Volume 24, Issue 2 June 2018

MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

Managed Care Implementation, CHIP Procurement Key Concerns in 2018

DREW L. SNYDER
Executive Director
MS Division of Medicaid

The Mississippi Division of Medicaid (DOM) has seen a busy but productive few months, working closely with our elected officials in the Mississippi Legislature to chart a course for the next fiscal year. We also have been working closely with the Medical Care Advisory Committee, whose members help to shape policies to improve beneficiary outcomes and enhance the health-care system in Mississippi.

Now as we look ahead to the second half of the year, DOM has a number of key developments that will require substantial effort and concentration on the part of the agency. Two of the most visible will be the implementation of our new managed care contracts and the procurement of the Children's Health Insurance Program (CHIP) contracts.

Last year, DOM successfully procured new contracts for its managed care program, MississippiCAN, and announced that the new contracts would be awarded to Magnolia Health, Molina Health, and UnitedHealthcare Community Plan. We usually refer to these as coordinated care organizations (CCOs).

The contracts were submitted to the Centers for Medicare and Medicaid Services (CMS) in the fall, and the painstaking legwork for the actual implementation of the new contracts got underway.

The first major deadline this year is on June 30, 2018, when the three CCOs were required to complete their Readiness Reviews. CMS requires this to be finished at least three months before the "go-live" date. Next, an open enrollment period will be held this summer from July 1 – August 31, during which beneficiaries will make their choice of which plan they want to enroll with for the upcoming year.

The go-live date is set for October 1, which will be the first day the CCOs are responsible for beneficiary care under the new contracts.

Between now and October, regular meetings are being held to monitor progress, and a steering committee has been formed of DOM employees to oversee the implementation and make strategic decisions, should issues arise.

CHIP made headlines in January when Congress reauthorized spending for the program after failing to do so before the end of the federal fiscal year last September.

CHIP is a federal program providing health coverage for children in families that do not qualify for Medicaid and do not have other insurance. It was created in 1997 and is administered differently in every state.

In Mississippi, DOM administers the CHIP program, and this summer will reprocure the CHIP contracts.

Now what does that mean exactly?

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DOM has only been administering CHIP since 2013 when the Mississippi Legislature granted us the authority to run the program. Before that it was administered by the Department of Finance and Administration. In the beginning of 2015, the Legislature authorized DOM to operate CHIP through a managed care delivery system.

In managed care, beneficiaries must have an option to choose from at least two health care plans, so bids were accepted for the CHIP contract, and the two current CCOs won the contract.

Because CHIP represents a smaller pool of beneficiaries, only the two companies currently participating in MississippiCAN chose to bid on the original contract.

DOM will re-procure the CHIP contract this year and will also be implementing the new managed care contract, which includes three CCOs instead of two. The new procured CHIP contract will continue to be administered by only two vendors.

The most important aspect of the upcoming procurement is that DOM will have the ability to provide more effective and thorough contract oversight for CHIP. The CHIP services will be more in line with the services provided to children on Medicaid, which is something CMS has encouraged. This is just one more way we are working to improve the Medicaid program and better serve the state.

As always, we will have to adapt to new dynamics in the coming year, but my focus will continue to be delivering quality services to Mississippi providers, beneficiaries and the state as a whole.

DOM's mission is to responsibly provide access to quality health coverage for vulnerable Mississippians. With our partners in the provider community, Medicaid can achieve much more than that. For many low-income Mississippi children, Medicaid helps lay the foundation for a healthy and successful life. In fact, Medicaid covers about 65 percent of all births in Mississippi, and the services we provide to pregnant mothers are resulting in healthier deliveries. For the elderly and disabled, we provide critical services that ensure quality of life for a vulnerable population, strengthening families and the community. These are just a few examples of the kind of difference the Medicaid program and health-care providers make together in the lives of Mississippians.

Thank you for the work you do every day to serve the State of Mississippi. I look forward to strengthening our communication and collaboration in the months to come.

