Mississippi Medicaid Bulletin

Volume 11, Issue 3

March 2005

Inside this Issue

EDI Transition

Effective February 1, 2005, you will be speaking with local representatives when you need EDI assistance. Providers will no longer have to contact EDI Gateway in Tallahassee, Florida, for help. Our on-site ACS Call Center will be resolving your EDI inquiries. Once you dial the number for the ACS Call Center (800-884-3222), please listen for the option number for EDI. When the EDI option is selected, your call will be immediately routed to a live and local Customer Service Associate. We hope that this seamless transition will help us to continue providing excellent customer service to all our Mississippi Medicaid providers.

Call Center Update

Since October of 2004, the ACS Call Center has maintained an average speed of answering calls that is less than 60 seconds. When you call to speak with a representative, your call is answered in less than one minute. We have recently experienced days where there has been no hold time at all. Additionally, the Call Center Research Team is responding to inquiries within 48 hours – which translates to issues being resolved more quickly. We are working very hard to give each provider the best service we can offer. We hope that each interaction with the ACS Call Center is a positive one.

Reenrollment Ends

Reenrollment for all Medicaid providers has ended. For any providers who did not successfully reenroll by the deadline of December 31, 2004, there is still time to have your files updated so that you may continue to see Medicaid patients. It is imperative that you act quickly. You must complete your reenrollment application and mail it to ACS Provider Enrollment, P. O. Box 23078, Jackson, MS 39225. Thanks to all the Mississippi Medicaid providers for your continued participation in our program and for helping us to make reenrollment a success.

BENEFICIARY HEALTH MANAGEMENT PROGRAM

In the year 2005, Division of Medicaid will be implementing a program called **Beneficiary Health Management.**

The Mississippi Medicaid Agency closely monitors program usage to identify beneficiaries who may be potentially overutilizing or misusing Medicaid services and benefits. For beneficiaries who are identified, reviews will be performed by Medicaid Program Nurse(s) to determine overuse or misuse of services. If the review indicates overuse and/or misuse of services, the Medicaid Program Nurse(s) will obtain a physician and/or pharmacy consultation to confirm the beneficiary's pattern of misuse/overuse of Medicaid services.

The beneficiary will be sent a letter of education regarding the usage of one physician and/or one pharmacy for his/her medical/pharmaceutical needs. The letter will explain the quality of medical care that can occur with the use of one physician and/or one pharmacy. Also included will be detailed information regarding ongoing monitoring of the beneficiary's usage of the Medicaid program. If a pattern of continued overuse/misuse of services is identified, the beneficiary will be required to specify one physician and/or one pharmacy and up to five physician specialists (if requested) for his/her medical/pharmaceutical services and will be placed in the Beneficiary Health Management program. Beneficiaries will be placed in the program for a period of 18 months with ongoing reviews to monitor pattern of care.

Beneficiaries may be referred to another provider for consultation by the specified physician or specialists by using the Beneficiary Health Management Referral Form. Prior Approval must be received before the beneficiary can see the referral physician (this excludes any emergency situation).

Beneficiaries will continue to have unrestricted access to the emergency room, inpatient hospitalization, dental, optical, psychiatric, home health, hospice, Medicaid waiver and DME services.

When a beneficiary is placed in Beneficiary Health Management, his/her specified physician and/or pharmacy will be notified and instructed that CPT code 99401-99402 (preventive medicine counseling, 15 minutes and 30 minutes) is appropriate to bill each time they provide this service to the beneficiary. This code can be billed along with any other service the physician provides to the beneficiary. Documentation in the beneficiary's medical record must support billing for CPT code 99401-99402 by the physician and/or pharmacy.

Questions can be directed to the Bureau of Program Integrity, Medical Review Division, Beneficiary Health Management Unit at 1-800-880-5920.

ICD-9-CM Coding Tip

ICD-9-CM is composed of codes with three, four, or five digits. A code is invalid if it has not been coded to the full number of digits required for that code. To ensure proper coding, providers must use the most current version of the ICD-9-CM, updated October 1 of each year.

One Servicing Provider Per Claim

Effective immediately the Division of Medicaid will no longer allow multiple servicing providers to be billed on the same claim. This includes both paper and electronic claims. The servicing provider information is input in field locator 24K on the CMS 1500 form. Billing for multiple servicing providers on the same claim may cause substantial delays in processing and denial of these claims.

Returning Money to the Division of Medicaid

ACS State Healthcare and the Division of Medicaid have received numerous inquiries from providers regarding the procedures for returning money to Medicaid.

The most efficient way to return money to Medicaid is for providers to submit an adjustment/void request for each claim to be voided. Boxes 1 through 6 of the adjustment/void request form must be completed.

If providers choose not to have the overpayments deducted from future claims payments, a personal check should be attached to the adjustment/void request form.

If a provider has an extenuating circumstance which makes completing the adjustment/void request unfeasible, the following information should be included with their personal check:

- Provider ID number
- A list of TCNs (transaction control numbers) to be voided
- Beneficiary ID numbers
- Dates of service
- Payment amount
- Remittance advice date

Please note the information requested in the paragraph above is needed for each claim to be voided. The completed adjustment/void forms or the documentation referenced above should be mailed to:

Mississippi Medicaid Program
P.O. Box 6014
Ridgeland, MS 39158

INJECTABLE DRUGS - REMINDER

When submitting claims for injectable drugs, only the units actually administered are to be reported on the CMS-1500 claim form. For example: J0150, Adenosine, 30 mg, is supplied in 90 mg vials (single or multi-use). If 120 mg are administered, 2 vials would be used, and 60 mg wasted. Only the 120 mg (4 units) actually administered should be reported on the CMS-1500 claim form.

