Mississippi Medicaid Bulletin

Special Issue

June 2005 *Volume 11, Issue 6*

Medicaid Changes

This is a special issue of the Medicaid Provider Bulletin to notify providers of changes in the Medicaid program as a result of House Bill 1104 and other cost containment policies. Below is a summary of the changes and the articles in this bulletin that provide details of the program changes.

- Medicaid will allow six emergency room (ER) visits per fiscal year for adults. Outpatient hospital services such as chemotherapy, radiation, surgery, and therapy visits that are not billed as an emergency room service will be allowed even if the six ER visit limit is reached.

- Precertification will be required for outpatient physical therapy, occupational therapy, and speech therapy services effective for dates of services on and after July 1, 2005. Providers must precertify the services through HealthSystems of Mississippi, the Utilization Management and Quality Improvement Organization for the Division of Medicaid.

- Medicaid will allow 25 home health nurse and/or aide visits per fiscal year for adults if approved based on medical necessity. Home health aide visits will be allowed without the requirement for a skilled nurse. Physical and speech therapy are not covered through the home health program for adults.

- Physician fees will be set at 90 percent of the current Medicare fee and may be updated each July

- Effective June 1, 2005, and July 1, 2005, there are changes to requirements for certifying and reporting admissions for deliveries.

- Medicaid will reimburse for five prescriptions per month, including refills, with no more than two being for brand name drugs. This limit does not apply to those beneficiaries residing in any type of long-term care facility. The only exception to this benefit is for those beneficiaries under the age of 21 when medical necessity has been determined.

- Prescriptions will be limited to a 31-day supply based on the daily dosage.

- The requirement for the use of a counterfeit-proof prescription pad for controlled substances in the Medicaid program has been removed.

- The copayment for all prescriptions will be increased to $3.00 per prescription.

- The estimated acquisition cost of drugs is being changed to reflect a more accurate estimate of pharmacy acquisition cost. The reimbursement methodology will include use of the Wholesale Acquisition Cost (WAC) and prices will be based on brand name and single source status versus multiple source generic status.

- Medicaid will reimburse for certain maintenance drugs, which may be dispensed in three-month supply increments.

- House Bill 1104 mandated the elimination of the hospice specific category of eligibility (COE). Effective May 1, 2005, no new Medicaid beneficiaries will be accepted into the hospice category of eligibility. Hospice services are included as State Plan covered service. As a result of this change, hospice lock-ins will no longer be required.

Emergency Room Visits and Outpatient Hospital Services

The Medicaid program provides for six medically necessary emergency room (ER) visits (revenue codes 450 through 459) per fiscal year for beneficiaries age 21 and over. Additional ER visits may be covered for beneficiaries under age 21 through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.

Effective for dates of service beginning July 1, 2005, visits for other medically necessary outpatient hospital services, such as chemotherapy, radiation treatments, surgery, and therapy, that are not billed as emergency room visits, will be allowed for all beneficiaries. These services (not billed as emergency room visits) will NOT be counted toward the limit of six ER visits and can continue to be covered after the limit is exhausted.

Home Health Visits Reduced

Effective for dates of service beginning July 1, 2005, Medicaid will allow 25 home health visits per fiscal year (July 1-June 30) for beneficiaries age 21 and over. The visits may be a combination of skilled nurse and/or home health aide if approved by the Division of Medicaid's Utilization Management and Quality Improvement Organization (UM/QIO) based on medical necessity. Home health aide visits will be allowed without the requirement for skilled care by a nurse.

Physical therapy (physical therapist or physical therapist assistant) and speech therapy visits will not be covered through the home health program for beneficiaries age 21 and over. Additional nurse and/or aide visits, as well as physical therapy or speech therapy home visits, are available for children under age 21 through the Early and Periodic Diagnostic, Testing, and Screening (EPSDT) program when approved for medical necessity by the UM/QIO.

This change does not apply to home visits covered through the Home and Community Based Waiver (HCBS) programs.

Physician Fees Updated

Effective for dates of service beginning June 1, 2005, and in accordance with House Bill 1104, the Mississippi Division of Medicaid will reimburse physician fees as follows:

All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and may be adjusted each July thereafter, under Medicare (Title XVIII of the federal Social Security Act, as amended).

Providers were notified in May via remittance advice banner messages about the changes. The list of CPT codes and fees that changed is posted on the DOM website at www.dom.state.ms.us, Click on Fee Schedules for Medicaid Provider Services, then click on Physician Fee Changes.