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

HOSPITAL INPATIENT APR-DRG ALERT – July 1, 2018 Updates

The Mississippi Division of Medicaid (DOM) is proposing the following changes to the hospital inpatient APR-DRG payment methodology effective for the payment of hospital inpatient claims for discharges on and after July 1, 2018:

1. DOM will adopt V.35 of the 3M Health Information Systems APR-DRG Grouper and Hospital-Specific Relative Value (HSRV) weights.

2. DOM will update the existing methodology used to assign pediatric and adult policy adjustors which is based on principal diagnosis codes and the age of the beneficiary. The new methodology will use the APR-DRG assigned to the stay and the age of the beneficiary to assign a pediatric or adult Medicaid Care Category (as established by DOM). The Medicaid Care Category will be used to assign a policy adjustor to the inpatient stay.

3. Charge cap: If the sum of the APR-DRG base payment including effects of policy adjustors, APR-DRG cost outlier payment, APR-DRG day outlier payment, and transfer and/or prorated adjustments, if applicable, is more than the total billed charges on the claim, the total APR-DRG payment amount, net of medical education payments, will be limited to the total billed charges.

4. The following APR-DRG parameters will be updated:
   a. Base Payment – will change from $6,415 to $6,585
   b. Neonate policy adjustor – will change from 1.45 to 1.40
   c. DRG Cost Outlier Threshold – will change from $50,000 to $45,000
   d. DRG Cost Outlier Marginal Cost Percentage – will change from 50% to 60%

DOM estimates the overall impact of the above changes will be a savings of $165,620 in state and federal funds.

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, 2018.

Training will be scheduled with dates to be provided. Hospitals will be notified via e-mail and the DOM website www.medicaid.ms.gov.

Attention: Medicaid Working to Address Changes to the Ordering of Medical Supplies, Equipment and Appliances

The Centers for Medicare and Medicaid Services (CMS) has recently required that the Mississippi Division of Medicaid (DOM) update its 2006 state plan language to comport with 42 C.F.R. § 440.70, which explicitly permits only a physician to order medical equipment, supplies and appliances. In May pursuant to the CMS communication, DOM announced that it will no longer cover medical supplies, equipment and appliances ordered by non-physician practitioners effective September 1, 2018.

DOM shares the concerns of providers who believe this interpretation of the C.F.R. poses an additional barrier to needed services and care. The agency is actively working with CMS and other stakeholders to address compliance with 42 C.F.R. § 440.70 while ensuring that non-physician providers continue to serve as a vital access point for patients enrolled in the Mississippi Medicaid program. To that end, DOM is in discussions with the Mississippi Board of Nursing, the Mississippi Nurses Association, the Mississippi State Board of Medical Licensure, and the Mississippi Academy of Physician Assistants on how compliance might be achieved through collaborative agreements and/or standing orders between non-physician providers and physician providers.

For more information regarding the ordering requirements of medical supplies, equipment and appliances, please contact the Office of Medical Services at (601) 359-6150.

Attention: Qualified Providers Need to Attest/Re-attest to Receive Increased Primary Care Services Payments

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers at 100% of the Medicare Physician Fee Schedule for certain primary care Evaluation and Management (E&M) and Vaccine Administration codes. Qualified providers who attest to a specialty designation in family medicine, general internal medicine, obstetric/gynecologic medicine, pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), the American Congress of Obstetricians and Gynecologists (ACOG), and the American Osteopathic Association (AOA) may be eligible for increased payment of certain primary care E&M and Vaccine Administration codes.

Effective July 1, 2018, reimbursement of certain primary care services provided by eligible providers will be 100% of the Medicare Physician Fee Schedule, which is updated July 1 of each year and takes effect January 1. To receive the increased payment for dates of service beginning 7/1/2018, eligible providers must send a completed and signed 7/1/2018 – 6/30/2021 Self-Attestation Statement form to Conduent Provider Enrollment by **6/30/2018** through one of the following means:

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

Providers must notify Conduent of any change(s) to their completed 7/1/2018 – 6/30/2021 Self-Attestation Statement form. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at https://www.ms-medicaid.com/msenvision/.

