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MS Medicaid PROVIDER BULLETIN

MISSISSIPPI DIVISION OF MEDICAID

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Executive Director
MS Division of Medicaid

Coming Soon! Providers will be asked to test EDI connection with new MMIS

In December's Provider Bulletin, I explained that the Mississippi Division of Medicaid (DOM) is in the process of implementing a new Medicaid Management Information System (MMIS), which is the bedrock that underpins the two core Medicaid functions of determining the eligibility of Medicaid members and timely and accurately processing payments to health care providers for the care they deliver.

The new system – MESA – is expected to go-live later this year, replacing outdated technology with a more efficient version that is easier to maintain. It is being developed by Gainwell Technologies, and DOM employees have already been heavily involved with end-user testing for several months now.

MESA, like any other state's MMIS, has many different components and functions pertaining to provider information and claims. As with the current system, Mississippi providers will interact with MESA through an online portal, which will be introduced to you in the near future. When the new system goes live, you will use that portal to submit claims, determine a member's eligibility, check the status of prior authorizations and so on.

However, before that portal can be accessed and used successfully, an important step comes first.

The information that will eventually be transmitted between the portal and the core MMIS must be exchanged through a secure file transfer connection known as Electronic Data Interchange (EDI). This ensures that the transmission of any files being submitted or received is in compliance with federal privacy regulations.

MORE ONLINE
To learn more about what will be required in the EDI testing process, review the DOM Companion Guides online at: **https://medicaid.ms.gov/edi-technical-documents/**

All covered entities – including all Medicaid-enrolled providers, trading partners, clearing houses and coordinated care organizations – will have to enroll in the new portal and complete a testing process with Gainwell to ensure the security and functionality of their connections. In short, before any claims can be submitted when go-live arrives, all providers and covered entities must be certain that they have a secure connection.

The timeframe for this process is still in development, but more information will be coming soon on how providers can enroll and get registered in the new system. In the meantime, DOM Companion Guides are available online to help you prepare for testing. These documents describe the specific technical and procedural requirements for

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submitting secure transactions. Additional information and resources will be available online as the MMIS implementation progresses.

This is a critical step that ties directly to the foundation of DOM's mission. The secure transmission of electronic information is essential for accurately and timely billing and reimbursing for needed services, determining eligibility with real-time precision, and safeguarding the protected data of our members as well as providers. As of January 2022, there were 841,550 Mississippians enrolled in Medicaid and the Children's Health Insurance Program, the most ever in the state's history. We are counting on your valued partnership to help us transition to a modernized system to serve Mississippi's growing needs.

We are committed to providing you with the resources and support that will ensure you can successfully test submissions in the new system.

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: MYPAC Providers

The new HCPCS code H0037 – Community Psychiatric Supportive Treatment Program, now requires a Prior Authorization (PA) for services to be rendered under the Mississippi Youth Programs Around the Clock (MYPAC). Please review DOM Mental Health Services State Plan Amendment (SPA) 21-0028 located at **https://medicaid.ms.gov/wp-content/uploads/2021/09/Pages-from-MS-SPA-21-0028-Approval-Pages-1.pdf**. The filing of corresponding Division of Medicaid Administrative Code for MYPAC services with the Secretary of State's Office is pending.

HCPCS H0037 – Community Psychiatric Supportive Treatment Program

- Prior authorization will be required for HCPCS code H0037 beginning January 6, 2022.
- Required Modifiers:
  - HW – State Mental Health Agency Funded
  - HT – Multi Disciplinary Team
    Allowed Provider Types:
  - X00 – Community Mental Health Center
  - X01 – Private Mental Health Center
- DOM Fee Schedule Per Diem Rate $241.00
- Retroactive Rate Effective Date – For dates of service July 1, 2021 and going forward.
- Providers must be certified by the Department of Mental Health to provide MYPAC.
- This service is excluded from the Children's Health Insurance Program (CHIP).

