Mississippi Medicaid

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November 2002 Bulletin

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## Changes in Dental and Eyeglasses For Pregnancy-only Eligibles

Women who are eligible for Medicaid only because of pregnancy, as specified in the Mississippi State Plan, are covered only for those services that are related to:

- Pregnancy (including prenatal, delivery, postpartum, and family planning services); and
- Other conditions which may complicate pregnancy.

Effective November 1, 2002, dental services, eyeglasses, and contact lenses will **NOT** be included in coverage for women in these eligibility categories. The Division of Medicaid is working with the fiscal agent to include a message on the AVRS system stating "No dental or eyeglass coverage on and after 11/01/02" for beneficiaries in these eligibility categories. Providers should use the AVRS system to verify whether a female beneficiary is eligible for these services.

## Resubmitting Claims

The Division of Medicaid and the fiscal agent, ACS State Healthcare, have identified many problems resulting from providers resubmitting claims repeatedly, sometimes daily, as a means of following up on claims on which processing has not been completed. The Division of Medicaid is directing that claims not be resubmitted as a means of following up on claims. If providers need to check on the status of claims which are in process, they must contact the fiscal agent for a status report. If, upon completion of processing, the claim is rejected for a reason that justifies resubmission, then and only then should providers resubmit claims.

## Updates to State Plan

For updates to the Medicaid State Plan, please refer to the DOM website (www.dom.state.ms.us). Proposed amendments, retracted/withdrawn amendments, and approved amendments will be posted under the topic "State Plan."

MISSISSIPPI DIVISION OF MEDICAID

## Questions and Answers

The following questions were submitted to the DOM by optometry providers; however, questions specifically related to eye care may be applicable to all providers of eye care. In addition, please note some general questions are applicable to all providers.

1. What are optometrists supposed to bill in the charge column on the HCFA-1500 claim form?

    - Providers should list the usual and customary charge for those services being billed to the Division of Medicaid (DOM) for examinations, fitting, etc. (refer to page 139 of the current Mississippi Medicaid Eyeglass Manual).

    - The provider's actual acquisition cost, as it appears on the invoice, should be indicated for all lenses (refer to pages 139 & 251 of the current Mississippi Medicaid Eyeglass Manual).

    - The provider may bill the cost for the frames as listed in the frames publication (refer to page 251 of the current Mississippi Medicaid Eyeglass Manual).

2. What can providers do to resolve duplicate payments and returning money to ACS?

    - The staff of ACS is working to identify the problems associated with duplicate payments made by the fiscal agent since the takeover of January 1, 2002. The DOM will require reprocessing of claims and recoupment of overpayments without any action on the part of the providers. Any duplicate payments due to provider error should be handled according to current Medicaid policy.

3. Explain what happens as the beneficiary transitions from benefits as a child to being age 21 as it relates to time lines when eyeglasses can be dispensed?

    - Eyeglass benefits for children are available until the last day of the month that they turn age 21. Beneficiaries age 21 and over who have received eyeglasses since July 2000 cannot obtain another pair until 5 years from the date they received the last pair.

4. Providers are getting the wrong information when verifying eligibility from ACS staff because the provider does not know the different eligibility categories which exclude eyeglass services. How can this be resolved?

    - DOM has discussed these problems with ACS and further training will be provided to the ACS staff in regard to these issues.

5. Beneficiaries covered under certain programs are not eligible for eyeglass services. Could ACS staff provide such information regarding program codes?

    - It is the responsibility of the fiscal agent (ACS) to be knowledgeable of program codes and to properly advise providers regarding specific exclusions.

6. Explain abuse of the program as it relates to billing for eyeglasses when the beneficiary has not received the glasses prior to the provider billing the claim to Medicaid.

- Refer to the Eyeglass Policy Manual, Chapter 7-Billing Procedures, page 160, #31, which in part states "I certify that the services listed on this claim were medically indicated and necessary to the health of this patient and all services were personally **rendered** by me or under my personal supervision." Therefore, a provider cannot bill for any service(s) until the service(s) has been rendered, which includes providing the beneficiary with eyeglasses. To bill prior to dispensing the eyeglasses is to bill for services not rendered.

- Federal law, Section 1902(a)(37) of the Social Security Act, states providers must keep records and documents that disclose the extent of the services provided to beneficiaries for which payment was made.

