Volume 27, Issue 1 June 2021

MS Medicaid PROVIDER BULLETIN

MISSISSIPPI DIVISION OF MEDICAID

DREW L. SNYDER
Executive Director
MS Division of Medicaid

Medical Care Advisory Committee resumes with newly appointed members

Among the many things put on hold by the COVID-19 pandemic was the reconstitution of the Medical Care Advisory Committee (MCAC). This federally required body designed to advise the Mississippi Division of Medicaid (DOM) about health and medical care services last convened on Nov. 1, 2019, during the previous administration.

Now with Governor Tate Reeves and Lt. Governor Delbert Hosemann in office, new members have been appointed, and planning is underway for the first quarterly meeting. The MCAC is made up of 11 members appointed by the governor, lieutenant governor and the speaker of the House of Representatives who are either healthcare providers or consumers of healthcare services. The committee must include representatives who are board-certified physicians. The committee also includes legislative members from the Mississippi Senate and House of Representatives to serve as ex officio nonvoting members.

The MCAC is charged with advising DOM on issues related to State Plan changes, reimbursement rates and the quality and quantity of services covered by Medicaid.

The committee serves as a liaison between DOM and providers, sharing the perspectives and concerns of clinicians with the agency, and disseminating Medicaid viewpoints and circumstances with the healthcare community.

The MCAC examines issues and explores improvements to the program that could lead to better health outcomes and encourage more healthcare providers to participate in the Medicaid program.

The last committee, chaired by Dr. Steve Demetropoulos from Pascagoula, met regularly for three years beginning in December of 2016. With support and information provided by DOM, as well as managed care organizations and other stakeholders, the committee examined a wide range of issues, including infant mortality and the use of 17 Hydroxyprogesterine, bariatric surgery, non-emergency transportation, hospital and physician reimbursement, and behavioral health readmissions. They made dozens of recommendations to the Legislature, some of which were included in the 2018 Medicaid technical amendments bill.

When the new committee members meet, they will elect a new chairman. The first meeting is expected to be held in June. Details will be made available on DOM's website

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at https://medicaid.ms.gov/resources/legislative-resources/medical-care-advisory-committee/.

In the last issue of the Provider Bulletin, I expressed how we will continue to work toward becoming a high-functioning government agency that aims to improve the health and the life outcomes of the people it serves, and in turn the state as a whole, while optimally managing public funding and public trust to ensure the Medicaid program remains stable and sustainable.

These objectives complement those of the MCAC, and I look forward to working with the new committee and exploring more ideas for future improvements.

DOM Change of Ownership Policy

A provider that undergoes a Change of Ownership must notify the Division of Medicaid within thirty-five (35) days after any change in ownership through the submission of a complete Mississippi Medicaid Provider Application packet and proof of the Change of Ownership. A Change of Ownership of an entity as defined by the Division of Medicaid includes, but is not limited to inter vivos gifts, purchases, transfers, lease arrangements, cash, and/or stock transactions or other comparable arrangements whenever the person or entity acquires or controls a majority interest of the facility or service. To review the entire Change of Ownership policy section, please refer to the Mississippi Division of Medicaid's Administrative Code, Part 200, Chapter 4, Rule 4.3 located at https://medicaid.ms.gov/providers/administrative-code/.

Failure to report changes to the Mississippi Division of Medicaid may result in revocation and/or result in recoupment of funds for paid claims.

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 Hospital Providers Intensive Outpatient Psychiatric (IOP) and Chemical Dependency Services

Intensive outpatient psychiatric service is considered a covered Mental Health service when provided in an outpatient department of a general hospital or freestanding psychiatric facility.

Effective May 1, 2021, HCPCS code S9480 will only be applicable to Intensive Outpatient Psychiatric programs operated in the outpatient programs in general hospitals and freestanding psychiatric hospitals.

- Effective **May 1, 2021**, the following revenue codes are open for Outpatient Prospective Payment System (OPPS) billing:
  - 0905 – IOP Psychiatric Services
  - 0906 – IOP Chemical Dependency
- Effective **May 1, 2021** physicians, NPs and PAs are to bill for their professional services separately from the IOP per diem rate. All other non-physician practitioner services, such as LCSW, LPC, psychologists, will be included in the per diem rate.