Prior Authorization (PA) for HCPCS code H0037 will begin January 6, 2022. All fee-for service beneficiaries currently receiving MYPAC services will receive a retroactive authorization. Please contact Alliant Health Solutions if you have any questions regarding the PA process for non-MSCANs beneficiaries. Prior to submitting requests for prior authorization for this service, please verify with your Coordinated Care Organizations' Provider Representative corresponding system updates have been activated.

This HCPCS code new reimbursement is retroactive to July 1, 2021 and after. A mass adjustment for affected fee-for-service claims has been requested and is forthcoming. Prior to submitting claims for this service, please verify with your Coordinated Care Organizations' Provider Representative to ensure corresponding claim system updates have been activated.

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

ATTENTION: Acute Partial Hospitalization Providers

Effective January 1, 2022, DOM requires all claims for Acute Partial Hospitalization (APH) to treat substance use disorders (SUD) to include the HF modifier to distinguish SUD service claims from those that treat a mental illness. Claims may need to be refiled to correct any payment issues.

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

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

2021 Cost Reports

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2021 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 2022 are as follows:

Category	Maximum Allowable Cost for 2021
0 to 99 Beds	$4,571
100 to 199 Beds	$6,856
200 to 299 Beds	$9,142
300 to 499 Beds	$11,427
500 or More Beds	$13,713

PROVIDER COMPLIANCE

2022 New Bed Values for Nursing Facilities, ICF-IIDs, PRTFs, and NFSD

The new bed values for FY 2022's Nursing Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs), Psychiatric Residential Treatment Facilities (PRTFs) and Nursing Facility for the Severely Disabled (NFSD) have been determined by using the R.S. Means Historical Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care Facilities.

Facility Class	FY 2022 New Bed Value
Nursing Facilities	$107,220
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)	$128,664
Psychiatric Residential Treatment Facilities (PRTF)	$128,664
Nursing Facilities Severely Disabled (NFSD)	$187,635

2021 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 2021 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 2021 are as follows:

Small Nursing Facilities (1 to 60 Beds)	$148,211
Large Nursing Facilities (61 or more Beds)	$179,685
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)	$135,071
Psychiatric Residential Treatment Facilities (PRTF)	$134,232

COORDINATED CARE NEWS

Managed Care Provider Inquiries & Issues Online Form

The Office of Coordinated Care (OCC): Provider Services is pleased to introduce our online Managed Care Provider Inquiries & Issues Form. The online Managed Care Provider Inquiries & Issues Form provides an avenue for providers to submit information to OCC's Provider Services who will assist in the validation and investigation of issues providers may be encountering with the coordinated care organizations (CCOs).

Providers should ensure they report all issues to the respective CCO and exhaust their review processes prior to submitting an issue to the Division of Medicaid. Please record the reference/inquiry number(s) so that it can be submitted on the Managed Care Provider Inquiries & Issues Form. The Division of Medicaid (DOM) wants to ensure that provider issues are addressed appropriately, and their resolutions align with our values of conducting operations with accountability, consistency, and respect.

A link to this form, which can be completed by anyone, is available on the DOM website and all are encouraged to save the link to your web browser Favorites. It is very important that as much information is completed as possible to assist OCC Provider Services in their resolution process.

The Managed Care Provider Inquiries & Issues Form is composed of four (4) sections:

- **General Information** Allows the submitter to identify the CCO network, program, and type of issue they are encountering. The reference/inquiry number is required before proceeding with the rest of the form.

- **Contact Information** The submitter provides contact information (name, phone number, and email address) for the person either DOM or the CCO can contact regarding the reported issue. Please be sure to record **one (1) email address** in the space provided and to check it for accuracy. Upon completion of the form, a summary of the information will be sent to this email address.

- **Provider Information** Allows submitter to provide identifiable information, such as their NPI number and Medicaid ID Number, that will assist the DOM and/or CCO reviewer in searching their respective system(s) for available information related to the reported issue.

- **Description of Issue** Allows the submitter to detail their issue and/or inquiry and provide enough information for the reviewer to identify available data to either educate the provider on any managed care questions or validate the existence of a potential issue. While attachments must be sent securely via email or faxed, the submitter is able to provide the member's name, ID number and date of birth if an issue is related to a specific member(s)*.