Lead Fact Sheet Available in Spanish

The Mississippi Department of Health's Childhood Lead Poisoning Prevention Program has a Spanish Lead Fact Sheet available for pediatricians, physicians, and primary care providers to use as an educational tool with their clients. If you are interested in obtaining a copy, please contact Crystal Veazey, State Lead Coordinator, at 601-576-7447.

Modifiers 54 (Surgical Care Only) and 55 (Post Operative Only)

The Division of Medicaid does not currently require procedure modifiers 54 (Surgical Care Only) and 55 (Postoperative Care Only). Providers performing the surgical procedure and the postoperative care should bill the appropriate CPT code without a modifier. The surgical code includes payment for postoperative care. Providers performing the postoperative care only should bill the appropriate evaluation and management code

Clarification of Information for Crossover Claims

The information below is intended to clarify and expand on the article entitled, "Crossover Processing," from the January 2005 Mississippi Medicaid Bulletin:

If your Medicare claims are not electronically crossing over to Medicaid, you may need to update your Medicaid provider file with your Medicare group and individual numbers. The provider numbers list on your Medicare Explanation of Medicare Benefits (EOMB) (Provider Number and PERF.PROV) are the numbers that must be loaded on your Medicaid file if your Medicare claims are to cross over electronically to Medicaid.

On CAHABA Medicare EOMB, PERF.PROV identifies the individual number that needs to be added to your Medicaid provider file. This may or may not be different on other Medicare intermediary EOMBs.

You can update your Medicaid file by providing the below information:

Medicaid Provider Number, Name,
Contact Name & Number
Medicare Provider Number (Group)
Medicare PERF.PROV Number

Tetanus Toxoid Injections for Adults

Beginning with date of service October 1, 2004, Tetanus Toxoid will no longer be billed with J3490. CPT code 90703 has been opened for billing for adults starting at age 21.

Pricing from Invoices

For any codes requiring pricing from an invoice, the invoice attached to the claim should reflect the materials or medications given. If the invoice has multiple units purchased, ACS Medical Services will track and deduct the units from the invoice. Once those units have been used, that invoice is no longer valid. Any further claims billed with an invoice with no further available units will be denied requesting other documentation (denial code N66—missing/incomplete/invalid documentation).

Policy Manual Additions/ Revisions

The following policies and policy sections have been added and/or revised to the DOM Provider Policy Manual. Providers of these services may view these changes by accessing the DOM website at www.dom.state.ms.us and clicking on "Provider Manuals" in the left window.

Section	Policy	Effective Date	New	New Sections	Revised	Revised Sections
1.0	Introduction	03/01/05			X	1.11
6.0	Third Party Recovery	03/01/05			X	6.02
10.0	Durable Medical Equipment	03/01/05			X	10.32, 10.84, 10.91
31.0	Pharmacy	03/01/05			X	31.12, 31.24

THIS PAGE INTENTIONALLY LEFT BLANK

Change in Occurrence Code Used in Billing Medicaid Hospital Inpatient Claims

Occurrence code 23 is no longer the appropriate occurrence code to be used when a hospital provider is billing a Medicaid inpatient claim. Hospital providers are required to split inpatient stays which span the fiscal year end of June 30. When split billing a stay which spans fiscal years, the first claim should be type of bill 112. Occurrence code C3 should be used in field locator 32 of the UB-92 claim form with the occurrence date of June 30. In conjunction with occurrence code C3, occurrence code 42 should be used in field locator 33 of the UB-92 claim form to indicate the occurrence date representing the actual date of discharge for the beneficiary. Patient status code 30 should be entered in field locator 22 since the patient has not been discharged.

Occurrence code C3 should also be used when a Medicaid beneficiary's inpatient days are exhausted during a hospital stay. Occurrence code C3 should be used in field locator 32 of the UB-92 claim form with the date benefits were exhausted. In conjunction with occurrence code C3, occurrence code 42 should be used in field locator 33 of the UB-92 claim form to indicate the occurrence date representing the actual date of discharge for the beneficiary. Patient status code 30 should be entered in field locator 22 since the patient has not been discharged.

DME Providers

When billing for medical supplies, DME providers must bill the appropriate number of units according to the description of the code that is billed. Providers should use the current HCPCS manual and not the descriptions on the Medicaid DME fee schedule. The descriptions on the DME fee schedule are abbreviated and may be incomplete. When calculating the number of units, providers must be aware of the unit of issue for the HCPCS code that is billed. For example, A4253, blood glucose test or reagent strips for home blood glucose monitor, per 50 strips, should be billed one unit per 50 strips, and S8490, Insulin syringes (100 syringes, any size), should be billed one unit per 100 syringes. Overpayments resulting from the improper billing of units may be considered fraudulent and could result in the recoupment of funds.

Acquiring Additional Bulletins

One copy of the monthly Medicaid Bulletin is sent to every provider with an active provider number. If additional copies are needed, the bulletins may be downloaded from the publications page of the web portal at the following address: **http://msmedicaid.acs-inc.com**. Or, providers may call the ACS Provider and Beneficiary Services call center at 1-800-884-3222 to request additional copies.