IOP – Psychiatric Services

• **Effective May 1, 2021, HCPCS Code S9480 IOP Psychiatric Service billed with revenue code 0905 - IOP Psychiatric Services will be reimbursed for facility services at a rate of $122.54 (Factor Code O1) when billed in the Outpatient Hospital.**

IOP – Chemical Dependency Services

• Effective **May 1, 2021**, HCPCS Code H0015 - IOP Chemical Dependency (SUD) Service will be reimbursed at a rate of $122.54 (Factor Code O1) when billed with revenue code **0906 - IOP Chemical Dependency** in the Outpatient Hospital.

Please contact Kimberly Evans or Charlene Craft at 601-359-9545 or Kimberly.Evans@medicaid.ms.gov or Charlene.Craft@medicaid.ms.gov if you have questions.

HOSPITAL INPATIENT APR-DRG ALERT – July 1, 2021 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, 2021:

1. DOM will adopt V.38 of the 3M Health Information Systems (3M HIS) APR-DRG Grouper and Hospital-Specific Relative Value (HSRV) weights

2. V.38 of the APR-DRG HSRV weights are substantially lower on average for Medicaid inpatient stays relative to V.35 (current for SFY 2021). In order to avoid substantial changes in the base price from year-to-year due to changes in the average relative weight, the Division has opted to implement a process to re-center the APR-DRG relative weights to a population average of 1.0 each year. The relative weights will still be based on the values published by 3M but will be adjusted so that the average weight across Mississippi Medicaid inpatient stays is 1.0. This new process will mean that the average APR-DRG relative weight will not change from year-to-year, which will reduce the need to adjust the base price each year. However, because this process will significantly increase the average weight in SFY 2022 relative to SFY 2021, the Division will need to make a one-time significant decrease in the base price to maintain budget neutrality.

3. The following APR-DRG parameters will be updated:
   a. Base Payment – will change from $6,590 to $5,350. This change in the base price is designed to compensate for increased HSRV weights and will not affect overall payment levels.
   b. Pediatric mental health policy adjustor – will change from 1.95 to 1.90 to maintain current payment levels
   c. Adult mental health policy adjustor – will change from 1.50 to 1.45 to maintain current payment levels

PROVIDER COMPLIANCE

d. Obstetrics policy adjustor – will change from 1.50 to 1.40 to maintain current payment levels
e. Normal Newborn policy adjustor – will change from 1.50 to 1.45 to maintain current payment levels
f. DRG Cost Outlier Threshold – will change from $53,500 to $60,000
g. DRG Cost Outlier Marginal Percentage – will change from 60% to 50%

DOM estimates the overall impact of the above changes will be a savings of $210,588 in state and federal funds, which is budget neutral to SFY 2021.

Please keep in mind that 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, 2021.

Sessions regarding APR-DRG payment updates will be scheduled with dates to be provided. Hospitals will be notified via e-mail and the DOM website www.medicaid.ms.gov.

ATTENTION Opioid Treatment Providers Medication Assisted Treatment (MAT) including Opioid Treatment Fee Schedule Updates

Effective April 1, 2021, the Division of Medicaid (DOM) will be utilizing bundled codes for MAT for Opioid Treatment services. Please refer to the Medication Assisted Treatment fee schedule located at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

These bundled services include 1). Opioid Treatment Programs (OTPs) certified by the Mississippi Department of Mental Health that provide methadone treatment and 2). Physicians, non-physician practitioners and clinics operating within their scope of practice that are appropriately licensed and certified to prescribe MAT drugs excluding methadone.

Please contact Kim Sartin-Holloway at 601-359-6630 or Kimberly.Sartin-Holloway@medicaid.ms.gov if you have questions.

ATTENTION Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Claims Submissions

The Division of Medicaid (DOM), in accordance with Federal Regulations § 455.440 National Provider Identifier and § 456.360 Certification and recertification of need for inpatient care, requires Ordering, Referring or Prescribing (ORP) providers to be identified on ICF/IID facility claims. Claims submitted by ICF/IID providers will be denied unless the ORP Provider is actively enrolled in Medicaid and the National Provider Identifier (NPI) number is included on the claim submitted to Medicaid by the billing provider.

Please contact Kim Sartin-Holloway at 601-359-6630 or Kimberly.Sartin-Holloway@medicaid.ms.gov if you have questions.