** The submitter is only able to include information for up to three (3) members/beneficiaries per issue via the online form.*

2021-2022 Flu Season

The Advisory Committee on Immunization Practices (ACIP) continues to recommend annual influenza vaccinations for everyone who is at least six months of age and older and who does not have contraindications. It's especially important that certain people get vaccinated, either because they are at high risk of having serious flu-related complications or because they live with or care for people at high risk for developing flu-related complications. Additionally, flu vaccinations can reduce the prevalence of flu symptoms that might be similar to and confused with COVID-19.

A licensed, recommended, and age-appropriate vaccine should be used. Inactivated influenza vaccines (IIV4s), recombinant influenza vaccine (RIV4), and live attenuated influenza vaccine (LAIV4) are expected to be available for the 2021–22 season.

COORDINATED CARE NEWS

1. All seasonal influenza vaccines expected to be available for the 2021–22 season are quadrivalent, containing hemagglutinin (HA) derived from one influenza A(H1N1)pdm09 virus, one influenza A(H3N2) virus, one influenza B/Victoria lineage virus, and one influenza B/Yamagata lineage virus.

2. The composition of the 2021–22 U.S. seasonal influenza vaccines includes updates to the influenza A(H1N1) pdm09 and influenza A(H3N2) components. For the 2021–22 season, U.S.-licensed influenza vaccines will contain an influenza A/Victoria/2570/2019 (H1N1)pdm09-like virus (for egg-based vaccines) or an influenza A/Wisconsin/588/2019 (H1N1)pdm09-like virus (for cell culture–based and recombinant vaccines); an influenza A/Cambodia/e0826360/2020 (H3N2)-like virus; an influenza B/Washington/02/2019 (Victoria lineage)-like virus; and an influenza B/Phuket/3073/2013 (Yamagata lineage)-like virus.

3. One labeling change is described. In March 2021, FDA granted approval for the use of Flucelvax Quadrivalent (cell culture–based quadrivalent inactivated influenza vaccine [ccIIV4]) for children aged 2 through <4 years. Flucelvax Quadrivalent had previously been approved for persons aged ≥4 years; approval for those aged 4 through <18 years was based on immunogenicity data and required a post marketing efficacy study. The new approval is based on a randomized observer-blinded clinical efficacy study conducted among children aged 2 through <18 years over three seasons, in which Flucelvax Quadrivalent demonstrated efficacy against laboratory-confirmed influenza of 54.6% (95% confidence interval [CI] = 45.7%–62.1%) compared with a noninfluenza control vaccine. Flucelvax Quadrivalent is now approved for persons aged ≥2 years (21).

4. Guidance regarding administration of influenza vaccines with other vaccines has been updated to reflect consideration for COVID-19 vaccination, which is expected to continue in the United States before and during the 2021–22 influenza season. Current guidance for the use of COVID-19 vaccines indicates that these vaccines can be coadministered with other vaccines, including influenza vaccines. Providers should consult current COVID-19 vaccine recommendations and guidance for up-to-date information. ACIP recommendations for the use of COVID-19 vaccines are available at **https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/covid-19.html**. Interim clinical guidance for the use of COVID-19 vaccines is available at **https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html**. These pages should be checked periodically for updated information.

5. Guidance concerning timing of vaccination has been modified. Women in the third trimester of pregnancy may now be considered for vaccination soon after the vaccine is available. As in previous seasons, children who need 2 doses of influenza vaccine administered ≥4 weeks apart (those aged 6 months through 8 years who have never received influenza vaccine or who have not previously received a lifetime total of ≥2 doses) are recommended to receive the first dose as soon as possible after vaccine becomes available. For nonpregnant adults, early vaccination (i.e., in July and August) should be avoided unless there is concern that later vaccination might not be possible.