- The Mississippi Code has a similar provision at 43-13-118 stating that "It is the duty of each provider participating in the medical assistance program to keep and maintain books, documents, and other records as prescribed by the Division of Medicaid in substantiation of its claim for services rendered Medicaid recipients for a minimum of five (5) years or for whatever longer period as may be required or prescribed under federal or state statutes and shall be subject to audit by the Division." Included in 43-13-117 is the language that medical assistance authorized by the statute shall include "the following..." with payment of costs of services rendered to beneficiaries. "The following" includes eyeglasses. Thus, payment by DOM can only be made for the beneficiary who has received eyeglasses.

7. Can a provider send the eyeglasses to the beneficiary by certified mail and then bill Medicaid the fees for fitting and eyeglasses?

- No, because the fitting of spectacles, including the final adjustment, is a service covered by Medicaid. If the final adjustment of the eyeglasses is not provided to the beneficiary, the fitting fee cannot be billed to Medicaid. Mailing the eyeglasses does not allow the provider the opportunity to do the final fittings.

- If the beneficiary does not return for the final fitting and the eyeglasses within two weeks of notification, the provider may contact the Beneficiary Relations Division at the Division of Medicaid and request assistance in getting the beneficiary to cooperate with the provider. DOM will contact the beneficiary to try to determine why he/she has not returned for completion of the eyeglass services.

8. Are pregnant women being excluded from the dental and eyeglass program during pregnancy?

- Pregnant women who qualify for pregnancy-only services under Medicaid will not be eligible for dental services or eyeglasses as of November 1, 2002. These women are covered in program code 88. DOM has requested that ACS modify the AVRS system to generate a message to the providers.

9. Pregnant women often experience visual changes due to hormonal changes. Do they qualify for glasses if they have symptoms such as headache or asthenopia?

- Pregnant women who qualify for pregnancy-only services (program code 88) are not eligible for eyeglasses. Pregnant women covered through other eligibility categories do not qualify for eyeglasses solely on the symptoms associated with hormonal changes.

10. Should a copayment be applied for pregnant women?

    - Pregnant women are exempt from copayments. If the "P" indicator is properly indicated as a suffix to the Medicaid ID number on the claim no copayment should be deducted when the claim is processed. If there are problems with copayments being incorrectly deducted the provider should contact the fiscal agent.

11. Beneficiaries not showing for appointments! Could providers give the beneficiary two tries with an appointment, with the third time as a walk-in and work them in?

    - Beneficiaries may not be billed for missed appointments. Office policies for "working in" missed appointments must be consistently applied to all patients, not just Medicaid beneficiaries.

12. What is the procedure to report patients who attempt and succeed in abusing the program by using someone else's card? What penalties do these people face? Can providers refuse service if they know abuse of the program exists? Can they refuse service if the patient has no picture ID?

    - If you suspect abuse, additional identification (with photo) should be requested and copied. Also, the Medicaid card can be retained and then only released to an authorized DOM representative. The provider should contact the local law enforcement agency and after that the provider is required to contact the Bureau of Program Integrity. The statewide Fraud and Abuse Hotline Number is 1-800-880-5920.

    - If it is found that the person presenting for services was not the Medicaid beneficiary to whom the card was issued, the provider is responsible for refunding any monies paid by Medicaid to the provider for those services provided.

    - Penalties related to abuse of the program in connection with state or federally funded assistance programs may be found in Section 97-19-71 of the Mississippi Code of 1972.

    - Providers may refuse to provide services if they have knowledge that the beneficiary is not eligible for Mississippi Medicaid and is using the identification of another beneficiary.

    - Providers may not refuse services solely on the basis that the patient cannot provide a picture ID. If no picture ID is available, it is suggested that confirmation of identity be done by verifying the Social Security number and/or birth date. Also, if another form of identification is not available, providers could compare signatures with a signature on file or contact ACS at 1-800-884-3222 to confirm identifying information (examples: name, date of birth, address, etc.).

13. How can a provider get a second form of ID from a child?

    - The provider has the responsibility of confirming that the person presenting the card is the person to whom the card is issued. This can be done by requesting a picture ID, such as a driver's license, school ID card, or verifying the Social Security number and/or birth date.

    - If a second form of ID cannot be obtained from a child, the provider should request additional identification from the caretaker who brought the child to the provider.