COORDINATED CARE NEWS

UnitedHealthcare® Community Plan

UHC Claims Corner

In an effort to increase claim consistency and timeliness, UHC applies Electronic Data Interchange (EDI) editing at the point of claim receipt. Please remember your clean claims must include the following:

- The following NPIs always require validation on the **CMS 1500 claim form**:
  - Rendering Provider
  - Billing Provider
  - Rendering NPI are billed in Box 24J
  - Billing NPI and Taxonomy are billed in box 33a and 33b
  - When submitting a taxonomy code, please be sure to include the qualifier ZZ on CMS 1500 (HCFA) forms

- The following NPIs always require validation on the **CMS 1450 claim (UB) form**:
  - Billing Provider
  - Attending Provider
  - Operating Provider
  - Billing NPI is billed in Box 56
  - Billing Taxonomy is billed in box 81
  - Attending and Operation are billed in boxes 76 and 77
  - When submitting a taxonomy code, please be sure to include the qualifier B3 on CMS 1450 (UB04) form

You must provide us the NPI that aligns with your MS Medicaid ID. Failure to do so may impact claims payment.

Immunizations for Adolescents (IMA)

Immunizations for Adolescents (IMA) is a new HEDIS measure for 2021. IMA is the percentage of adolescents age 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

The following vaccines should be completed by the 13th birthday for IMA compliance:

HPV
Number of Doses: 2
Special Circumstances:
- Dose must be administered on or between the ninth and 13th birthdays.
- There must be at least 146 days between the first and second dose of HPV vaccine.
- CPT®/CPT II 90649-51

Meningococcal Conjugate
Number of Doses: 1
Special Circumstances: Dose must be administered on or between the 11th and 13th birthdays.
- CPT®/CPT II 90734

Tdap
Number of Doses: 1
Special Circumstances: Dose must be administered on or between the 10th and 13th birthdays.
- CPTR/CPT II 90715

Tips and Best Practices to Help Close This Care Opportunity:
- Schedule appointments for your patient's next vaccination before they leave your office.
- Remind parents of the importance of keeping immunizations on track.
- Use phone calls, emails, texts or postcards/letters to help keep parents engaged.
- When possible, please review vaccine status with parents and give immunizations at visits other than only well-child appointments.

COORDINATED CARE NEWS

After-Hour Care – Members need to be able to reach a provider by phone after normal business hours.

Physicians (PCP, Specialists and Behavioral Health) are *required* to provide 24-hour a day, 7-day coverage to members.

Acceptable after-hours messages or responses are:

- Primary Care Provider's (PCP) answering service will verify that it will contact the physician on-call for a patient's emergency.
- PCP's triage nurse will verify that he or she will speak with the patient for an emergency call, evaluate the nature of the emergency and contact the physician on-call or direct the patient to a hospital emergency room.
- PCP can be reached when called directly.
- PCP's office phone message directs the patient to call a specific telephone number to reach the PCP's answering service, who will then contact the physician on-call for an emergency.
- PCP's office answering machine directs the patient to call a specific telephone number to reach a hospital switchboard and/or hospital emergency room that will reach the physician on-call for emergencies.

Unacceptable for after-hours coverage are:

- PCP's answering machine directs the patient to proceed to the nearest hospital emergency room.
- PCP's office telephone number rings without an answer.

UnitedHealthcare Transition to InterQual Criteria from Milliman Care Guidelines (MCG)

We have transitioned to InterQual criteria for all benefit plans effective May 1, 2021. We expect that using InterQual will further streamline our current clinical review processes while helping to reduce clinical decision turnaround times.

What is InterQual?
InterQual criteria are nationally recognized, evidence-based clinical criteria that we will use for utilization management for all our benefit plans.

No disruption to your processes
The change to InterQual is happening within our internal technology structure. This should be seamless to care providers using our online portals and other systems. Your processes should not be affected and your daily work shouldn't be disrupted.

We're here to help you
If you have questions, please contact your Provider Advocate, UnitedHealthcare network representative or call Provider Services at 877-743-8734 also located on the member's ID card.

MOLINA® HEALTHCARE

Joining Our Provider Network

Contracted providers are an essential part of delivering quality care to our members. We value our partnership and appreciate the family-like relationship that you pass on to our members.