Submission of Adjustment/Void Request

When submitting an Adjustment/Void request, complete boxes 1 through 6 on the Adjustment/Void request form for proper processing. If filing for an adjustment with or without a returned check to Medicaid, attach a corrected claim and any other appropriate documentation that will aid in properly processing your request.

Please mail Adjustment/Void request and appropriate documentation to:

Mississippi Medicaid Program
P.O. Box 23077
Jackson, Mississippi 39225

ACS Customer Service

For quicker, more efficient service, please have all pertinent information ready when contacting Provider and Beneficiary Services at 1-800-884-3222.

You will need your:

- Provider ID Number
- Beneficiary ID Number
- Dates of Services
- Billed Amount

Billing Instructions: Freestanding and Hospital Outpatient Dialysis

Covered Revenue Codes

These revenue codes are covered for all dialysis providers and should price as follows: facility composite rate times the number of units. A procedure code should not be billed for these revenue codes.

821 Hemodialysis –Outpatient or Home Dialysis – Hemodialysis/Composite or Other Rate

831 Peritoneal Dialysis – Outpatient or Home - Peritoneal/Composite or Other Rate

841 CAPD (Dialysis) – Outpatient or Home – CAPD/Composite or Other Rate

851 CCPD (Dialysis) – Outpatient or Home – CCPD/Composite or Other Rate

Covered CPT Procedure Codes

The following CPT procedure codes are covered for all dialysis providers and should price as follows: lesser of charges or fee on file times the number of units subject to max units. Medicaid will accept revenue codes 250 or 636 for these procedure codes.

Vaccines

90658 Influenza virus vaccine, split virus, for use in individuals 3 years of age and above, for intramuscular use

90659 Influenza virus vaccine, whole virus, for intramuscular or jet injection use (**code closed effective 4/1/04 – do not bill for dates of service beginning 4/1/04**)

90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for use in individuals 2 years or older, for subcutaneous or intramuscular use

90740 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (3 dose schedule), for intramuscular use

90747 Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use

NOTE: Vaccines administered to children up to age 18 are covered through the Vaccines for Children program and must be administered by a VFC provider. Payment will not be made to non-VFC providers for vaccine codes when billed for children under age 18.

Continued on next page

(Billing Instructions continued from page 7)

Diagnostic Tests

Bone Survey	Hepatitis B Surface Antibody Or Hepatitis B Core Antibody	Serum Aluminum	Serum Ferritin	Chest X-ray	EKG	Nerve Conduction
76078 - TC	86704	82108	82728	71010-TC	93005	95900 – TC
78350 - TC	86705			71015-TC		95903 – TC
78351 - TC	86706			71020-TC		95904 – TC
				71021-TC		
				71022-TC		
				71023-TC		
				71030-TC		
				71034-TC		
				71035-TC		

The following revenue codes will be accepted for these CPT codes: 300-309; 320-329; 340-349; 390; 730; 920-929; or 933.

NOTE:

For radiological procedures from the CPT 70,000 through 79,999 range, it is expected that the facility will bill for the technical component if the facility owns the x-ray equipment. It is expected that the interpretation of the x-ray will be billed by radiologists under their own provider number.

For EKG, it is expected that the facility would bill for the technical component only if the facility provides the EKG equipment. It is expected that physicians would bill the interpretation and report (professional component) under their own provider number.

For nerve conduction studies, it is expected that the facility will bill for the technical component only if the facility provides the nerve conduction equipment. It is expected that physicians will bill the interpretation and report (professional component) under their own provider number. Further, for nerve conduction studies, the studies must be restricted to those diagnoses listed in Dialysis Policy Section of the Medicaid Provider Policy Manual.

For lab, it is expected that the facility can bill for the procedure only if the facility performs the test. If the facility sends the test to an outside lab, the lab performing the test must bill under the lab's provider number.

Non-Covered CPT Codes for Dialysis Facilities

The following CPT codes are not covered when billed by a dialysis provider and will be denied if billed on the dialysis facility provider number. These codes are covered when billed with the individual physician provider number and may be paid based on the physician fee schedule. **Do not bill these CPT codes on the dialysis claim.**

Continued on next page

(Billing Instructions continued from page 8)

90918	End stage renal disease (ESRD) related services per full month; for patients under two years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90919	End stage renal disease (ESRD) related services per full month; for patients between two and eleven years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90920	End stage renal disease (ESRD) related services per full month; for patients between twelve and nineteen years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90921	End stage renal disease (ESRD) related services per full month; for patients twenty years of age and over
90922	End stage renal disease (ESRD) related services (less than full month), per day; for patients under two years of age
90923	End stage renal disease (ESRD) related services (less than full month), per day; for patients between two and eleven years of age
90924	End stage renal disease (ESRD) related services (less than full month), per day; for patients between twelve and nineteen years of age
90925	End stage renal disease (ESRD) related services (less than full month), per day; for patients twenty years of age and over

HCPCS Codes for Injectable Drugs

Injectable drugs must be billed by the dialysis provider with the HCPCS code that is valid for the date of service. These codes will price as follows: lesser of charges or fee on file times the number of units subject to the specifications set up in the Reference File for the specific code. Medicaid will accept revenue codes 250, 634, 635, or 636 for these procedure codes.