14. How should a provider handle providing services to a Medicaid beneficiary who is a minor, without the presence of a parent or guardian?

    - Providers should apply the same office policy for treatment of Medicaid beneficiaries as they do for all minors who are not accompanied by a parent or guardian.

15. Is there a code for hi-index/polycarbonate (high prescription) lenses?

    - Coverage in this situation is allowed only through the EPSDT program for beneficiaries less than 21 years of age. There is no coverage for hi-index/polycarbonate (high prescription) lenses for beneficiaries age 21 and older.

    - Claims for hi-index/polycarbonate (high prescription) lenses can be filed using unspecified codes (V2199, V2299, V2399, V2499, V2599 and V2799) which can be submitted with the PA and the invoice from the supplier for manual pricing.

16. Does Medicaid pay the deductible and/or coinsurance for the eyeglasses for dual eligibles?

    - If Medicare covers the eyeglasses, Medicaid will reimburse toward the deductible and/or co-insurance.

17. Is age 18 or 19 the correct age to collect copayment? Clarify.

    - Children under age 18 are exempt from copayments.

18. When can two copayments be taken for the same date of service?

    - If a provider bills for both a visit and eyeglasses (fitting) on the same date, the copayment amount for both the visit and eyeglasses is applied.

19. Which codes are subject to copayment for eyeglasses?

    - A copayment of $3.00 is applied when a provider bills one of the following fitting codes: 92340, 92341, 92342, 92352, 92353. (Refer to the March, 2002 Mississippi Medicaid Special Provider Bulletin for exception codes.)

20. Which codes are subject to copayment for visits? Medicaid services subject to copayment are:

    - Ophthalmological office visit codes: 92002 and 92004 for new patients and 92012 and 92014 for established patients.

    - E&M codes: 99201-99205 for office or other outpatient services for new patients and 99211-99215 for established patients.

    - Home Visits: 99341-99343 for new patients and 99351-99353 for established patients.

    - Emergency Room visits: 99281-99285 for new or established patients.

    (Refer to the March, 2002 Mississippi Medicaid Special Provider Bulletin for exception codes.)

21. Can a provider bill a patient who is covered by Medicaid only for a refraction?

    - If a provider bills CPT Codes 92004 or 92014, the patient cannot be billed for a refraction because current Medicaid policy includes refractions in the descriptions and reimbursements of these codes.
    - If a provider performs a refraction with any other code, the beneficiary may be billed for the refraction.

22. Can the provider bill the patient for refraction if Medicare/Medicaid and Medicare does not cover refraction?

    - Providers may bill the patient for the refraction unless the service is being provided through CPT Codes 92004 or 92014.

23. When the 20% coinsurance for eyeglasses is paid for dual (Medicare/Medicaid) patients, providers have been told conflicting things: either that Medicaid will pay for eyeglasses later or that they will not pay for five years. If this is correct that Medicaid will not pay for five years, do providers need to encourage a patient to pay the 20% after surgery so beneficiaries can save their Medicaid eyeglasses for the next time?

    - If coinsurance is paid for eyeglasses, it applies toward the 5 year benefit limit. Providers should not ask or require patients to pay the coinsurance amount for the purpose of avoiding Medicaid service limits.

24. If a Medicare/Medicaid patient receives glasses after cataract surgery, do they have to wait 5 years for Medicaid to pay for glasses, since Medicaid only paid 20% of the pair after surgery?

    - When the coinsurance is paid by Medicaid for eyeglasses, it does apply toward the 5-year benefit limit.

25. Is it 6 months after cataract surgery or 6 months after any eye surgery that changes the vision?

    - Medicaid policy states “surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses or a change in eyeglasses is medically indicated within six (6) months of the surgery and is in accordance with policies established by the division”.

26. In some publications, it states that “patient must be present to authorize benefits information.” How can eligibility for an eye exam be determined on Saturday or after hours?

    - Medicaid providers may verify eligibility status by one of the following methods: 1. Calling the AVRS or 2. Using the point of service eligibility verification system. Providers can now call the Mississippi Medicaid Voice Information System directly by calling 1-866-597-2675 or 601-206-3090.