For more information about joining our Mississippi network of participating providers, please visit https://www.molinahealthcare.com/providers/ms/medicaid/comm/Join-Our-Network.aspx.

Molina's Prior Authorization Lookup Tool has launched!

A new Prior Authorization Lookup Tool is now available on www.MolinaHealthcare.com. It allows you to look by

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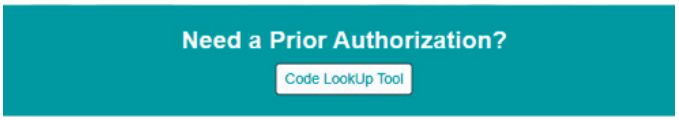
CPT/HCPCS code (along with state and line of business) to determine if Prior Authorization is/is not required. Additionally, the tool will indicate if a code is not a covered benefit, or if authorization for that service has been delegated by Molina to a vendor along with information regarding how to contact the vendor.

This helpful tool is accessible via our Provider Portal and the Molina website provider landing page. Simply go to www.MolinaHealthcare.com and select "I'm a Provider" and choose your state from the pop-up. You will see the Prior Authorization Lookup Tool on the Provider Landing page under "Need a Prior Authorization?"



There are many other valuable resources available to access on our website:

Provider Training and Resources (MSCAN/CHIP)
https://www.molinahealthcare.com/providers/ms/medicaid/comm/Pages/training.aspx

Provider Manual (MSCAN/CHIP)
https://www.molinahealthcare.com/providers/ms/medicaid/manual/Pages/medical.aspx

Frequently Used Forms (MSCAN/CHIP)
https://www.molinahealthcare.com/providers/ms/medicaid/forms/pages/fuf.aspx

Provider Web Portal
https://provider.molinahealthcare.com/Provider/Registration

Provider Newsletter
Our Provider Newsletter is a great way for providers in Mississippi to receive helpful information, education, important updates and more! Sign up today to stay connected with Molina Healthcare of Mississippi. https://www.molinahealthcare.com/providers/ms/medicaid/comm/Pages/newsletters.aspx

Provider Training and Resources (Marketplace)
https://www.molinahealthcare.com/providers/ms/marketplace/comm/Pages/training.aspx

Provider Manual (Marketplace)
https://www.molinahealthcare.com/providers/ms/marketplace/Pages/home.aspx

Frequently Used Forms (Marketplace)
https://www.molinahealthcare.com/providers/ms/marketplace/forms/pages/fuf.aspx

Requirements for Submitting Prior Authorization for Molina All Lines of Business

Molina requires prior authorization (PA) for specific services. Molina offers three tools on the MolinaHealthcare.com website to assist you in knowing what services require prior authorization:

- The Prior Authorization Code Matrix https://www.molinahealthcare.com/providers/ms/medicaid/forms/~/media/Molina/PublicWebsite/PDF/Providers/ms/medicaid/PA-code-matrix-q2.pdf,
- the Prior Authorization Guide https://www.molinahealthcare.com/providers/ms/chip/forms/~/media/Molina/PublicWebsite/PDF/providers/ms/Medicaid/PA-Guide-Request-Form.pdf, and
- the newly launched Prior Authorization Code Lookup Tool https://www.molinahealthcare.com/members/ms/en-us/health-care-professionals/home.aspx.

Both the PA Code Matrix and the PA Lookup Tool offer detailed information by CPT and HCPCS code regarding PA requirements. Additional information about the new Prior Authorization Code Lookup Tool, including how to access the tool, is available in a separate article included in this bulletin.

When submitting a prior authorization request, it is important to include all clinical information and medical records necessary to support the medical necessity of the requested service/item. The following is an example of documentation needed:

- Current (up to six months) patient history related to the requested service/item
- Relevant physical examination that addresses the problem
- Relevant lab or radiology results to support the request (include previous MRI, CT, lab or X-ray report/results)
- Relevant specialty consultation notes
- Any other information or data specific to the

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request showing the member meets the criteria for approving the service/item
- Any authorization approvals received from another payer

By providing all necessary clinical information with the initial request, Molina will be able to make a more timely and complete decision based on the member's current health condition while potentially avoiding a need to request additional supporting documentation.