6. Contraindications and precautions to the use of ccIIV4 and RIV4 have been modified, specifically with regard to persons with a history of severe allergic reaction (e.g., anaphylaxis) to an influenza vaccine. A history of a severe allergic reaction (e.g., anaphylaxis) to a previous dose of any egg-based IIV, LAIV, or RIV of any valency is a precaution to use of ccIIV4. A history of a severe allergic reaction (e.g., anaphylaxis) to a previous dose of any egg-based IIV, ccIIV, or LAIV of any valency is a precaution to use of RIV4. Use of ccIIV4 and RIV4 in such instances should occur in an inpatient or outpatient medical setting under supervision of a provider who can recognize and manage a severe allergic reaction; providers can also consider consulting with an allergist to help identify the vaccine component responsible for the reaction. For ccIIV4, history of a severe allergic reaction (e.g., anaphylaxis) to any ccIIV of any valency or any of component of ccIIV4 is a contraindication to future use of ccIIV4. For RIV4, history of a severe allergic reaction (e.g., anaphylaxis) to any RIV of any valency or any component of RIV4 is a contraindication to future use of RIV4.For a complete copy of the ACIP recommendations and updates or for information on the flu vaccine options for the 2021-2022 flu season, please visit the Centers for Disease Control and Prevention at **https://www.cdc.gov/mmwr/volumes/70/rr/rr7005a1.htm**.

COORDINATED CARE NEWS

Early Periodic Screening, Diagnostic and Treatment (EPSDT) Program

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental and specialty services.

Molina is required to provide comprehensive services and furnish all appropriate and medically necessary services needed to correct and ameliorate health conditions, based on certain federal guidelines. EPSDT is made up of screening, diagnostic, and treatment services and all providers serving members eligible for EPSDT are required to:

- Inform all Medicaid-eligible individuals under age 21 that EPSDT services are available and of the need for age-appropriate immunizations;
- Provide or arrange for the provision of screening services for all children; and
- Arrange (directly or through referral) for corrective treatment as determined by child health screenings.

As a provider, it is your responsibility to adhere to and understand EPSDT guidelines and requirements to ensure access to the right care at the right time in the right setting.

MCG Cite Guideline Transparency Tool Offers Medical Determination Transparency

Molina has deployed the Transparency tool and it is now live. We are excited to offer this enhancement that will provide medical determination transparency to our provider partners.

What is Cite Guideline Transparency?

Milliman Care Guidelines (MCG) guidelines are proprietary to MCG and Molina is not able to distribute them without the permission of MCG. Cite Guideline Transparency is a tool offered through MCG that allows providers to view all MCG guidelines that Molina currently uses.

Access to Cite Guideline Transparency is available via the Molina Provider Portal and Availity Portal. Within both Portals, providers will find a link to view the evidence-based criteria used to support member care decisions.

COORDINATED CARE NEWS

Molina Legacy Provider Portal

Information for all network providers

On March 1, 2022, the Molina Legacy Provider Portal will no longer accept new user registrations. Providers should register with Availity at availity.com. Once registered with Availity at availity.com, providers will have access to the Availity Portal training by following these steps:

1. Log in to Availity Portal
2. Select Help & Training > Get Trained
3. In the Availity Learning Center (ALC) that opens in a new browser tab, search the catalog and enroll for this title: **Availity Overview for Molina Providers -Recorded Webinar**

Atypical Providers: Once registered with Availity, under Help & Training > Get Trained, search **"Service Providers Not Required to have an NPI"** to view training sessions.

For questions about enrolling in courses **email training@availity.com**.

To view the Availity new user guide visit: **https://www.availity.com/documents/Welcome_New_User.pdf**

Suicide Prevention

Forty-five percent of individuals who die by suicide visit their primary care physician within a month before their death and 67% of those who attempt suicide receive medical attention as a result of their attempt (SAMHSA.gov).

In recognition of National Suicide Prevention Month, which occurred in September, Molina introduced an enterprise-wide Suicide Prevention Program—an organizational strategy to provide more awareness and education around preventing suicides.

To better support our network providers, Molina offers resources related to assessment and intervention for suicidal ideation through the bh_toolkit (molinahealthcare.com), located on the provider pages of the MolinaHealthcare.com website.