In addition, the annual Physician Fee Schedule update will be done for all CPT codes in July. Effective for dates of service beginning July 1, 2005, fees for the CPT codes will generally be set at 90 percent of the 2005 Medicare fee. Providers may use the Web Portal look-up feature to determine fees for specific procedure codes.

Hospital Provider Workshop Set

The Division of Medicaid and ACS State Healthcare will conduct a Hospital Provider Workshop on Friday, June 10, 2005, at Eagle Ridge Conference Center. Registration will begin at 8:00 a.m.

Multiple sessions will cover topics such as Adjusting/Voiding claims electronically using WINASAP 2003, Envision web portal, and education on top denials being experienced by hospital providers. A UB-92 session for any new hospital biller will be provided.

More specific information, including dates and locations, will be posted on the Late Breaking News section of the Mississippi Medicaid Web Portal at http://msmedicaid.acs-inc.com when it becomes available.

Maternity Admissions For Deliveries

Deliveries on June 1, 2005 through June 30, 2005

Effective for dates of services on and after June 1, 2005, through June 30, 2005, hospitals must certify inpatient days admissions for deliveries with HealthSystems of Mississippi if the length of stay for a vaginal delivery is more than two (2) days and a delivery by Cesarean Section is more than four (4) days. This is a change from the current policy which requires certification if the length of stay is beyond three (3) days for a vaginal delivery and five (5) days for a delivery by Cesarean Section.

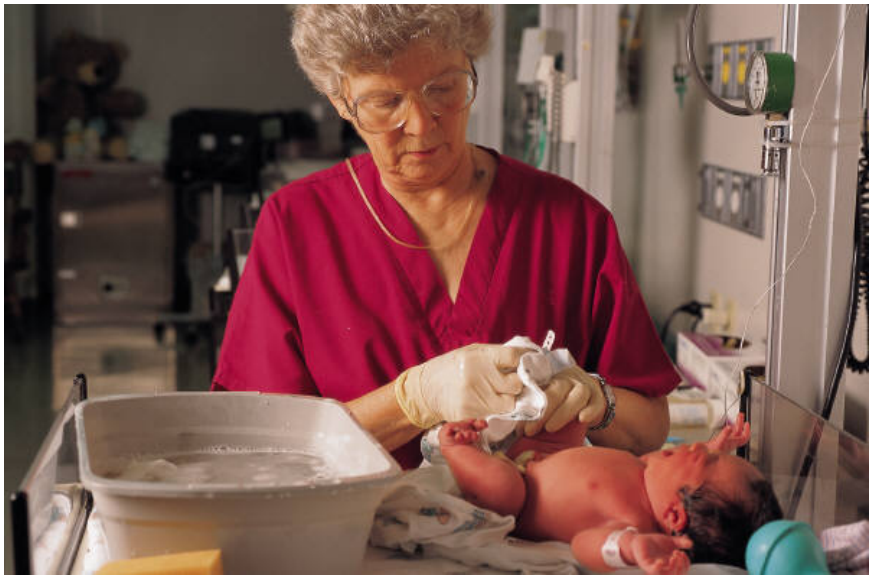
Deliveries on and after July 1, 2005

Effective for dates of services on and after July 1, 2005, the Division of Medicaid will require reporting of all maternity admissions for deliveries to HealthSystems of Mississippi. The hospitals must report the admission if the length of stay for a vaginal delivery is two (2) days or less or if the delivery for Cesarean Section is four (4) days or less. Admissions beyond the two (2) days or four (4) days will continue to require further certification of the inpatient days based on medical necessity.

HealthSystems of Mississippi has been contracted by the Division of Medicaid to handle the processes and issue Treatment Authorization Numbers (TAN) beginning with the first day of admission. The TAN must be obtained to ensure payment of hospital and physician claims.

HealthSystems of Mississippi will be conducting workshops in early June and will be contacting hospitals in the near future regarding workshop registration. The workshops will include instructions for the reporting requirements.

In addition, providers may view the revision in the Hospital Inpatient Section 25.25 by accessing at the DOM website at www.dom.state.ms.us and clicking on “Provider Manuals” in the left window.