27. After a Medicaid beneficiary receives eyeglasses, can providers bill copayment amounts through monthly statements?

    - Providers may bill the beneficiary for the copayment on a monthly statement. Providers are responsible for collecting the copayment on applicable Medicaid services. This amount will then be withheld from the Medicaid payment when the claim is processed.

28. Who should a provider notify when erroneous information is received on a patient's eligibility?

    - The provider should contact the fiscal agent at 1-800-884-3222 or 601-206-3000.

29. Can Medicaid patients pay for extras such as scratch coating and tints?

    - Scratch coating is not a Medicaid covered item and may be billed to the beneficiary if he/she chooses the option. Tints are covered by Medicaid.

30. What is the phone number to call for the Division of Medicaid's Provider/Beneficiary Relations?

    - The telephone number is 601-359-6133 or 1-800-421-2408.

31. If a provider has claims which have been pending payment for a long time, what action should the provider take to have the claims resolved?

    - The provider may discuss the problems with the DOM Provider Relations Division.

32. When a PA is obtained for medical services, does such an authorization guarantee payment from Medicaid?

    - Providers should be aware that approval of services does **not** guarantee Medicaid eligibility of the patient or payment of the service.

33. Patients in a nursing facility should be exempt from copay. When we examine a patient that resides in a nursing facility, we put a code "N" on the electronic claim on the copay field. However, we still are charged a copay. Is there something else we should do?

    - If the "N" is properly billed, no co-pay should be charged. The "N" copay indicator should be entered at the end of the Medicaid ID number.

    - If a denial is received in this situation when the "N" copay indicator has been entered appropriately, verification of receipt of the data in this field is needed. Providers using a software vendor should first verify with the vendor that the software allows for the copay indicator to be captured and transmitted. It may then be necessary to contact the fiscal agent EDI Department to verify that the "N" copay is being received in the claims transmission.

34. Why do I get a denial that says "does not match PA info" when it matches PA perfectly? The fiscal agent has been unable to explain the denial.

    - It is the responsibility of the fiscal agent to thoroughly research the problem and assist the provider with resolution.

35. If a provider receives an error code 650 with no history of the patient having had eye surgery, how should the provider resolve this claim?

    - The provider should call the fiscal agent who is responsible for researching the problem and assisting in claim resolution.

36. Is it okay for a beneficiary to pay for deluxe frames or contact lenses not covered by Medicaid, because they don't want the frames covered by Medicaid?

    - If the beneficiary chooses this option, he/she may choose to be treated as private pay. However, the provider cannot bill Medicaid and require the beneficiary to pay the difference. Medicaid beneficiaries may exercise freedom of choice in this situation. As for the provider, split billing is not allowed. The beneficiary must be treated as either Medicaid or private pay.

37. Are there any plans for a picture ID card for Medicaid beneficiaries?

    - The DOM is assessing the feasibility and costs relating to pictures on the Medicaid ID card.

38. The Tomography code 92135 is a two line item for Medicare reimbursement. Is there any way DOM can make the Medicaid filing for code 92135 like Medicare to simplify the process?

    - Mississippi Medicaid does not utilize the modifier RT and LT to direct reimbursement of procedure. Providers should bill this code on one line with the 50 modifier when billing for a bilateral procedure.

## Notice to Nursing Facilities: Utilization of the Minimum Data Set (MDS) MPAF Assessment Form

Effective Immediately: The Division of Medicaid will accept the new MDS Medicare PPS Assessment Form (MPAF) as the quarterly assessment with exceptions as follows:

**Full Assessment Required**: The Omnibus Budget Reconciliation Act (OBRA) of 1987 assessment requirements supercede the use of the abbreviated form. A full assessment must be submitted for initial assessments, significant change in status assessments, significant correction assessments and annual assessments.

**Full Assessment Required**: Nursing facilities with a designated Alzheimer's Unit must submit a full assessment for the quarterly assessment in order to receive consideration for reimbursement.

**Additional Requirement**: A Mississippi Specific Section S must accompany **ALL** assessments.

*Use of the MPAF form is **optional.*** Facilities may continue to complete and submit the MDS full assessment form for all assessment types.

If you have any questions, please call the Case Mix Helpline at 601-359-5191 or 601-359-6750.

# Updates to the Pharmacy Program

Effective November 1, 2002, the following changes have been made to Division of Medicaid's Pharmacy Prior Authorization (PA) requirements:

***Drugs/Drug Classes Removed from the PA List***

BENZODIAZEPINES: PA is no longer required for benzodiazepines. Appropriate prescribing and usage will be monitored via the drug utilization review process.