Expedited Prior Authorization
When submitting an expedited prior authorization request, be sure to submit all necessary clinical information as the timeframe to process the request is extremely short from date and time of receipt of the initial request. The goal is to have all necessary information to make the appropriate decision during the initial review of the service/item and avoid the need for an appeal if the service/item is denied.

Appeals
In the event a denial is issued and subsequently appealed, please be sure to reference the original decision. If the denial was due to missing information needed to justify coverage, not providing that information with your appeal request will not change the decision and could further delay medically necessary covered services/items. Let's work together to ensure timely and appropriate care for your patients.

magnolia health™

Magnolia Updates: Provider Panel Member Re-Assignment

Magnolia is working to ensure membership assignment is in accordance with the Plan's Value Based Contract model. This initiative will help drive member/provider relations, improve members care and help close the gap for our high-risk members who have limited access to medical care.

What is changing?
With this initiative, Magnolia has identified roughly 82,000 members who were re-assigned to providers with whom they have utilized for at least three times during the last 24 months. Providers may see members removed or added to their panel as a result.

Date of re-assignment?
Magnolia began the process of re-assigning members on March 1, 2021 through March 17, 2021. With this process, members received an updated ID Card with their new PCP name listed.

Providers have the ability to view their member panel list by logging into Magnolia's secure provider portal at www.provider.magnoliahealthplan.com or by contacting Provider Services.

For additional member panel questions or if you would like more information on opening and closing your member panel, please contact Provider Services at 1-866-912-6285; Relay 711. Thank you for your continued partnership with Magnolia Health in delivering care to our members.

Magnolia Updates: Transportation Reminders

MTM Authorizations
Non-emergent transports from a home or provider office to a hospital are part of the MTM benefit and should not be billed to the health plan. To schedule a non-emergent transport, contact MTM at 1-866-331-6004 at least 3 business days in advance, unless the trip is urgent.

Magnolia Authorizations
Facility to facility transportation is not part of the MTM benefit and authorization should be obtained from Magnolia Health. The provider has **1 business day** after transport to submit a request for authorization.

For more information on Magnolia Health, visit our website: https://www.magnoliahealthplan.com/

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Magnolia Updates: Denial Code Announcement

Effective April 1, 2021, Magnolia began increasing specificity of denial reason codes (EX) related to MS Medicaid Provider Enrollment, Missing or Invalid Provider Medicaid ID number, and NPI Registration with the Division of Medicaid (DOM).

This enhancement will make it easier for providers to understand and troubleshoot these type of claim denials.

Requirements for MSCAN claim reimbursement include, but are not limited to:

- MS Medicaid Provider enrollment,
- Medicaid Provider ID number, and
- NPI registration with MS DOM.

Magnolia utilizes the MS Division of Medicaid's Provider State File as a mechanism for confirming active provider enrollment/participation with the state.

Refer to the MS Medicaid Provider Billing Handbook, Section: General Billing Information, 1.7 National Provider Identifier (NPI), for information regarding registering your NPI. https://medicaid.ms.gov/wp-content/uploads/2016/07/1.7-NPI-Provider-Enrollment.pdf

Providers may expect to see the following EX (denial reasons) specifications appear on remits beginning April 1, 2021, as provided below:

Medical EX codes:

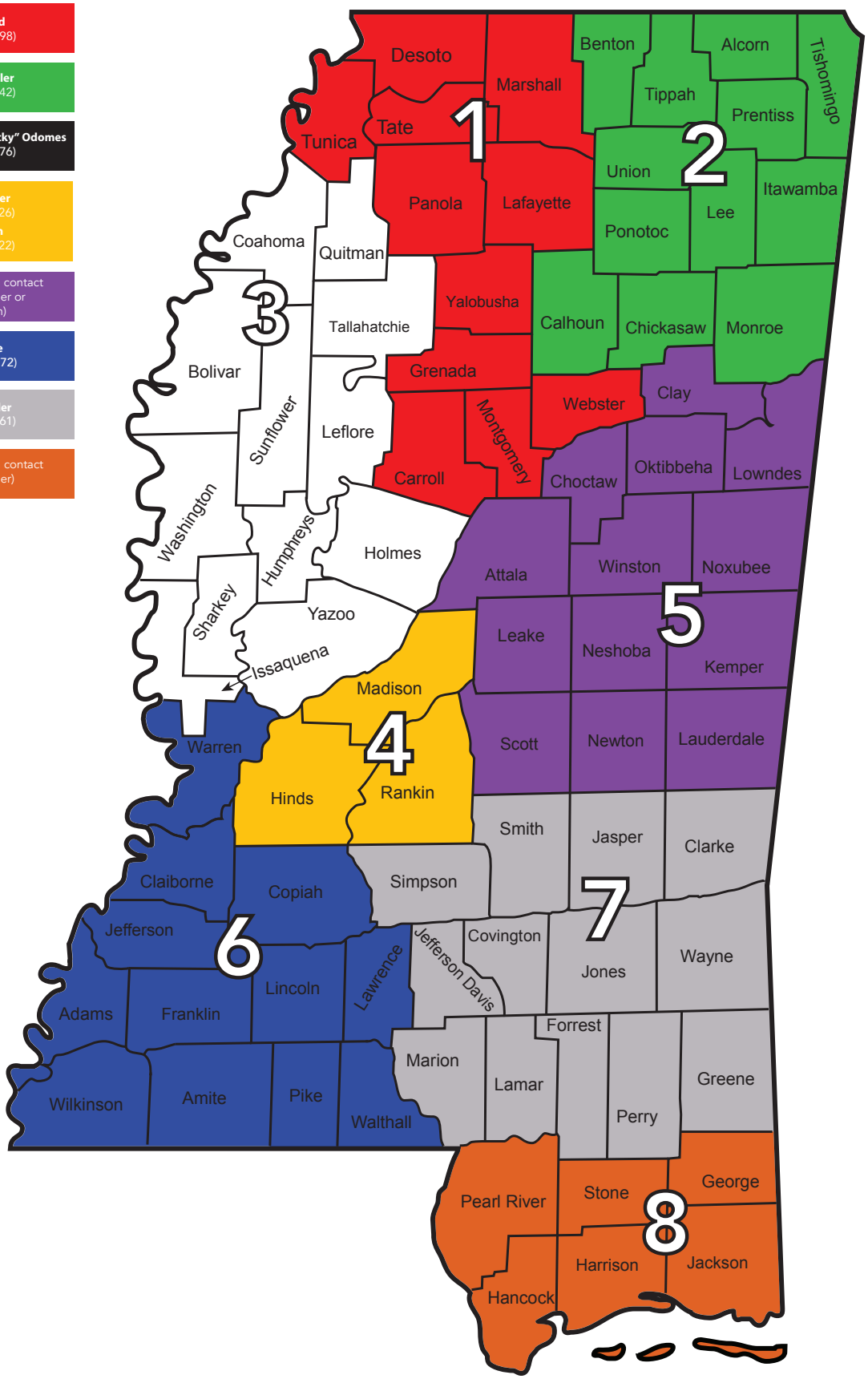
- EX2C DENY: REFERRING PROV INACTIVE/NOT REGISTERED W/STATE ON DOS
- EX2d DENY: ORDERING PROV INACTIVE/NOT REGISTERD W/STATE ON DOS
- EX1n DENY: BILLING PROV INACTIVE/NOT REGISTERD W/ STATE ON DOS
- EX1T DENY: RENDERING PROV INACTIVE/NOT REGISTERED W/ STATE ON DOS
- EX1W DENY: ATTENDING PROV INACTIVE/NOT REGISTERED W/ STATE ON DOS

BH EX CODES:

- EXRv DENY: ORIGINATING PROV INACTIVE/NOT REGISTERED W/ STATE ON DOS
- EXRw DENY: BILLING PROV INACTIVE/NOT REGISTERED W/ STATE ON DOS
- EXRx DENY: RENDERING PROV INACTIVE/NOT REGISTERED W/ STATE ON DOS
- EXRy DENY: ATTENDING PROV INACTIVE/NOT REGISTERED W/ STATE ON DOS
- EXRz DENY: REFERRING PROV INACTIVE/NOT REGISTERED W/ STATE ON DOS