Additional information can be found on the DOM website (www.medicaid.ms.gov) and Envision Web Portal (www.ms-medicaid.com/msenvision/), including the PCP Self-Attestation General Instructions and the 7/1/2018 – 6/30/2021 Self-Attestation Statement form, or it can be requested by contacting the Conduent Call Center at 800-884-3222.

Attention: Nursing Facilities

Effective January 1, 2018, Respiratory Therapy services will be an allowable cost for nursing facilities, as a result of the Centers for Medicare and Medicaid Services' (CMS) 5/17/18 approval of the Division of Medicaid's State Plan Amendment 18-0001 Long Term Care Updates. Refer to the Administrative Code, Part 207: Institutional Long-Term Care Services, Chapter 2: Nursing Facility, Rule 2.6: Per Diem for this upcoming revision. For more information please call 601-359-6141.

Attention: Nursing Facility Billing

Effective July 1, 2018, in compliance with Miss. Code Ann. § 43-13-117, the maximum number of nursing facility therapeutic/home leave days will be reduced from 52 days to 42 days annually. The following therapeutic/home leave days are in addition to the 42 day limitation: Christmas, the day before and after Christmas, Thanksgiving and the day before and after Thanksgiving. If you have any questions, you may call the Office of Long-Term Care at 601-359-6141.

Attention: Hospice Providers

Effective April 1, 2018, the Mississippi Administrative Code Title 23: Medicaid, Part 205: Hospice prior authorization requirements have been updated. The Administrative Code updates can be reviewed in their entirety at https://medicaid.ms.gov/providers/administrative-code.

Additionally, required hospice forms have been updated and are available at https://medicaid.ms.gov/programs/hospice.

Summary of Changes to Prior Authorization Forms for Hospice Enrollment:

- Election Statement Form 1165-A and Enrollment Form 1165-B have been combined into one form: Election Notice Form 1165 A-B

- Physician Certification/Recertification of Terminal Illness has the following changes:
  - Certification of the terminal illness must be completed by the Hospice Medical Director or the Hospice Interdisciplinary Group (IDG) Physician, and the Attending Physician, if any, within two (2) calendar days of the initiation of hospice care. Recertification of the terminal illness must be completed by the Hospice Medical Director or IDG physician no later than two (2) calendar days after the beginning of that period.
  - Certifications/Recertifications cannot be completed more than fifteen (15) calendar days prior to the start of each benefit period. A nurse practitioner is not allowed to certify or recertify the terminal illness.
  - The certifying physician must complete a brief narrative explanation of the clinical findings that supports a life expectancy of six (6) months or less on the certification/recertification form, or as an attachment to the certification/recertification form.
  - If the narrative exists as an attachment to the certification/recertification form, in addition to the physician's signature on the certification/recertification form, the physician must also sign immediately following the narrative in the attachment.
  - Verbal verification is required within two (2) days of election date.

- Clinical information and other documentation that support the medical prognosis of six (6) months or less must accompany the Certification including, but not limited to,
  - Terminal diagnosis and related diagnoses,
  - Specific clinical findings, prognostic indicators, functional ability scales, symptom management scales, and other pertinent medical documentation,
  - Coordinating national or local coverage determinations, if any,
  - Laboratory reports,
  - Radiology reports, and/or
  - Pathology reports.

Attention: Family Planning Waiver Providers

The Family Planning Waiver (FPW) standard terms and conditions (STCs) approved by the Centers for Medicare and Medicaid (CMS) effective January 1, 2018 through December 31, 2027, requires the Division of Medicaid (DOM) to report clinical breast exams. As defined by the Centers for Disease Control and Prevention (CDC), a clinical breast exam is an examination by a doctor or nurse, who uses his or her hands to feel for lumps or other changes. A clinical breast exam must be performed during the initial and annual FPW visits.