J0000 through J7599
Q9920 through Q9940
Q4054 beginning with dates of service on and after January 1, 2004
Q4055 beginning with dates of service on and after January 1, 2004

HCPCS codes for items/services other than injectable drugs, such as medical supplies, are not covered for dialysis providers and will be denied.

Continued on next page

Division of Medicaid **State of Mississippi** **Provider Policy Manual**	**New: X** **Revised:** **Current:**	**Date:** **02/01/05** **Date:**
Section: General Medical Policy **Subject: Physical Examinations**	**Section: 53.18** **Pages: 2** **Cross Reference:**	

Annual Physical Exams Covered Beginning February 1, 2005

As authorized in House Bill 1434 during the 2004 Legislative Session, the Division of Medicaid will cover annual physical examinations. Through this provision, eligible Mississippi Medicaid beneficiaries will be encouraged to choose a medical home and undertake a physical examination to establish a base-line level of health.

A medical home is defined as the usual and customary source that provides both preventive and treatment or diagnosis of a specific illness, symptom, complaint, or injury. The medical home will serve as the focal point for a beneficiary's health care, providing care that is accessible, accountable, comprehensive, integrated, and patient centered.

Physical Examinations for Beneficiaries for Adults (Age 21 and over)

Coverage for the annual physical examination for adults will be effective as of February 1, 2005. To bill for the service, providers will utilize the age appropriate code from the CPT Evaluation and Management Preventive Medicine codes 99385, 99386, 99387, 99395, 99396, or 99397.

The co-payment amount of $3.00 for a physician visit will be applicable to beneficiaries age 18 and over. The annual physician examination will be counted toward the physician visit limit of twelve (12) per fiscal year. The examination and ancillary diagnostic/screening services are not covered after the expiration of the twelve (12) authorized physician visits.

Continued on next page

(Billing Instructions continued from page 9)

Helpful Hints

Always use the ICD-9 diagnosis, CPT, or HCPCS code that is valid for the date of service. Use current code books and discard outdated references.

ICD-9 diagnosis codes must be entered to include 4th and 5th digits as required or the claim will deny for an invalid code.

HCPCS codes for injectable drugs may include dosage amounts in the code description. Allowed units are set up to accommodate the usual maximum dosage in accordance with the code description. Bill only the number of units for the HCPCS code that corresponds to the dosage amount in the code description. For example, the HCPCS code description for J1270 is "Injection, doxicalciferol, 1mcg". Therefore, one unit equals 1 mcg of medication.

Enter the dates of service correctly on all entries of the claim. If you enter 12/01/2004 in one field, it must be entered the same way in all other related date fields. Do not enter 12/1/2004 or the claim may deny.

Be sure to check for Medicare coverage or other third party insurance coverage that may be primary, with Medicaid as the secondary payer.

THIS PAGE INTENTIONALLY LEFT BLANK

(Annual Physical Exams continued from page 10)

Physical Examinations for Children (Under Age 21)

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, a mandatory service under Medicaid, provides preventive and comprehensive health services for Medicaid eligible children and youths up to age twenty one (21). Children will access the mandatory periodic screening services through EPSDT providers. EPSDT providers will continue to follow the Division of Medicaid's policy and procedures for the EPSDT Program.

No co-payment is applicable for services to children under age 18. The provider must report the Co-payment Exception Code "C" on claims for beneficiaries under age 18. The codes for the periodic screening examinations do not apply toward the physician visit limit per fiscal year.

Dual Eligibles

Beneficiaries whose Medicare Part B coverage begins on or after January 1, 2005 will have Medicare coverage for a one time only "Welcome to Medicare" Physical Examination within the first six months of the Medicare coverage.

If the beneficiary has both Medicare and Mississippi Medicaid, the routine annual physical examination is not covered under Medicaid if the beneficiary is eligible for or has already received the "Welcome to Medicare" physical examination. The Division of Medicaid will not duplicate benefits for routine annual physical examinations covered by Medicare and will not provide an annual physical examination until twelve (12) months have elapsed from the original effective date of the Medicare Part B coverage. For these instances, it is the sole responsibility of the provider to determine whether Medicare or Mississippi Medicaid is the appropriate billing source.

Dual eligibles whose Medicare Part B effective date is prior to January 1, 2005 will be eligible for the physical examination as outlined above for adults or children.

Diagnostic and/or Screening Procedures

Radiology and laboratory procedures which are a standard part of a routine adult annual age/gender physical examination or well child periodic screening may be billed by the provider performing the procedure, and coverage will be determined based on current Mississippi Medicaid policies for the individual procedures.

Exclusions

The purpose for providing a benefit for routine annual physical examinations and well child screenings is to assist Mississippi Medicaid beneficiaries in establishing a medical home and to assist the beneficiary in accessing preventive services. Using the examination as a tool for other purposes, such as physicals for school, sports, or employment, will not be covered and must not be billed to Medicaid.

This benefit is not covered for beneficiaries in an institutional setting, i.e., locked-in to a nursing home or intermediate care facility for the mentally retarded (ICF/MR) or those covered in Category of Eligibility 029 (Family Planning) or 088 (Pregnant Women – 185%).

Mandatory Preferred Drug List

All prescribing providers should have received letters in February which addressed the Division of Medicaid's Mandatory Preferred Drug List (PDL) which will be effective March 1, 2005.