Precertification Requirements for Therapy

Effective for dates of services on and after July 1, 2005, pre-certification of outpatient physical therapy, occupational therapy, and speech therapy is required by the Division of Medicaid. Providers must precertify the therapy services through HealthSystems of Mississippi, the Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid. All procedures and criteria set forth by the UM/QIO are applicable and are approved by the Division of Medicaid.

This requirement is applicable to:

(1) therapy services provided to beneficiaries under age 21 through the EPSDT Expanded Services program by individual therapists in offices or therapy clinics. Services provided to adult beneficiaries age 21 and over are not covered in individual therapist's offices or clinics;

(2) therapy services provided to beneficiaries (adult or children) in the outpatient department of hospitals;

(3) therapy services provided to beneficiaries by a Hospice Provider for conditions not directly related to the terminal illness (adult and children);

(4) therapy services provided to beneficiaries under 21 in physician offices/clinics. Services provided to adult beneficiaries age 21 and over are not covered in physician offices/clinics;

(5) therapy services provided to beneficiaries covered under both Medicare and Medicaid when Medicare benefits have been exhausted.

This requirement is not applicable to:

(1) therapy services provided to beneficiaries under age 21 and billed by school providers;

(2) therapy services provided to beneficiaries in nursing facilities;

(3) therapy services provided to beneficiaries in ICF/MRs;

(4) therapy services provided by a Hospice provider for a condition resulting from or directly related to the terminal diagnosis;

(5) therapy services provided to beneficiaries in Home and Community Based Services (HCBS) waiver programs;

(6) therapy services provided to beneficiaries covered under both Medicare and Medicaid when Medicare benefits have not been exhausted;

(7) therapy services provided by non-covered providers under the Medicaid Program (such as CORF's). Services provided by non-covered providers are not covered.

HealthSystems of Mississippi will be conducting workshops in early June 2005 and will be contacting providers impacted by this requirement. Providers are encouraged to participate in the educational workshops in preparation for the July 1, 2005, effective date.

Medicaid Pharmacy Program Update

Summary description

- Medicaid will reimburse for five prescriptions per month, including refills, with no more than two being for brand name drugs. This limit does not apply to those beneficiaries residing in any type of long-term care facility. The only exception to this benefit is for those beneficiaries under the age of 21 when medical necessity has been determined.
- Prescriptions will be limited to a 31-day supply based on the daily dosage.
- Medicaid will reimburse for certain maintenance drugs, which may be dispensed in three-month supply increments.
- The requirement for the use of a counterfeit-proof prescription pad for controlled substances in the Medicaid program has been removed.
- The copayment for all prescriptions will be increased to $3.00 per prescription.
- The estimated acquisition cost of drugs is being changed to reflect a more accurate estimate of pharmacy acquisition cost. The reimbursement methodology will include use of the Wholesale Acquisition Cost (WAC) and prices will be based on brand name and single source status versus multiple source generic status.

Full description

Benefit Limit: Effective July 1, 2005, the number of prescriptions reimbursed by Medicaid will change from a limit of five per month and two additional with a prior authorization (max of seven) to a limit of five per month with no more than two of those being for brand name drugs. This limit does not apply to those beneficiaries residing in any type of long-term care facility. All prescriptions, including refills, are subject to this benefit limit. Existing authorizations on file for the two additional prescriptions above the five per month benefit limit will be invalid.

The only exception to this benefit is for those beneficiaries under the age of 21 when medical necessity has been determined. For those beneficiaries that require more than five prescriptions per month or more than two brand name drugs per month, the physician or treating practitioner must request prior authorization by completing the Prior Authorization Form for Beneficiaries under Age 21 and submit it via facsimile to Health Information Designs (HID) at 800-459-2135. The form may be found on Medicaid's web site at www.dom.state.ms.us under Pharmacy Services or you may call HID at 800-355-0486.

Maximum days supply: Prescriptions are decreased from a 34-day supply to a 31-day supply based on the daily dosage. Therefore, a pharmacy may not bill for a quantity that exceeds a 31-day supply unless it is a Medicaid approved maintenance drug.

Maintenance drug list: The Division of Medicaid has identified certain drugs that are used to maintain certain conditions. These drugs may be dispensed in 90-day supply increments. The list of maintenance medications is included in this bulletin and labeled as the 90-Day Maintenance List. Please note that this list may be routinely revised. Refer to our web site at www.dom.state.ms.us under Pharmacy Services for the current listing of drugs that may be dispensed in a 90-day supply as maintenance drugs.