In an effort to distinguish between the initial/annual visits and follow up visits, effective January 1, 2018, DOM will require FPW initial/annual visits be billed with the appropriate preventive medicine code (99384, 99385, 99386, 99394, 99395, or 99396). Follow-up FPW visits should continue to be billed with the appropriate evaluation and management codes (99201-99205 or 99211-99215).

If you have any questions, please contact the Office of Medical Services at (601) 359-6150.

Attention: Elderly & Disabled Waiver Providers

Pursuant to Mississippi Administrative Code, Title 23: Medicaid, Part 200 General Provider Information, Rule 2.2, the Division of Medicaid does not cover services provided by anyone legally responsible for a beneficiary/participant which includes, the following family members: 1) spouse, 2) parent, step-parent or foster parent, 3) child, step-child, grandchild or step-grandchild, 4) grandparent or step-grandparent, 5) sibling or step-sibling, or anyone who resides in the home with the beneficiary regardless of relationship except as specified by the State Plan or a 1915(c) waiver.

Appendix C-2 of the approved Elderly and Disabled Waiver effective July 1, 2017 allows an exception for services provided by family members as follows, "Personal Care Services may be furnished by the family members provided they are not legally responsible for the person and they do not live with the person. Family members must be employed by a Medicaid approved agency that provides Personal Care Services, must meet provider standards, and must be deemed competent to perform the required tasks." If your agency has direct care staff providing services to a participant that they are legally responsible for, or live in the home with, you must remediate the issue immediately to ensure compliance with waiver requirements. This exception is only applicable to personal care services.

The approved waiver can be reviewed in its entirety at https://medicaid.ms.gov/wp-content/uploads/2017/05/ED-Approval.pdf.

Attention: All ID/DD Waiver Providers

As of May 1, 2017, current ID/DD Waiver claim payments should reflect tiered rates for Supervised Living, Home and Community Supports, and In-Home Respite.

Claims submitted without tiered rates for Supervised Living, Home and Community Support, and Respite-In Home services for dates of service on or after May 1, 2017 will need to be voided and resubmitted with additional coding in order to be considered for reimbursement under the current ID/DD Waiver rates.

Claims submitted at a rate less than the published ID/DD Waiver rates in effect May 1, 2017 will need to be voided and resubmitted.

Claims submitted for dates of service on or after May 1, 2017, that were billed at the published rate but reimbursed at the previous lower rate, will be reprocessed and changes in reimbursement will appear on a future remittance advice. No further action on the part of the provider is needed.

The current ID/DD Waiver fee schedule is located on the DOM website at www.medicaid.ms.gov under the 'Provider' section.

If you have questions, please contact the Office of Mental Health at 601-359-9545.

Reporting Lead Levels

As a reminder, please make sure to report all blood lead levels (those that are less than 5µg/dL and those that are above 5 µg/dL) to the Mississippi State Department of Health (MSDH), Lead Poisoning Prevention and Healthy Homes Program (LPPHHP) as required by the MSDH List of Reportable Diseases and Conditions http://www.msdh.state.ms.us/msdhsite/index.cfm/14,877,194,pdf/ReportableDiseases.pdf.

The Report of Lead Levels Form should be used for reporting all blood lead levels to the MSDH LPPHHP and can be obtained here: https://msdh.ms.gov/msdhsite/_static/resources/6612.pdf. This form must be completed in its entirety and faxed to the MSDH LPPHHP at 601-576-7498 on a weekly basis.

If there are questions about the reporting requirement or form, please contact the MSDH LPPHHP at (601) 576-7447.