For questions not answered in the letter, please see our website (www.dom.state.ms.us) or call the Pharmacy Bureau at 1-800-421-2408 or 601-359-5253.

Included in this Bulletin:
Frequently Asked Questions
PDL Exception Request Form
MS Preferred Drug List

Preferred Drug List Exceptions
Criteria to be satisfied for approval of non-preferred drugs:

1) Beneficiary must have used the preferred agents for a thirty (30) day course of treatment per drug (as reflected in paid Medicaid claims) and failed trials, within six (6) months prior to requesting the exception,
OR
2) Documentation of therapeutic failure of preferred drugs,
OR
3) Documentation of stable therapy as reflected in ninety (90) days of paid Medicaid claims.

Approval will not be granted for non-FDA approved indications. No payment may be made under the Medicaid program for services, procedures, supplies or drugs which are still in clinical trials and/or investigative or experimental in nature.

Criteria Exceptions
Exceptions to the PDL criteria may be considered by the Pharmacy Benefits Manager if there is sufficient documentation of:

- Adverse event(s) reactions(s) to preferred agents,
OR
- Therapeutic failure(s) of preferred agents,
OR
- Contraindications to preferred agent(s), i.e., drug interaction, existing medical condition preventing the use of preferred agent(s).

When applicable, a copy of a MedWatch form may be requested. The MedWatch form can be found at http://www.fda.gov/medwatch/safety/3500.pdf.

Policy Manual Reminder

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

MISSISSIPPI DIVISION OF MEDICAID
MANDATORY PREFERRED DRUG LIST
FREQUENTLY ASKED QUESTIONS (FAQ)

Is the Preferred Drug List a formulary?
No. The Preferred Drug List (PDL) is **not** a formulary. It is a list of drugs, which have been reviewed by a committee of physicians, pharmacists, and a nurse practioner referred to as the Pharmacy & Therapeutics (P&T) Committee. All the listed drugs are FDA-approved, and are as effective as non-preferred drugs.

Brand name drugs approved for the PDL are listed in **bold print**.

Are the drugs on the PDL the only drugs that can be prescribed for Medicaid beneficiaries? What if I want to write for a drug not listed?
No. The drugs on the PDL are not the only drugs that can be prescribed. All drugs covered by DOM are still available. Non-preferred drugs will require submission of a PD Exception Request and have a higher co-pay.

Why should I write a prescription for a drug on the PDL?
The drugs on the PDL have gone through a review process by the P & T Committee and have been determined to be the safest and most effective in their class. Physicians are encouraged to prescribe these agents when possible to meet patients' needs. The Division of Medicaid's policy is to provide optimal health care outcomes at reasonable costs for all beneficiaries. Compliance with this list assists the State in slowing the growth of expenditures for prescription drugs.

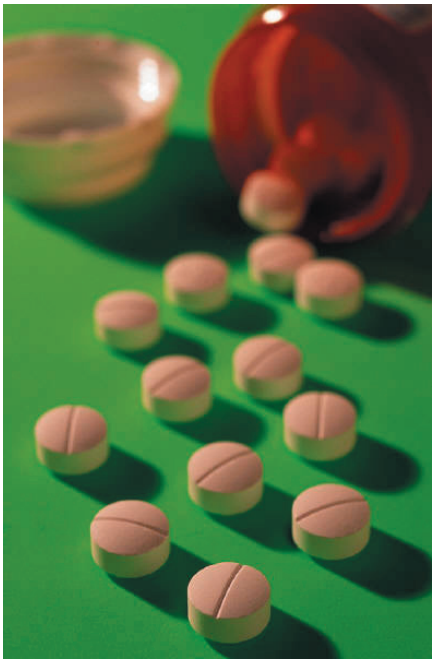
Some classes of drugs are not on the PDL. What about them?
This PDL is a starting point for establishing a method of determining which drugs DOM recommends to prescribing physicians. The PDL will be reviewed and updated regularly by the P&T Committee, who will make recommendations to DOM's Executive Director. In the coming months, the P&T Committee will be reviewing additional classes of drugs for possible inclusion on the PDL.

Can the drugs listed on the PDL change?
Yes. The P & T Committee has the responsibility for ongoing maintenance of the PDL. The Committee will evaluate agents for safety, efficacy, and overall therapeutic significance. After thorough evaluation, the Committee may recommend addition or deletion of certain drugs and/or drug classes to or from the PDL. Providers will be notified of changes to the PDL via the monthly Medicaid Provider Bulletin. The Division of Medicaid will also update the PDL on the agency's web site at www.dom.state.ms.us any time there is a change.

Is an Exception Request required for brand name drugs on the PDL?
No. Per State law, prior authorization is required for those brand name drugs with generic equivalents. The exceptions are five drugs designated as narrow therapeutic index (NTI) drugs and identified as Dilantin®, Lanoxin®, Tegretol®, Coumadin®, and Synthroid®.

Continued on next page

(Frequently Asked Questions continued)



Does the PDL pertain to children and residents in a long-term care setting?
Yes. The PDL contains the drugs Medicaid recommends to prescribers for all Medicaid beneficiaries. Please note that children and residents in a long-term care setting continue to have unlimited prescription benefits.