CLOZAPINE: PA is no longer required for clozapine. Appropriate prescribing and usage will be monitored via the drug utilization review process.

CHILDREN: PA is not required for Extension of Benefits (7 prescriptions) for children under the age of 21. Appropriate prescribing and usage will be monitored via the drug utilization review process.

***New Drugs/Drug Classifications added to the PA List***

Brand Oral Sustained Release (SR) Opioid Agonists PA Criteria

Beneficiaries appropriate for brand oral SR opioid agonists must have chronic, severe pain that has not responded to alternative pain management choices, such as schedule II opioid agonists, physical therapy, cognitive behavioral techniques and/or medical techniques.

Additional justification for approval:

- Diagnosis of cancer (ICD-9 codes 141.0-208);
- Arthropathies (ICD-9 codes 715.01-715.9 & 742.2);
- Spinal neurological disorders (ICD-9 codes 720-725);
- Other ICD-9 codes with supporting documentation; or
- Additional medical justification for the absence of alternative therapies in debilitated patients.

Contraindications:

- Hypersensitivity to opiates
- Respiratory depression/hypoxia/hypercarbia
- Severe asthma or COPD
- Paralytic ileus

Approval will be granted for up to two tablets per day of any single strength. If the request is for more than two tablets per day, additional medical justification will be required for approval based on asymmetric dosing or titration.

For opioid dependent patients, documentation of a titration-weaning schedule must be provided. Approval may be granted for a 34-day supply for up to six months.

The PA form is attached for your use.

# BRAND ORAL SR OPIOID AGONIST

PRIOR AUTHORIZATION REQUEST FORM

NOTE: Oral SR opioids agonist are narcotic analgesics and schedule II controlled substances. They are not intended for use as a PRN analgesic or for short-term (10 days or less) pain management.

FAX OR MAIL TO:
HEALTH INFORMATION DESIGNS
P.O. BOX 320506
Flowood, MS 39232
Phone: (800) 355-0486 or Fax: (800)459-2135

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid #: _____

Address: _____ City: _____ State _____ Zip _____

DOB: _____ (Month Day 4-Digit Year)

PRESCRIBER INFORMATION

Medicaid ID #: _____

Prescribing Physician: _____

Address: _____ Phone #: _____ (Area Code)

_____ City _____ State _____ Zip Fax #: _____ (Area Code)

***A physician, nurse practitioner or physician assistant who attests to the medical necessity of the prescribed medication, who knowingly or willingly makes, or causes to be made, any false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments, may be prosecuted under federal and/or state criminal laws and/or may be subject to civil monetary penalties and/or fines. I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form. I certify that the medical necessity information is true, accurate and complete to the best of my knowledge. I certify that I have reviewed the items requested in this form and that I deem them medically necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil monetary penalties, fines or criminal prosecution.***

_____
Physician's Signature and Date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider #: _____

Address: _____ Phone #: _____ (Area Code)

_____ City _____ State _____ Zip Fax #: _____ (Area Code)

DRUG/CLINICAL INFORMATION

Drug Name: _____

Diagnosis: _____ Daily Dose _____ Quantity/month: _____

Duration of Therapy: _____ months ICD-9: _____ NDC #: _____

Additional Medical Justification: _____

Indicate type of pain: Acute ☐ Chronic; ☐ Indicate severity of pain: ☐ Mild ☐ Moderate ☐ Severe

Does the patient have a history of substance abuse or addiction? ☐ Yes ☐ No

Does the patient have a history of the following?

- ☐ Hypersensitivity to opiates
- ☐ Respiratory depression/hypoxia/hypercarbia
- ☐ Severe asthma or COPD
- ☐ Paralytic ileus
- ☐ Pregnancy/lactation
- ☐ Increased intracranial pressure
- ☐ Circulatory shock

Indicate prior and/or current analgesic therapy or alternative management choices:

Drug/therapy: _____ Dose: _____
Length of therapy: _____ Reason of d/c: _____
Drug/therapy: _____ Dose: _____
Length of therapy: _____ Reason of d/c: _____