Medicaid Improper Payments and Fraud for Personal Care Services

Medicaid personal care services (PCS) are valuable and the need for them is growing. However, Medicaid improper payments for PCS, including any payments made for treatments or services that were not covered by program rules, not medically necessary, or billed but never provided, are a major concern and the law mandates their recoupment. The following are common types of improper PCS payments and may constitute fraud:

- Services provided under forged credentials
- Services never rendered
- False claims submitted by an excluded individual
- Services provided by uncertified individuals
- Services delivered to ineligible recipients
- Claims paid without supporting documentation
- Services provided without required supervision
- Services provided by unqualified PCAs or PCAs without verification and documentation of their required qualifications
- Payments made for care provided while a beneficiary was in an institution, such as a hospital (not including payments to a PCA to retain services or during a period in which the individual is receiving covered respite care)
- PCS workers coercing or colluding with beneficiaries to obtain signed blank timesheets and splitting the money with them
- PCS providers offering kickbacks for favorable authorization for more services than needed for beneficiaries

PCS fraud may subject a provider to State and Federal civil, monetary, and criminal penalties, and exclusion from participation in Federal health care programs like Medicaid. Providers can avoid the consequences of overpayments and fraud through preventive strategies, including:

- Learning and understanding agency and applicable Medicaid plan and waiver rules
- Requiring mandatory attendance at Medicaid-offered trainings and reading educational materials
- Contacting Medicaid for guidance when Federal and State rules are not well understood

Reporting Fraud, Waste, and Abuse

All parties involved in providing, authorizing, and supervising PCS are responsible for protecting the quality and integrity of the Medicaid program. You can report suspected fraudulent activity by calling the Division of Medicaid Fraud Hotline at 800-880-5920 or by fax at 601-576-4161. You may also mail your complaint to:

Office of Program Integrity
Mississippi Division of Medicaid,
550 High Street
Jackson, MS 39201

If you would like more information or a training workshop on fraud, waste and abuse, please call the Office of Program Integrity at 601-576-4162.

Magnolia Health Plan Prior Authorization TIPS

Tip # 1 How to complete the PA form:

In order to efficiently process authorization requests, Magnolia requests that providers complete each field of the authorization forms, especially the fields with an asterisk. **Incomplete forms are subject to being faxed back to the provider.**

If you are the servicing provider and are submitting the authorization request, list yourself as the requesting and servicing provider. By doing this, it eliminates unnecessary outreach to the referring physician, allows for one contact person, and ensures that you are aware of any requests for additional information.

Providers should include a **valid contact number on the PA form, for both Requesting and Servicing Providers**. We have noticed that some providers put the main hospital number (which is patient information) on the PA form. This is not the appropriate contact to request additional information or provide a notification of determination. We want to effectively be able to communicate with the requestor in a timely manner.

Tip # 2 Do not use copies of old PA forms:

When submitting a PA form, please print a **new copy** from the Magnolia website at www.MagnoliaHealthPlan.com. Please do not submit copies of outdated PA forms or copies of previously submitted requests. When submitting a PA form that has been copied, the bar codes can be distorted, causing the request to go into the wrong processing area which may possibly delay receipt and/or processing of your request in a timely manner.

Tip # 3 Follow-Up:

If the provider has not received an approval notification or some other form of contact within **two (2) business days of submission** of their request, they should call to check the status of their authorization request. Sometimes

providers wait weeks or months to follow-up, only to find out their requested was faxed back due to incomplete information.

Tip #4 Doctor's Orders:
In order to efficiently process authorization requests, Magnolia requests that providers ensure that submitted doctor's orders are signed and dated for required service types with the current PA request. This authenticates the requested service.

Tip #5 Non-Participating Providers Documentation Requirements:
Magnolia requires that every authorization request from Non-Participating Providers is accompanied by the following:

1. Copy of Malpractice Insurance
2. Copy of MS Practitioner's License
3. Valid MS Medicaid Identification Number
4. Completed W-9 Form (form located on the Magnolia website at www.MagnoliaHealthPlan.com)
5. Completed Ownership & Disclosure Form (form located on the Magnolia website at www.MagnoliaHealthPlan.com)

All submissions without these documents will be rejected.

Tip # 6 Timeliness of Prior Authorization Requests:
In order to efficiently process PA requests, Magnolia requests that providers submit PA requests prior to services being rendered. For all **pre-scheduled services including scheduled and elective admissions** (excluding maternity deliveries) requiring PA, providers should notify the Plan **14 calendar days** but no later than **five (5) calendar days** prior to the requested service date by contacting the Prior Authorization Department via phone, fax, mail, secure email or secure web portal.