What happens if a manufacturer discontinues a brand name drug listed on the PDL? Will another drug be substituted?
If the manufacturer discontinues a drug, it will be removed from the PDL. If another drug in that classification is needed, reevaluation of this category will be considered by the P&T Committee.

My patient needs a non-preferred drug. What do I do?
Submit a PDL exception form (located at DOM's web site www.dom.state.ms.us, select Pharmacy Services, and forms) to Medicaid's Pharmacy Benefits Manager.

Criteria to be satisfied for approval of non-preferred drug:

1) Beneficiary must have used preferred agents for a (30) day course of treatment per drug (as reflected in paid Medicaid claims) and failed trials, within six (6) months prior to the request,
OR
2) Documentation of therapeutic failure of preferred drugs,
OR
3) Documentation of stable therapy as reflected in ninety (90) days of paid Medicaid claims.

Exceptions to the PDL criteria may be considered by the Pharmacy Benefits Manager if there is sufficient documentation of:

- Adverse event(s) reactions(s) to preferred agents,
OR
- Therapeutic failure of preferred agents,
OR
- Contraindications to preferred agent(s), i.e., drug interaction, existing medical condition preventing the use of preferred agent(s).

I have questions that are not answered here. Who do I call to get answers?
Please call the Division of Medicaid's Pharmacy Bureau staff at 601-359-5253.

Remember, in emergency situations, after hours, or on weekends, pharmacists are authorized by Federal Law to dispense a **72- hour emergency supply** of any non-preferred medication without an Exception Request. Please see Pharmacy Manual for details.

Preferred Drug List Exception Request
Division of Medicaid
State of Mississippi
239 N. Lamar Street, Suite 801
Jackson, Mississippi 39201

Administered by
Health Information Designs (HID)
Fax, Phone, Mail Completed form to:
Fax: 1-800-459-2135
Phone: 1-800-355-0486
P.O. Box 320506
Flowood, MS 39232

Patient Name (Last) (First) MI	**MS Medicaid 9 Digit ID #:**	**Date of Birth**

Practitioner Name (Last) (First) (MI)	**Practitioner Provider Number**

Practitioner Address (Street) (City) (State) (Zip)	**Phone #** **Fax #**

Pharmacy Name & Address (City) (State)	**Provider Number**	**Phone#** **Fax #**

Non-Preferred Drug Requested	**Dose**	**Directions**

Diagnosis (Optional) Diagnosis Code (ICD-9-CM
|___| |___| |___| — |___| |___|

Please answer each of the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred products(s)? □ Yes □ No
   1st Drug _____ Length of Therapy_____Reason for D/C_____
   2nd Drug_____ Length of Therapy_____Reason for D/C_____

Attach additional documentation of other treatment failures with preferred drugs if necessary.

2. Does the patient have a condition that prevents the use of the preferred products(s)? □ Yes □ No
   If YES, list the interaction(s) in the box below:

3. Is there a potential drug interaction between another medication and the preferred products(s)? □ Yes □ No
   If YES, list the interaction(s) in the box below:

4. Has the patient experienced intolerable side effects while on the preferred product(s)? □ Yes □ No
   If YES, list the side effects in the box below:

When applicable, a copy of a MedWatch form may be requested by HID. A MedWatch form can be found at http://www.fda.gov/medwatch/safety/3500.pdf

****MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.***

Practitioner Signature: _____ **Date:**_____

Confidentiality Notice: The documents accompanying this telecopy contain legally confidential information belonging to the sender. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copy distribution or actions taken in reliance on the content of these documents is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for return of the documents.

MISSISSIPPI DIVISION OF MEDICAID
PREFERRED DRUG LIST

Therapeutic Drug Class	Preferred Drugs (Override Not Required)	Non-Preferred Drugs (Override IS Required)
ANALGESICS		
NSAIDS		
Effective 3/1/2005		
	Cox-2 Selective	
		Bextra (valdecoxib)
		Celebrex (celecoxib)
		Mobic (meloxicam)
	Nonselective	
	diclofenac potassium	Ponstel (meclofenamate)
	diclofenac sodium	
	etodolac	
	fenoprofen	
	flurbiprofen	
	ibuprofen	
	indomethacin	
	ketoprofen	
	ketorolac	
	meclofenamate	
	nabumetone	
	naproxen	
	naproxen sodium	
	oxaprozin	
	piroxicam	
	sulindac	
	tolmetin sodium	
	NSAID/GI Protectant Combinations	
		Arthrotec (diclofenac/misoprostol)
		Prevacid NapraPAC (naproxen/lansoprazole)
ANTIDEPRESSANTS		
Effective 3/1/2005		
	SSRIs	
	citalopram	Celexa (citalopram)
	fluoxetine	Paxil & CR (paroxetine)
	Lexapro (escitalopram)	Pexeva (paroxetine mesylate)
	paroxetine	Prozac (fluoxetine)
	Zoloft (sertraline)	Sarafem (fluoxetine)