Pharmacy Update (**continued from page 5**)

Copayments: The copayment for all prescriptions will be $3.00 per prescription. This is a change from the copayment tier of $1- generics, $2 - preferred brand, and $3 - non-preferred brand. The following groups of beneficiaries and services do not require copayments: beneficiaries less than 18 years of age, pregnant women, newborns, long-term care facility residents, and family planning.

Drug Reimbursement: The Division of Medicaid has worked to refine its reimbursement methodology legend in order to control spiraling pharmacy costs. Over the counter (OTC) reimbursement formulas are unchanged. Therefore, effective July 1, 2005, the reimbursement for drugs will change.

Reimbursement for brand name drugs and single source generic drugs is:

- The lesser of
    - The usual and customary charge; or
    - The Federal Upper Limit (FUL), if applicable, and a dispensing fee of $3.91; or
    - Average Wholesale Price (AWP) less 12% and a dispensing fee of $3.91; or
    - Wholesale Net Unit Price/Wholesale Acquisition Cost (WAC) plus 9% and a dispensing fee of $3.91.

- Less the applicable copayment of $3.

  Brand name drugs are defined as single source or innovator multiple source drugs. Single source generic drugs are defined as those drugs going off patent and a single source generic house has exclusivity for a period of time.

Reimbursement for multiple source generic drugs is:

- The lesser of
    - The usual and customary charge; or
    - The Federal Upper Limit (FUL), if applicable, and a dispensing fee of $4.91*;
    - Average Wholesale Price (AWP) less 25% and a dispensing fee of $4.91*; or
    - Wholesale Net Unit Price /Wholesale Acquisition Cost (WAC) plus 9% and a dispensing fee of $4.91*.

- Less the applicable copayment of $3.

- The dispensing fee for prescriptions to beneficiaries in long-term care facilities for multi-source generic drugs is limited to $3.91.

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.

90-Day Maintenance Drug List*

DRUG /STRENGTH	*COMPARES TO*
ACYCLOVIR 200 MG	ZOVIRAX
ALLOPURINOL 100 MG TABLET	ZYLOPRIM
ALLOPURINOL 300 MG TABLET	ZYLOPRIM
ATENOLOL 25 MG TABLET	TENORMIN
ATENOLOL 50MG TABLET	TENORMIN
ATENOLOL 100 MG TABLET	TENORMIN
ATENOLOL/CHLORTHAL 50/25 TB	TENORETIC
ATENOLOL/CHLORTHAL 100/25	TENORETIC
CAPTOPRIL 12.5 MG TABLET	CAPOTEN
CAPTOPRIL 25 MG TABLET	CAPOTEN
CAPTOPRIL 50 MG TABLET	CAPOTEN
CAPTOPRIL 100 MG TABLET	CAPOTEN
CAPTOPRIL/HCTZ 25/15 TABLET	CAPOZIDE
CAPTOPRIL/HCTZ 25/25 TABLET	CAPOZIDE
CAPTOPRIL/HCTZ 50/25 TABLET	CAPOZIDE
CLONIDINE HCL 0.1 MG TABLET	CATAPRES
CLONIDINE HCL 0.2 MG TABLET	CATAPRES
DILTIAZEM 30 MG TABLET	CARDIZEM
DILTIAZEM 60 MG TABLET	CARDIZEM
DILTIAZEM 90 MG TABLET	CARDIZEM
DOXAZOSIN MESYLATE 1 MG	CARDURA
DOXAZOSIN MESYLATE 2 MG	CARDURA
DOXAZOSIN MESYLATE 4 MG	CARDURA
DOXAZOSIN MESYLATE 8 MG	CARDURA
ENALAPRIL MALEATE 5 MG TAB	VASOTEC
ENALAPRIL MALEATE 10 MG TAB	VASOTEC
ENALAPRIL MALEATE 20 MG TAB	VASOTEC
FAMOTIDINE 20 MG TABLET	PEPCID
FUROSEMIDE 20 MG TABLET	LASIX
FUROSEMIDE 40 MG TABLET	LASIX
FUROSEMIDE 80 MG TABLET	LASIX
GLIPIZIDE 5 MG	GLUCOTROL
GLIPIZIDE 10 MG	GLUCOTROL
GLYBURIDE-METFORMIN 2.5/500	GLUCOVANCE
GLYBURIDE-METFORMIN 5/500 MG	GLUCOVANCE
HYDROCHLOROTHIAZIDE 25MG TB	HYDRODIURIL
ISOSORBIDE MN 10 MG TABLET	MONOKET
ISOSORBIDE MN 20 MG TABLET	MONOKET,ISMO
ISOSORBIDE MN 60 MG TAB SA	IMDUR
LISINOPRIL 2.5 MG TABLET	ZESTRIL-PRINIVIL
LISINOPRIL 5 MG TABLET	ZESTRIL-PRINIVIL
LISINOPRIL 10 MG TABLET	ZESTRIL-PRINIVIL
LISINOPRIL 20 MG TABLET	ZESTRIL-PRINIVIL
LISINOPRIL 30 MG TABLET	ZESTRIL