***Supporting documentation must be available in the patient record.

FOR HID USE ONLY

Medicaid Eligibility verified _____ by _____
Approved_____ Date _____
Start Date _____ Stop Date _____
Qty Approved _____
Reviewed by _____
HID # _____

Medicaid Eligibility verified _____ by _____
Denied_____ Date _____
Reason _____
_____
Reviewed by _____
HID # _____

Form #1290 7/2/2002

## Reimbursement for CPT Code 99050

Beginning with dates of service on and after January 1, 2002, the Division of Medicaid began reimbursing for CPT code 99050, services requested after office hours in addition to basic service and in addition to an appropriate office visit charge. This was done in an effort to encourage Medicaid beneficiaries to utilize appropriate services for urgent, non-emergency conditions rather than going to the emergency room. The incentive fee should be billed with an appropriate evaluation and management (E/M) office visit procedure code and will be paid only if the associated office visit is covered. The extended hours office visit fee may not be billed with CPT code 99211.

Extended hours office visits are defined as those that occur outside of regular office hours; on Saturday and Sunday; and on specified legal holidays, i.e., Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Day, and New Year's Day. The Division of Medicaid considers regular office hours to be 8:00 a.m. to 5:00 p.m. Monday through Friday.

Providers are reminded that these extended hours fees are limited to visits for urgent situations that arise unexpectedly but are not emergencies that require the use of an emergency room as defined by the prudent layperson standard established by the Balanced Budget Act of 1997.

The fee also may not be billed for regularly scheduled, non-urgent visits or when an appointment was scheduled for regular office hours but took place at another time because the regular schedule went overtime. Documentation of the visit time and the urgent situation that arose unexpectedly must be included in the medical record, and documentation of the appointment time must be available for review if requested.

### Policy Manual Reminder

This bulletin is a document for the Mississippi Medicaid Policy Manual and must be placed behind Tab 88 of the manual. All providers are accountable for all policies in the monthly Mississippi Medicaid Bulletins.

## New Windows –Based Claims Submission Software


Currently, Mississippi Medicaid providers use the DOS-based electronic billing software, NECS, to submit claims to Mississippi Medicaid. In the near future, a new Windows-based software product will be available for electronic claims submission.

ACS has designed a new Windows-based software product called Windows Accelerated Submission and Processing 2000 (WINASAP2000). Just like NECS, this new Windows-based software allows the user to submit claim data electronically from a personal computer to ACS. And just like NECS, this software is free to all active Mississippi Medicaid providers.

Benefits of WINASAP2000:

- Electronic Void Capability
- Stable environment
- User friendly

To use WINASAP2000, your personal computer must meet the following minimum requirements:

- ✓ Windows 95 or higher operating system
- ✓ Pentium processor
- ✓ CD-ROM drive
- ✓ 50 megabytes of free disk space
- ✓ 64 megabytes of RAM
- ✓ Hayes compatible 9600 baud asynchronous modem
- ✓ Telephone connectivity

Look for more information about this exciting new product by ACS in the coming months by visiting our Mississippi Medicaid website at http:\\www.acs-gcro.com.

ACS
P.O. Box 23078
Jackson, MS 39255

Presorted
First Class Mail
U.S. Postage Paid
Jackson, MS
Permit No. 53

*If you have any questions related to the topics in this bulletin, please contact ACS at 1-800 -884 -3222 or 601 -206 -3000*

Mississippi Medicaid Bulletins and Manuals are on the Web www.dom.state.ms.us

# November

## November 2002

| SUNDAY | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | SATURDAY |
|---|---|---|---|---|---|---|
| | | | | | 1 | 2 |
| 3 | 4 CHECKWRITE | 5 | 6 | 7 EDI Cut Off 5:00 p.m. | 8 | 9 |
| 10 | 11 DOM and ACS CLOSED CHECKWRITE | 12 | 13 | 14 EDI Cut Off 5:00 p.m. | 15 | 16 |
| 17 | 18 CHECKWRITE | 19 | 20 | 21 EDI Cut Off 5:00 p.m. | 21 | 23 |
| 24 | 25 CHECKWRITE | 26 | 27 | 28 DOM, HSM and ACS CLOSED EDI Cut Off 5:00 p.m. | 29 | 30 |

**Checkwrites and Remittance Advices are dated every Monday. However, funds are not transferred until the following Thursday, and Remittance Advices usually arrive the following Friday.**