Additionally, to support provider office staff, Molina has partnered with PsychHub, the world's most comprehensive multimedia platform for mental health education. We are excited to offer providers and provider office staff the opportunity to become a Certified Mental Health Ally. With the Mental Health Ally Certification, Molina can help equip staff with valuable tools and resources to support mental health in the provider offices and beyond. The Mental Health Ally Certification program is an eight-module training program now available to provider offices with the use of the Cohort Code. Through this course, you will learn about critical mental health topics and gain actionable skills to help others during difficult times.

To access the Mental Health Ally Certification Program and other PsychHub education resources, please visit **https://lms.psychhub.com/** and create an account using Cohort Code: sGDcuXXmQXZEGsu.

magnolia health™

Magnolia Health: New Claim Dispute Process

Magnolia is dedicated to improving provider experience! Our 2021 Provider Satisfaction Survey provided valuable feedback and we are pleased to announce updates to our claim dispute process!

- **Reconsiderations are now optional.** Effective now, if you disagree with the outcome of a processed claim, you have the option to file either a reconsideration or claim appeal first. In our previous process, a Request for Reconsideration was a requirement and prerequisite to filing a claim appeal.
- **New Claim Reconsideration and Claim Appeal Forms**
- **Increased the Claim Dispute Submission Timeframes.** All corrected claims, requests

COORDINATED CARE NEWS

for reconsideration, or claim appeal must be received within 90 calendar days from the date of notification of payment or denial. Please note that changes do not impact first time claim submission timeframes.

Adjusted or Corrected Claims can be submitted through the Magnolia Secure Provider Portal or to Magnolia Health Attn: Corrected Claim PO Box 3090 Farmington, MO 63640-3800.

- The claim should include the appropriate resubmission code and the original claim number or the original EOP must be included with the resubmission.
- Failure to include the appropriate resubmission code and original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit

Request for Claim Reconsideration can be submitted by logging into your Magnolia Secure Provider Portal or by mail to Magnolia Health Attn: Reconsideration PO Box 3090 Farmington, MO 63640-3800. Magnolia encourages providers to utilize the Secure Web portal or the **Reconsideration Dispute form (https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/MHPlanClaimReconsideration.pdf)** when submitting reconsideration request.

- A request for reconsideration is a written communication from the provider about a disagreement in the way a claim was processed but does not require a claim to be corrected and does not require medical records.
- Request must include sufficient identifying information which includes, at minimum, the patient's name, patient ID number, date of service, total charges and provider name.
- Documentation must also include a detailed description of the reason for the request.

*Important: **Please note that a request for reconsideration cannot be filed after a request for a claim appeal or exhausting the claim dispute process**.

If the corrected claim or the request for reconsideration results in an adjusted claim, you will receive a revised Explanation of Payment (EOP). If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision and next steps in our claim dispute process.

Request for Claim Appeal must be submitted by mail to Magnolia Health Attn: Dispute PO Box 3090 Farmington, MO 63640-3800

- To ensure timely processing please utilize the **NEW! Claim Appeal Dispute form (https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/MH-Plan-Claim-Appeal-Form.pdf)** or the request must be clearly be marked as "Claim Appeal" at the top of your documentation
- Request must include detailed and sufficient information which includes, reason for claims appeal request, the patient's name, patient ID number, date of service, total charges and provider name.

If the request for a claim appeal is upheld or overturned, you will receive a letter detailing the decision. Please note that a reconsideration cannot be filed after an appeal.

If you have questions about this process or would like to receive education related to the changes, please contact Provider Services at **1.866.912.6285** or your Provider Network Specialist.

UnitedHealthcare® Community Plan

Access and Availability Standards

As a reminder, primary care providers (PCPs) and obstetricians must be available to members by phone 24 hours a day, 7 days a week, or have arrangements for telephone coverage by another UnitedHealthcare participating PCP or obstetrician. Any coverage arrangements that deviate from this requirement must be approved by a UnitedHealthcare medical director or physician reviewer.