(Continued on page 8)

Maintenance Drug List **(continued from page 7)**

LISINOPRIL 40 MG TABLET	ZESTRIL-PRINIVIL
LISINOPRIL-HCTZ 10/12.5 TAB	ZESTORETIC-PRINZIDE
LISINOPRIL-HCTZ 20/12.5 TAB	ZESTORETIC-PRINZIDE
LISINOPRIL-HCTZ 20/25MG TB	ZESTORETIC-PRINZIDE
LOVASTATIN 10 MG	MEVACOR
LOVASTATIN 20 MG	MEVACOR
METFORMIN HCL 500 MG TABLET	GLUCOPHAGE
METFORMIN HCL 850 MG TABLET	GLUCOPHAGE
METFORMIN HCL 1,000 MG TABL	GLUCOPHAGE
METOPROLOL 50 MG	LOPRESSOR
METOPROLOL 100 MG	LOPRESSOR
NIZATIDINE 150 MG CAPSULE	AXID
NIZATIDINE 300 MG CAPSULE	AXID
RANITIDINE 150 MG TABLET	ZANTAC
RANITIDINE 300 MG TABLET	ZANTAC
SPIRONOLACTONE 25 MG TABLET	ALDACTONE
SULFAMETHOXAZOLE/TMP DS TAB	BACTRIM DS
SULFAMETHOXAZOLE/TMP SS TAB	BACTRIM SS 400-80
VERAPAMIL 40 MG TABLET	CALAN,ISOPTIN
VERAPAMIL 80 MG TABLET	CALAN,ISOPTIN
VERAPAMIL 120 MG TABLET	CALAN,ISOPTIN
VERAPAMIL 180 MG TAB SA	CALAN SR CAPLET
VERAPAMIL 240 MG TAB SA	CALAN SR CAPLET
VERAPAMIL 120 MG CAP PELLET	VERELAN CAP
VERAPAMIL 240 MG CAP PELLET	VERELAN CAP
*Only these generic drugs and strengths have been approved by Medicaid for reimbursement in 90-day supply increments. Agents were selected for overall therapeutic/cost effectiveness.	
List Subject to Revision	

Available Websites Listed

In an effort to better serve the provider community, several websites are available with current and pertinent information. Please take a moment and visit the following websites:

www.dom.state.ms.us
Provider manuals may be accessed or printed from this site.

http://mississippimedicaid.acs-inc.com
Remittance advices may be accessed and downloaded from this site.

http://msmedicaid.acs-inc.com
This site is often referred to as the "Web Portal". You may check eligibility, claim status, and view the latest updates on Late Breaking News.

www.hidmsmedicaid.com
Drug Prior Authorization forms are available at this site.

www.hsom.org
Plan of Care forms can be downloaded from this site.

Help Slow Rising Prescription Costs

"Therapeutic alternative" is a term used to describe two or more chemically different medications that generally produce the same clinical effects. These are drug products of different chemical structure within the same pharmacologic or therapeutic class and that are expected to have similar therapeutic effects and safety profiles when administered in therapeutically equivalent doses. Some therapeutic alternatives may be available in over- the-counter formulations.