PA is ***not required*** for emergent or urgent care services. Post-stabilization services do not require authorization.

Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required. Facilities are required to **notify** the Plan of all inpatient admissions **within one (1) business day following the admission**. Facilities are required to submit a **request for authorization** within **two (2) business days** following the date of inpatient admissions that are not planned or elective, and sufficient clinical information must be submitted to support medical necessity.

Updates/Changes to your Medicaid Provider File

Medicaid providers are responsible for reporting any changes to their provider files within 30 days of the effective date of the change.

To prevent the non-receipt of important letters, notices, and payments to the incorrect banking information, providers should check and update their file with the most accurate information. Changes that should be reported include but are not limited to:

- Address
- Phone Number
- Fax
- Contact name
- E-mail address
- Banking information
- Provider affiliations
- Change of ownership- Requires completion of a Provider Enrollment application
- Managing/Directing employee information
- Change of tax identification
- Individual and group name changes
- NPI numbers
  - NPI numbers submitted to Medicaid should be the same number as submitted to other payers, such as Coordinated Care Organizations (CCOs), Medicare, and other payers, as this is your unique identifier.
  - NPI Updates - The NPI is meant to be a lasting identifier, and is expected to remain unchanged even if a health care provider changes their name, address, provider taxonomy, or other information that was furnished as part of the original NPI application process.

Providers may verify information on their provider file via the Mississippi Medicaid Envision web portal. Please log into the provider secure portal, select Inquiry Options, then select Provider Record Inquiry to view information.

The Change of Address form is located on our website at www.ms-medicaid.com by clicking on Provider/Forms.

The Direct Deposit Authorization Agreement is located on our website at www.ms-medicaid.com by clicking on Provider/Provider Enrollment.

Please fax or mail information to Conduent Provider Enrollment.
Fax number: 888-495-8169
Address: Conduent Provider Enrollment
P. O. Box 23078
Jackson, MS. 39225

If you have any questions, please contact Conduent Provider Enrollment at 800-884-3222.


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MS Medicaid
PROVIDER BULLETIN

MISSISSIPPI DIVISION OF MEDICAID

Snyder Charts New Course for Medicaid Program

DREW L. SNYDER
Interim Executive Director
MS Division of Medicaid

We are now well into 2018, and the agency has been undergoing a number of changes in recent months. With this first Provider Bulletin issue of the year, I would like to take the opportunity to introduce myself, and offer some insight into my priorities as the new head of the Mississippi Division of Medicaid in the Office of the Governor (DOM).

To begin with, my name is Drew L. Snyder, and I was named interim executive director of DOM in December by Governor Phil Bryant. Before joining DOM, I served in several public sector leadership roles, including most recently as Deputy Chief of Staff, Policy Director, and Legal Counsel for Governor Bryant. Prior to that, I was as an Assistant Secretary of State for Delbert Hosemann, and I also practiced law at Hollingsworth LLP in Washington D.C., specializing in complex and multi-district litigation, with a focus on pharmaceutical and medical device matters.

I come to DOM during a time of extraordinary change. In Washington, D.C., Congress continues to contemplate significant reforms to the American health-care system. This year, the section of state law dealing with the types of care and services Medicaid covers is set to expire. The 2018 Mississippi Legislature convened in early January, and legislative action throughout the session could either preserve the course DOM is presently on or dramatically transform how the agency operates. However, I believe extraordinary change brings extraordinary opportunities.

Two key priorities I intend to focus on while leading DOM is to help improve the health outcomes of Mississippians while being fiscally responsible, and strengthening partnerships with our various stakeholder groups. Arguably our most important stakeholder group is the provider community. The Medicaid program simply would not work without the care Mississippi's health-care professionals provide to the people of this state. You play a vital role in the health and wellbeing of more than 748,000 beneficiaries.