COORDINATED CARE NEWS

Standards for Timely Appointment Scheduling:
Emergency Care Immediately upon the member's presentation at a service delivery site.

Primary Care

- Urgent, symptomatic office visits must be available from the member's PCP or another care provider within 24 hours. This would involve the presentation of medical symptoms that require immediate attention but are not life-threatening.
- Routine office visits or non-urgent, symptomatic visits must be available from the PCP or another care provider within 7 calendar days. A non-urgent, symptomatic office visit would involve medical symptoms that don't require immediate attention.
- Non-symptomatic office visits must be available from the member's PCP or another care provider within 30 calendar days. This type of visit could include wellness and preventive care such as physical examinations, annual gynecological examinations, child and adult immunizations or other services.

Specialty Care

- Specialists and specialty clinics should arrange appointments within 45 days.

Behavioral Health (Mental Health and Substance Abuse)
Behavioral health care providers should arrange appointments for:

- Emergency care (non-dangerous to self or others) immediately upon presentation
- Urgent problems within 24 hours of the member's request
- Post Discharge from an acute psychiatric hospital within 7 days
- Routine Non-urgent issues within 21 days of the member's request

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 days 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.

COORDINATED CARE NEWS

Immunizations for Adolescents (IMA)

Percentage of adolescents age 13 who had 1 dose of meningococcal vaccine, 1 tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine and completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

Collection and Reporting Method
Administrative• Claim/Encounter Data and
Hybrid• Medical Record Documentation Review

Tips and Best Practices to Help Close This Care Opportunity:

- **Please check your Patient Care Opportunity Report (PCOR) often to see members with open care opportunities.** If you have questions, your UnitedHealthcare representative can help.
- When possible, please review vaccine status with parents and give immunizations at visits other than only well-child appointments.
- Offer options such as extended hours or walk-in vaccination clinics.
- Consider setting up a drive-up immunization site.
- 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

Important Notes

A member's medical record must include:

- A note with the **name of the specific antigen and the date** the vaccine was administered.
- An immunization record from an authorized health care provider or agency – for example, a registry – including the **name of the specific antigen and the date** the vaccine was administered.

For meningococcal conjugate, meningococcal recombinant – serogroup B (MenB) – will **not** meet compliance.

Documentation that a member is up to date with all immunizations, but doesn't include a list of the immunizations and dates they were administered, will **not** meet compliance.

Documentation of physician orders, CPT codes or billing charges will **not** meet compliance.