Here are some examples of commonly used drugs and corresponding therapeutic alternatives:

Drug class	**Commonly Used Drug***	**Optional Therapeutic Alternative***	**Price Differential Per Claim**
Antihistamine	Zyrtec 10 mg $60.09/30 Clarinex 5 mg $70.50/30	Loratadine 10 mg (compares to Claritin) $6.00/30 (average cost)	Ranges from $54.09 to $64.50
Sleeping agents	Ambien 5 mg $75.60/30 Ambien 10 mg $93.30/30	Temazepam 15 mg $4.95/30 Temazepam 30 mg $5.24/30 (compares to Restoril)	Ranges from $70.65 to $92.95
Antidepressants	Lexapro 10 mg $68.70/30	Citalopram 10 mg (compares to Celexa) $17.55/30 fluoxetine 20 mg (compares to Prozac) $7.56/30	Ranges from $51.15 to $61.14
Stomach acid reducers	Nexium 20mg $134.40/30 Aciphex 20mg $128.10/30 Protonix 20mg $111.10/30 Prevacid 30mg $130.95/30	Prilosec OTC 20 mg $17.00/28 (Prilosec OTC comes packaged in 28 and not in 30)	Ranges from $94.00 to $117.30

** based on DOM's maximum allowable costs*

Being knowledgeable about drug costs can help prescribers determine the most cost effective therapy for their patients.

Medicaid Identification Card

It is the responsibility of the Medicaid provider to verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service. The provider is also responsible for 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. It is preferred that providers verify the identity of the person presenting for service with a picture ID when possible. If it is found that the person presenting for services is 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.

Additional information regarding the Division of Medicaid's policy regarding the Medicaid identification card is in Section 3.05 of the Provider Policy Manual. Providers are reminded that they should review this policy periodically with their office staff.

House Bill 1104 Changes Hospice Services

Hospice Provider

The hospice provider continues to be responsible for providing hospice services under a written plan of care established and reviewed by the hospice's interdisciplinary team at each enrollment period and updated as required by the beneficiary's condition.

The hospice provider will no longer be required to submit to the Division of Medicaid the hospice election statement, hospice enrollment form, and the hospice disenrollment form, beginning with the dates of services on or after May 1, 2005.

The hospice provider will continue to be responsible for maintaining auditable records that will substantiate hospice claims submitted to Medicaid, as explained in the Hospice Section (14.2) of the Provider Policy Manual, Subject: Documentation Requirements, Page 1.

Nursing Facilities (NF) and Hospice Services

Nursing Facilities must submit a completed DOM 317 form to the appropriate Medicaid Regional Office (RO) on all residents that have previously been discharged to hospice care and continue to reside in the nursing facility, regardless of the beneficiary's COE. Once these completed forms are received, Medicaid will then process these as admissions to the appropriate NF and patient liability will begin.

Payment is reduced by the amount of the patient liability (Medicaid Income), reported on the DOM 317 form. The NF does not bill for Medicaid reimbursement when hospice services are being provided to a NF resident. Therefore, the hospice reimbursement will reflect the omitted Medicaid Income, for applicable dates of service, for the individuals whose residence is the NF.

It is the responsibility of the hospice and the nursing facility to coordinate billing and any necessary payment distribution for services provided to the Medicaid beneficiary.

Verifying Beneficiary Eligibility

Providers have a variety of resources for verifying the eligibility of a Medicaid beneficiary. Eligibility can be checked by contacting the Provider and Beneficiary Services Call Center at 1-800-884-3222, by calling the AVRS at 1-866-597-2675, by utilizing the Mississippi Envision Web Portal at:

http://msmedicaid.acs-inc.com

and by using a swipe card verification device. You may also access the Web Portal for interactive beneficiary eligibility verification.

When verifying eligibility through the call center, please obtain the call record number (CRN) from the Call Center Associate prior to ending the call. When verifying eligibility through the web portal, please print a copy of the documentation which contains the eligibility information. If verifying eligibility through the use of a swipe card verification device, please keep a copy of the receipt. If verifying eligibility though the use of the AVRS, please document the audit reference number.