I believe the best thing we can do as an agency is to provide outstanding customer service to the public, which includes the beneficiaries we serve, the approximately 30,300 providers who care for them, the roughly three million residents of the state and our partners in government. And I pledge to do so with high integrity. DOM must have integrity in our business processes, compliance obligations, and contracting practices. We must have integrity in our data. And we must have integrity in the way we treat people. In order to be successful, integrity must be at the center of everything we do.

IN THIS ISSUE

MISSISSIPPI DIVISION OF
MEDICAID

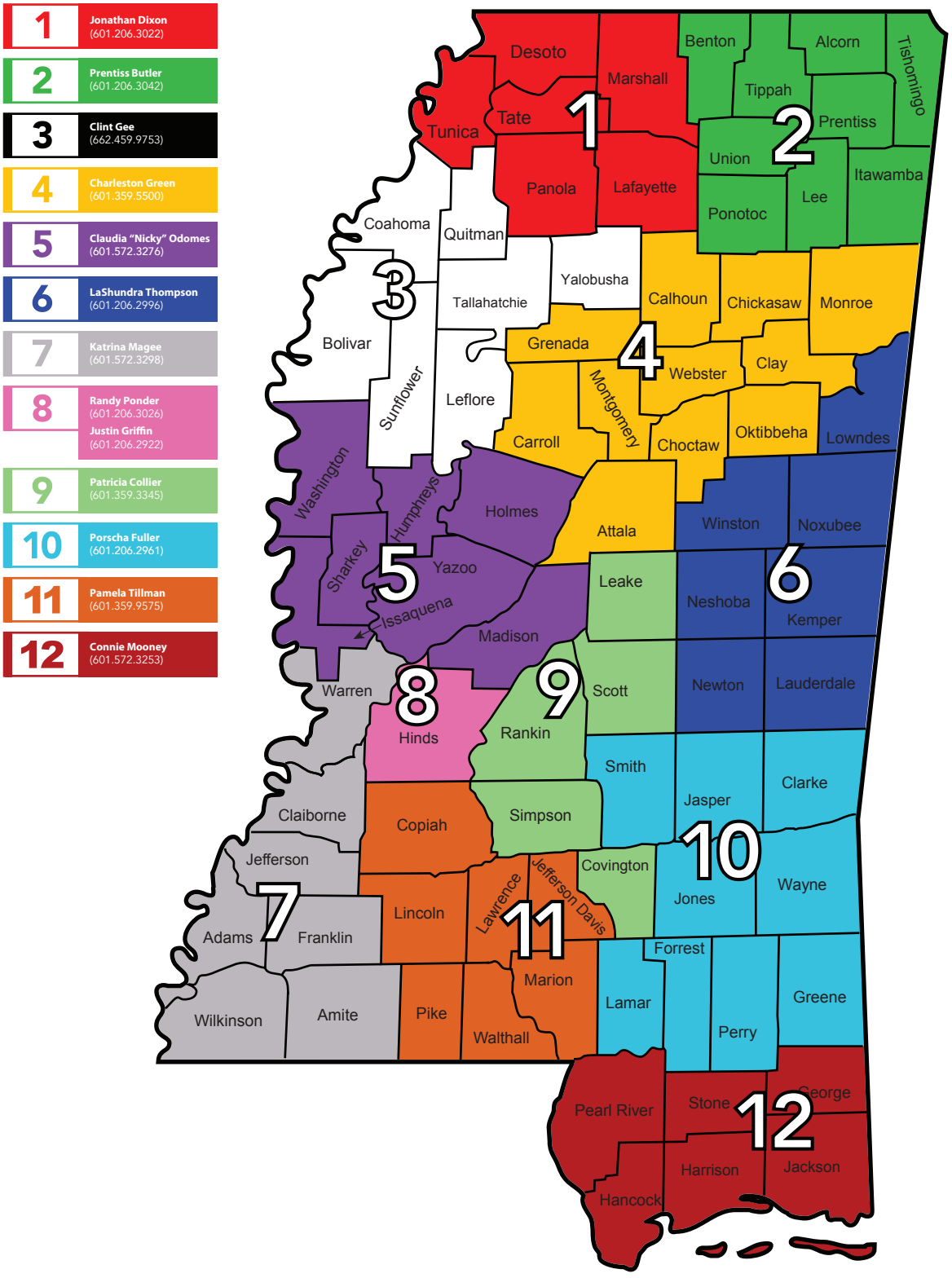
MEDICAID PROVIDER BULLETIN TRANSITION

Effective January 2018, the Mississippi Division of Medicaid (DOM) will no longer auto mail the quarterly publications of the Provider Bulletin.

All 2018 Issues of the provider bulletin are published and is posted to the Envision web portal and on DOM's website (http://medicaid.ms.gov). DOM providers may download the bulletin by visiting the Envision web portal at https://www.ms-medicaid.com.

The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

FIELD REPRESENTATIVE REGIONAL MAP



PROVIDER FIELD REPRESENTATIVES

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AREA 1 **Jonathan Dixon (601.206.3022)** jonathan.dixon@conduent.com	**AREA 2** **Prentiss Butler (601.206.3042)** prentiss.butler@conduent.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	
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County	**County**	**County**
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Carroll	Issaquena	Lowndes
Chickasaw	Madison	Neshoba
Choctaw	Sharkey	Newton
Clay	Washington	Noxubee
Grenada	Yazoo	Winston
Monroe		
Montgomery		
Oktibbeha		
Webster		