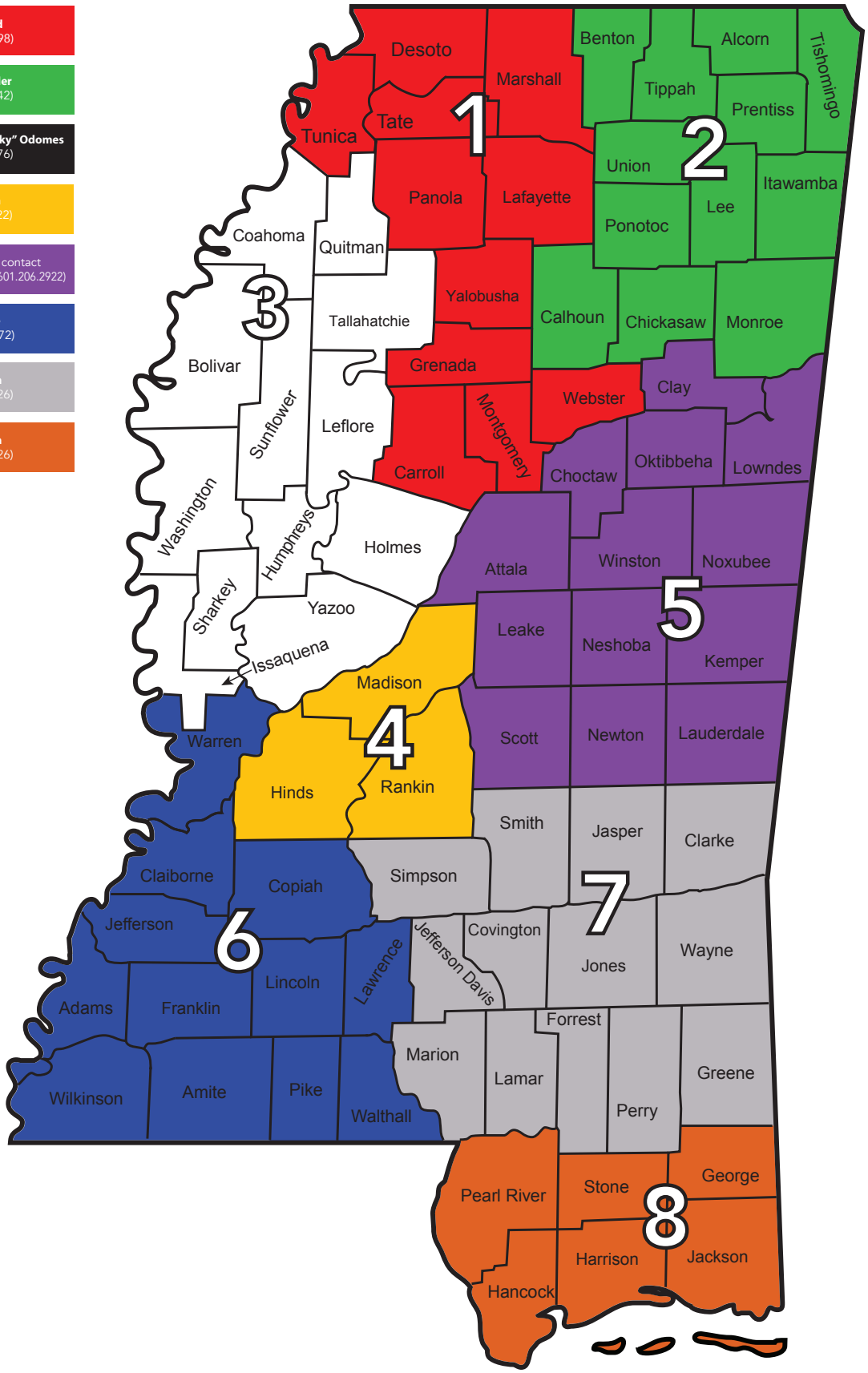
For documented history of anaphylaxis or encephalitis, there must be a note indicating the date of the event, which must have occurred by the member's 13th birthday.

Medical Record Detail Including, But Not Limited to

- History and physical
- Immunization record
- Lab results
- Problem list
- Progress notes

FIELD REPRESENTATIVE REGIONAL MAP

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



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	AREA 5 TBA (interim contact Justin Griffin 601.206.2922 justin.griffin@conduent.com)	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 Erica Guyton (601.206.3026) erica.guyton@conduent.com		AREA 8 Erica Guyton (601.206.3026) erica.guyton@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	**Justin Griffin (601.206.2922)** justin.griffin@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

MARCH 2022

THURS, MARCH 3	EDI Cut Off – 5:00 p.m.
MON, MARCH 7	Checkwrite
THURS, MARCH 10	EDI Cut Off – 5:00 p.m.
MON, MARCH 14	Checkwrite
THURS, MARCH 17	EDI Cut Off – 5:00 p.m.
MON, MARCH 21	Checkwrite
THURS, MARCH 24	EDI Cut Off – 5:00 p.m.
MON, MARCH 28	DOM Closed
THURS, MARCH 31	Checkwrite

APRIL 2022

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

MAY 2022

MON, MAY 2	Checkwrite
THURS, MAY 5	EDI Cut Off – 5:00 p.m.
MON, MAY 9	Checkwrite
THURS, MAY 12	EDI Cut Off – 5:00 p.m.
MON, MAY 16	Checkwrite
THURS, MAY 19	EDI Cut Off – 5:00 p.m.
MON, MAY 22	Checkwrite
THURS, MAY 26	EDI Cut Off – 5:00 p.m.
MON, MAY 30	Memorial Day DOM Closed

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.