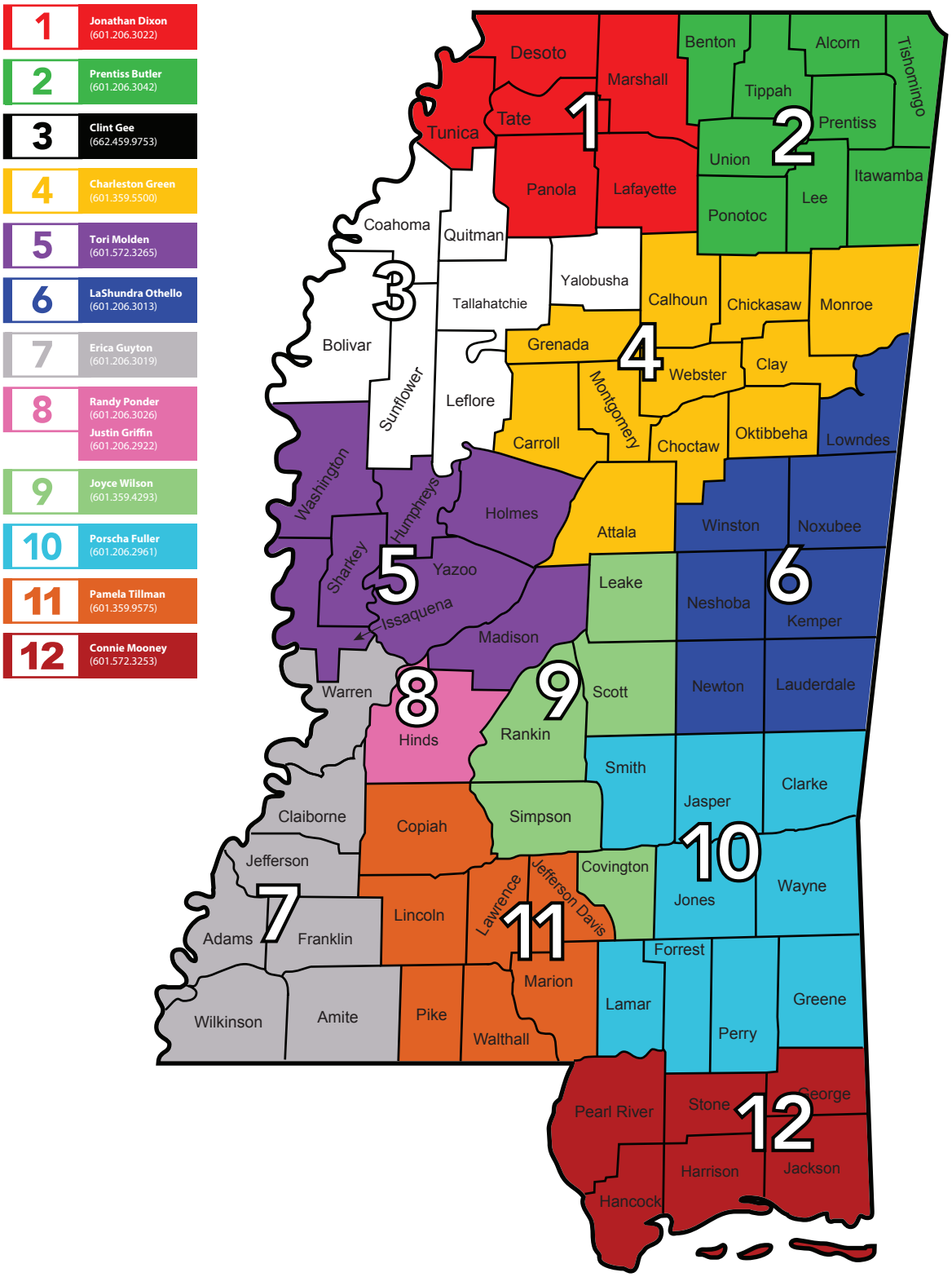
- CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016. http://www.cdc.gov/media/modules/dpk/2016/dpk-pod/rr6501e1er-ebook.pdf

- Food and Drug Administration. Fact Sheet – FDA Opioids Action Plan. http://www.fda.gov/NewsEvents/Newsroom/FactSheets/ucm484714.htm

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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DECEMBER 2016

THURS, DEC. 1	EDI Cut Off – 5:00 p.m.
MON, DEC. 5	Checkwrite
THURS, DEC. 8	EDI Cut Off - 5:00 p.m
MON, DEC. 12	Checkwrite;
THURS, DEC. 15	EDI Cut Off - 5:00 p.m.
MON, DEC. 19	Checkwrite
THURS, DEC. 22	EDI Cut Off - 5:00 p.m.
SUNDAY, DEC. 25	Christmas; DOM closed.
MON, DEC. 26	Checkwrite; DOM closed
THURS, DEC. 29	EDI Cut Off - 5:00 p.m.

JANUARY 2017

MON, JAN. 2	Checkwrite; DOM closed
THURS, JAN. 5	EDI Cut Off – 5:00 p.m.
MON, JAN. 9	Checkwrite
THURS, JAN. 12	EDI Cut Off – 5:00 p.m.
MON, JAN. 16	Checkwrite; Martin Luther King Day; DOM closed
THURS, JAN. 19	EDI Cut Off – 5:00 p.m.
MON, JAN. 23	Checkwrite
THURS, JAN. 26	EDI Cut Off – 5:00 p.m.
MON, JAN. 30	Checkwrite

FEBRUARY 2017

THURS, FEB. 2	EDI Cut Off – 5:00 p.m.
MON, FEB. 6	Checkwrite
THURS, FEB. 9	EDI Cut Off – 5:00 p.m.
MON, FEB. 13	Checkwrite
THURS, FEB. 16	EDI Cut Off – 5:00 p.m
MON, FEB. 20	Checkwrite; Presidents Day; DOM closed
THURS, FEB. 23	EDI Cut Off – 5:00 p.m.
MON, FEB. 27	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.