FIELD REPRESENTATIVE REGIONAL MAP

1	**Latasha Ford** (601.572.3298)
2	**Prentiss Butler** (601.206.3042)
3	**Claudia "Nicky" Odomes** (601.572.3276)
4	**Randy Ponder** (601.206.3026) **Justin Griffin** (601.206.2922)
5	**TBA** (interim contact Randy Ponder or Justin Griffin)
6	**Latrece Pace** (601-473-5172)
7	**Porscha Fuller** (601.206.2961)
8	**TBA** (interim contact Randy Ponder)



PROVIDER FIELD REPRESENTATIVES

PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY		
AREA 1 **Latasha Ford (601.572.3298)** Latasha.Ford@conduent.com	**AREA 2** **Prentiss Butler (601.206.3042)** prentiss.butler@conduent.com	**AREA 3** **Claudia "Nicky" Odomes (601.572.3276)** claudia.odomes@conduent.com
County	**County**	**County**
Desoto	Benton	Coahoma
Tunica	Tippah	Quitman
Tate	Alcorn	Bolivar
Panola	Tishomingo	Sunflower
Marshall	Prentiss	Leflore
Lafayette	Union	Tallahatchie
Yalobusha	Lee	Washington
Grenada	Pontotoc	Sharkey
Carroll	Itawamba	Humphreys
Montgomery	Calhoun	Yazoo
Webster	Chickasaw	Holmes
	Monroe	Issaquena
***Memphis**		
AREA 4 **Justin Griffin (601.206.2922)** justin.griffin@conduent.com **Randy Ponder (601.206.3026)** randy.ponder@conduent.com	**AREA 5** **TBA (interim contact** **Randy Ponder or Justin Griffin)**	**AREA 6** **Latrece Pace (601.473.5172)** Latrece.Pace@conduent.com
County	**County**	**County**
Hinds	Clay	Warren
Rankin	Oktibbeha	Claiborne
Madison	Choctaw	Jefferson
	Attala	Adams
	Leake	Franklin
	Scott	Wilkinson
	Lowndes	Amite
	Winston	Copiah
	Noxubee	Lincoln
	Neshoba	Pike
	Kemper	Lawrence
	Newton	Walthall
	Lauderdale	
AREA 7 **Porscha Fuller (601.206.2961)** porscha.fuller@conduent.com		**AREA 8** **TBA (interim contact** **Randy Ponder 601.206.3026)** randy.ponder@conduent.com
County		**County**
Simpson		Pearl River
Jefferson Davis		Stone
Marion		George
Lamar		Hancock
Covington		Harrison
Smith		Jackson
Jasper		
Jones		**Slidell, LA**
Forrest		**Mobile, AL**
Perry		
Greene		
Wayne		
Clarke		
OUT OF STATE PROVIDERS	**Contact: Deonna Dillanes (601.473.5109)** Deonna.Dillanes@conduent.com	

CONDUENT
P.O. BOX 23078
JACKSON, MS 39225

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

JUNE 2021

THURS, JUNE 3	EDI Cut Off – 5:00 p.m.
MON, JUNE 7	Checkwrite
THURS, JUNE 10	EDI Cut Off - 5:00 p.m.
MON, JUNE 14	Checkwrite
THURS, JUNE 17	EDI Cut Off - 5:00 p.m.
MON, JUNE 21	Checkwrite
THURS, JUNE 24	EDI Cut Off - 5:00 p.m
MON, JUNE 28	Checkwrite

JULY 2021

THURS, JULY 1	EDI Cut Off – 5:00 p.m.
MON, JULY 5	July 4 Observed DOM Closed
THURS, JULY 8	EDI Cut Off – 5:00 p.m.
MON, JULY 12	Checkwrite
THURS, JULY 15	EDI Cut Off – 5:00 p.m.
MON, JULY 19	Checkwrite
THURS, JULY 22	EDI Cut Off – 5:00 p.m.
MON, JULY 26	Checkwrite
THURS, JULY 29	EDI Cut Off – 5:00 p.m.

AUGUST 2021

MON, AUG 2	Checkwrite
THURS, AUG 5	EDI Cut Off – 5:00 p.m.
MON, AUG 9	Checkwrite
THURS, AUG 12	EDI Cut Off – 5:00 p.m.
MON, AUG 16	Checkwrite
THURS, AUG 19	EDI Cut Off – 5:00 p.m.
MON, AUG 23	Checkwrite
THURS, AUG 26	EDI Cut Off – 5:00 p.m.
MON, AUG 30	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.