MEDICAID REGIONAL OFFICES		
REGIONAL OFFICE LOCATION	**COUNTIES SERVED**	**PHONE NUMBER**
BRANDON REGIONAL OFFICE 3035 Greenfield Road Pearl, MS 39208	Rankin, Simpson, Smith	601-825-0477
BROOKHAVEN REGIONAL OFFICE 128 S. First Street Brookhaven, MS 39601-3317	Copiah, Lawrence, Lincoln	601-835-2020
CANTON REGIONAL OFFICE 616 E. Peace Street Canton, MS 39046	Madison, North Hinds	601-859-3230
CLARKSDALE REGIONAL OFFICE 528 S. Choctaw Street Clarksdale, MS 38614	Coahoma, Quitman, Tunica	662-627-1493
CLEVELAND REGIONAL OFFICE 201 E. Sunflower, Suite 5 Cleveland, MS 38732-7753	Bolivar, Sunflower	662-843-7753
COLUMBIA REGIONAL OFFICE 1111 Hwy 98 Bypass, Suite B Columbia, MS 39429-3701	Covington, Jeff Davis, Marion	601-731-2271
COLUMBUS REGIONAL OFFICE 2207 5th Street North Columbus, MS 39705	Lowndes, Monroe	662-329-2190
CORINTH REGIONAL OFFICE 2619 S. Harper Road Corinth, MS 38834-9399	Alcorn, Prentiss, Tishomingo	662-286-8091
GREENVILLE REGIONAL OFFICE 585 Tennessee Gas Road Greenville, MS 38701-8160	Washington	662-332-9370
GREENWOOD REGIONAL OFFICE 805 W. Park Avenue, Suite 6 Greenwood, MS 38930-2832	Leflore, Tallahatchie, Carroll	662-455-1053
GRENADA REGIONAL OFFICE 1321 Sunset Drive, Suite C Grenada, MS 38901-4005	Grenada, Calhoun, Montgomery Yalobusha	662-226-4406
GULFPORT REGIONAL OFFICE 101 Hardy Court Shopping Center Gulfport, MS 39507-2528	Harrison,	228-863-3328
HATTIESBURG REGIONAL OFFICE 132 Mayfair Blvd. Hattiesburg, MS 39042 – 1463	Forrest, Lamar, Perry	601-264-5386
HOLLY SPRINGS REGIONAL OFFICE 695 Salem Avenue Holly Springs, MS 38635-2109	Benton, Lafayette, Marshall	662-252-3439
JACKSON REGIONAL OFFICE 1695 High Street, Suite A Jackson, MS 39202	South Hinds	601-961-4361
KOSCIUSKO REGIONAL OFFICE 405 W. Adams Street Kosciusko, MS 39090	Attala, Choctaw, Leake	662-289-4477
LAUREL REGIONAL OFFICE 1100 Hillcrest Drive Laurel, MS 39440-4731	Greene, Jones, Wayne	601-425-3175
McCOMB REGIONAL OFFICE 301 Apache Drive McComb, MS 39648-6309	Amite, Pike, Walthall	601-249-2071
MERIDIAN REGIONAL OFFICE 3848 Old Hwy 45 N. Meridian, MS 39301	Clarke, Lauderdale	601-483-9944
NATCHEZ REGIONAL OFFICE 103 State Street Natchez, MS 39120	Adams, Franklin, Jefferson Wilkinson	601-445-4971
NEW ALBANY REGIONAL OFFICE 1410 Munsford Drive New Albany, MS 38652	Pontotoc, Tippah, Union	662-534-0441
NEWTON REGIONAL OFFICE 105 School Street Ext. Newton, MS 39345-2622	Jasper, Newton, Scott	601-683-2581
PASCAGOULA REGIONAL OFFICE 4119 Amonett Street Pascagoula , MS 39567-4413	George, Jackson	228-762-9591
PHILADELPHIA REGIONAL OFFICE 1122 E. Main St. Eastgate Plaza, Suite 15 Philadelphia, MS 39350-2300	Neshoba, Noxubee, Winston Kemper	601-656-3131
PICAYUNE REGIONAL OFFICE 1845 Cooper Road Picayune, MS 39466	Hancock, Pearl River.Stone	601-798-0831
SENATOBIA REGIONAL OFFICE 2776 Hwy 51 South Senatobia, MS 38668	Desoto, Panola, Tate	662-562-0147
STARKVILLE REGIONAL OFFICE 313 Industrial Park Drive Starkville, MS 39759	Chickasaw, Clay, Oktibbeha Webster	662-323-3688
TUPELO REGIONAL OFFICE 1830 N. Gloster Street Tupelo, MS 38804-1218	Itawamba, Lee	662-844-5304
VICKSBURG REGIONAL OFFICE 2734 Washington Street Vicksburg, MS 39180-4656	Claiborne, Issaquena, Sharkey Warren	601-638-6137
YAZOO CITY REGIONAL OFFICE 110 North Jerry Clower Blvd., Suite A Yazoo City, MS 39194	Holmes, Humphreys, Yazoo	662-746-2309

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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 Manuals
are on the Web
www.dom.state.ms.us
And
Medicaid Bulletins are on the Web Portal
http://msmedicaid.acs-inc.com

June

June 2005

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

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.