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Amite		Leake
Claiborne		Rankin
Franklin		Scott
Jefferson		Simpson
Warren		
Wilkinson		
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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**
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If you have any questions related to the topics in this bulletin, please contact Conduent at 800 - 884 -3222

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

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

PRSRT STD
U.S. Postage Paid
Jackson, MS
Permit No. 53

JUNE 2018

MON, JUNE 4	Checkwrite
THURS, JUNE 7	EDI Cut Off - 5:00 p.m.
MON, JUNE 11	Checkwrite
THURS, JUNE 14	EDI Cut Off - 5:00 p.m.
MON, JUNE 18	Checkwrite
THURS, JUNE 21	EDI Cut Off - 5:00 p.m.
MON, JUNE 25	Checkwrite

JULY 2018

MON, JULY 2	Checkwrite
WED, JULY 4	DOM Closed
THURS, JULY 5	EDI Cut Off – 5:00 p.m.
MON, JULY 9	Checkwrite
THURS, JULY 12	EDI Cut Off – 5:00 p.m.
MON, JULY 16	Checkwrite
THURS, JULY 19	EDI Cut Off – 5:00 p.m.
MON, JULY 23	Checkwrite
WED & THURS, JULY 25 & 26	MSCAN Provider Workshop Raymond, 9:30 a.m.-3:30 p.m.
THURS, JULY 26	EDI Cut Off – 5:00 p.m.
MON, JULY 30	Checkwrite
TUES & WED, JULY 25 & AUGUST 1	MSCAN Provider Workshop Tupelo, 9:30 a.m.-3:30 p.m.

AUGUST 2018

WED, AUGUST 1	EDI Cut Off – 5:00 p.m.
THURS, AUGUST 2	EDI Cut Off – 5:00 p.m.
MON, AUGUST 6	Checkwrite
THURS, AUGUST 9	EDI Cut Off – 5:00 p.m.
MON, AUGUST 13	Checkwrite
TUES & WED, AUGUST 14 & 15	MSCAN Provider Workshop Greenville, 9:30 a.m.-3:30 p.m.
THURS, AUGUST 16	EDI Cut Off – 5:00 p.m.
MON, AUGUST 20	Checkwrite
THURS, AUGUST 23	EDI Cut Off – 5:00 p.m.
MON, AUGUST 27	Checkwrite
TUES & WED, AUGUST 28 & 29	MSCAN Provider Workshop Gulfport, 9:30 a.m.-3:30 p.m.
THURS, AUGUST 30	EDI Cut Off – 5:00 p.m.

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