Continued on next page

	TCAs	
	amitriptylline	Surmontil (trimipramine)
	desipramine	Tofranil PM (imipramine pamoate)
	doxepin	Vivactil (protriptyline)
	imipramine	
	nortriptyline	
	Triazolopyride	
	trazodone	
	SNRIs	
	Effexor (venlafaxine)	Cymbalta-NR (duloxetine)
	Effexor XR (venlafaxine)	
	Aminoketones	
	bupropion IR & SR	Wellbutrin SR (bupropion)
		Wellbutrin XL (buproprion)
	Tetracyclics	
	mirtazapine (tabs & soltabs)	
	MAOIs	
		Nardil
		Parnate
ANTIHISTAMINES		
1st & 2nd Generation		
Effective 3/1/2005		
	DOM covered OTC antihistamines	Allegra (fexofenadine)
	Loratadine OTC	Clarinex (desloratadine)
	Generic antihistamines & decongestant combinations	
	Astelin Nasal Spray (azelastine)	
	Zyrtec (cetirizine)	
CARDIOVASCULAR AGENTS		
Effective 3/1/2005		
	ACE Inhibitors	
	Altace (ramipril)	Accupril (quinapril)
	captopril	Aceon (perindopril)
	enalaopril	Lotensin (benazepril)
	fosinopril	Mavik (trandolapril)
	lisinopril	
	moexepril	
	quinapril	
	Generic diuretic combinations	
	ACE Inhibitors/CCB Combinations	
	Lotrel (benazepril/amlodipine)	Lexxel (enalapril/felodipine)
		Tarka (tandolapril/verapamil)

	ARBs	
	Avapro (irbesartan)	Atacand (candesartan)
	Diovan (valsartan)	Benicar (olmesartan)
		Cozaar (losartan)
		Micardis (telmisartan)
		Teveten (eprosartan)
	ARB/Diuretic Combinations	
	None	
	Calcium Channel Blockers	
	diltiazem IR & ER	Calan SR (verapamil)
	nicardipine	Cardene SR (nicardipine)
	nifedipine ER	Cardizem CD/LA,SR (diltiazem)
	Norvasc (amlodipine)	Covera-HS (verapamil)
	verapamil IR & ER	Dilacor XR (diltiazem)
		Dynacirc CR (isradipine)
		Isoptin SR (verapamil)
		Plendil (felodipine)
		Sular (nisoldipine)
		Tiazac (diltiazem)
		Verelan PM (verapamil)
	Beta Blockers	
	acebutolol	Cartrol (cartelolol)
	atenolol	Levatol (penbutolol)
	betaxolol	Inderal LA (propranolol)
	bisoprolol	InnoPran XL (propranolol)
	Coreg (carvedilol)	
	labetalol	
	nadolol	
	pindolol	
	propranolol	
	sotalol	
	timolol	
	Toprol XL (metoprolol)	
CENTRAL NERVOUS SYSTEM DRUGS		
Effective 3/1/2005		
	Alzheimers	
	Aricept (donepezil)	Cognex (tacrine)
	Exelon (rivastigmine)	Reminyl (galantamine)
	Namenda (memantine)	
	Anxiolytics	
	alaprazolam	Klonopin Wafers (clonazepam)
	chlordiazepoxide	Tranxene SD (clorazepate)
	clonazepam	Xanax XR (alprazolam)
	clorazepate	Vistaril Suspension (hydroxyzine pamoate)

	diazepam	
	lorazepam	
	oxazepam	
	buspirone	
	hydroxyzine (HCl & Pamoate)	
	Sedative/Hypnotics	
	Ambien (zolpidem)	Butisol (butabarbital)
	estazolam	Doral (quazepam)
	flurazepam	Lunesta NR (eszopiclone)
	phenobarbital	Nembutal (pentobarbital)
	Sonata (zaleplon)	Restoril 7.5 mg (temazepam)
	temazepam	Seconal (secobarbital)
	triazolam	
	Skeletal Muscle Relaxants	
	baclofen	Dantrium (dantrolene)
	cyclobenzaprine	Flexeril 5 mg (cyclobenzaprine)
	tizanidine	Skelaxin (metalaxone)
DIABETES *Effective 3/1/2005*		
	Insulin	
	All Vial Products	All delivery systems other than vials
	Alpha Glucosidase Inhibitors (Oral)	
	Precose (acarbose)	Glyset (miglitol)
	Biguanides	
	metformin IR & ER	Fortamet (metformin)
		Riomet (metformin Liq.)
	Meglitinides	
	Prandin (repaglinide)	
	Starlix (nateglinide)	
	Sulfonylureas	
	acetohexamide	Amaryl (glimepiride)
	chlorpropamide	
	glipizide	
	glyburide	
	tolbutamide	
	tolazamide	
	Thiazolidinediones	
	Actos (pioglitazone)	
	Avandia (rosiglitazone)	
	Combination Products	
	glyburide/metformin	Metaglip (glipizide/metformin)

	Avandamet (rosiglitazone/metformin)	
GASTROINTESTINAL		
Effective 3/1/2005	**H 2 Blockers**	
	cimetidine	Pepcid RPD (famotidine)
	famotidine	Pepcid Suspension (famotidine)
	nizatidine	Zantac EFFERdose (ranitidine)
	ranitidine	
	Zantac Syrup - 12 & under	
	Proton Pump Inhibitors (PPIs)	
	Prilosec OTC	Aciphex (rabeprazole)
		Nexium (esomeprazole)
		omeprazole - Rx
		Prevacid (lansoprazole)
		Protonix (pantoprazole)
		Zegerid (omeprazole)
LIPIDS		
Effective 3/1/2005		
	Statins	
	lovastatin	Altoprev (lovastatin ER)
	Lipitor (atorvastatin)	Crestor (rosuvastatin)
	Pravachol (pravastatin)	Lescol (fluvastatin)
	Zocor (simvastatin)	
	Statins Combinations	
	Advicor (lovastatin/niacin)	Caduet (atorvastatin/amlodipine)
	Vytorin (ezetimibe/simvastatin)	Pravigard PAC (pravastatin/ASA)
	Niacin Products	
	Niacin OTC	
	Niaspan	
	Fibric Acid Derivatives	
	gemfibrozil	Lofibra (fenofibrate)
	Tricor (fenofibrate)	
	Bile Acid Sequestrants	
	cholestyramine	Colestid (colestipol)
		Welchol (colesevalam)
	Selective Cholesterol Absorption Inhibitor	
		Zetia (ezetimibe)
OSTEOPOROSIS		
Effective 3/1/2005		
	Actonel (risedronate)	Forteo (teriparatide)
	Evista (raloxifene)	
	Fosamax (alendronate)	

Miacalcin (calcitonin)	
PLATELET AGGREGATION INHIBITORS	
Effective 3/1/2005	
aspirin	Aggrenox (dipyridamole/ASA)
dipyridamole	
Plavix (clopidogrel)	
RESPIRATORY AGENTS	
Effective 3/1/2005	
Inhaled Corticosteriods	
Aerobid	
Aerobid M	
Azmacort	
Flovent Inhaler	
Flovent Rotadisk	
Pulmicort Respules	
Pulmicort Turbuhaler	
QVAR	
Nasal Corticosteriods	
flunisolide	Beconase AQ (beclomethasone)
Flonase (fluticasone)	Nasacort AQ (triamcinolone)
Nasonex (mometasone)	Nasarel (flunisolide)
	Rhinocort Aqua (budesonide)
Anticholinergic	
Atrovent MDI (ipratropium)	
ipratropium soln for inhalation	
Spiriva (tiotropium)	
Leukotriene Modifiers	
Singulair (montelukast)	Accolate (zafirlukast)
Mast Cell Stabilizers	
cromolyn na soln for inhalation	Tilade Inhaler (nedocromil)
Intal Inhaler (cromolyn na)	
Smooth Muscle Relaxants	
aminophylline	
dyphylline	
oxtriphylline	
theophylline	
Smooth Muscle Relaxants	
all generics	
Sympathomimetics	
albuterol	AccuNeb (albuterol)
metaproterenol	Foradil (formoterol)

terbutaline	Maxair (pirbuterol)
Serevant Diskus (salmeterol)	Vospire ER (albuterol)
	Xopenex (levalbuterol)
Sympathomimetics Combinations	
Advair (fluticasone/salmeterol)	DuoNeb (albuterol/ipratropium)
Combivent (albuterol/ipratropium)	

*If a brand name drug has a generic equivalent, the branded counterpart is considered non-preferred since the Mississippi Medicaid program has a generic mandate policy.

* Drugs/drug classes not included as preferred on this list do not require a PDL override.

Provider Quick Contact List

There are several resources designed to address your questions concerning Medicaid claims processing, billing, mailing, policy procedures and more. To effectively assist you with these needs, the following information will serve as a guide to contacting the proper resource.

Contact Name	Contact Address/Phone Number/Website (if applicable)
ACS Medicaid Web Portal	http://msmedicaid.acs-inc.com
ACS Provider and Beneficiary Services	P.O. Box 23078 Jackson, MS 39225 **1-800-884-3222 or 601-206-3000**
• **Claims**	P.O. Box 23078 Jackson, MS 39225
• **Adjustment/Void Requests**	P.O. Box 23077 Jackson, MS 39225
• **Financial Correspondence (Mail with Checks)**	P.O. Box 6014 Ridgeland, MS 39158-6014
Automated Voice Response System (AVRS)	**1-866-597-2675 or 601-206-3090**
ACS Prescription Benefits Services	ACS State Healthcare 365 Northridge Road Northridge Center One, Suite 400 Atlanta, GA 30350 **1-866-759-4108**
Health Information Designs (HID)- To obtain pharmacy prior authorization	**1-800-355-0486** **or** **601-709-0000**
Health Systems Mississippi (HSM) (Peer Review Organization – conducts certification reviews of some Medicaid services.)	**1-888-204-0221** **or** **601-352-6353**
ACS EDI – For assistance with transmission of electronic claims	www.acs-gcro.com **1-866-225-2502**
Division of Medicaid – • Third Party Liability • EPSDT Services	801 Robert E. Lee Bldg. 239 N. Lamar St. Jackson, MS 39201 **601-359-6050** www.dom.state.ms.us
Division of Medicaid – • Provider and Beneficiary Services	801 Robert E. Lee Bldg. 239 N. Lamar St. Jackson, MS 39201 **601-359-6133**

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

ACS
P.O. Box 23078
Jackson, MS 39225

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

March

March 2005

Sunday	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*
		1	2	3 EDI Cut Off 5:00 p.m.	4	5
6	7 CHECKWRITE	8	9	10 EDI Cut Off 5:00 p.m.	11	12
13	14 CHECKWRITE	15	16	17 EDI Cut Off 5:00 p.m.	18	19
20	21 CHECKWRITE	22	23	24 EDI Cut Off 5:00 p.m.	25	26
27	28 CHECKWRITE	29	30	31 EDI Cut Off 5:00 p.m.		