Mississippi Medicaid Bulletin

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Inside this Issue

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

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). The service ends on the last day of the 21st birthday month. The acronym EPSDT combines to make the program unique:

Early ----------Assessing health care in early life so that potential disease and disabilities can be prevented or detected in their preliminary states, when they are most effectively treated.

Periodic -------Assessing a child's health at regular, recommended intervals in the child's life to assure continued healthy development.

Screening -----The use of tests and procedures to determine if children being examined have conditions warranting closer medical or dental attention.

Diagnosis -----The determination of the nature or cause of conditions identified by the screening.

Treatment ----The provision of services needed to control, correct or lessen health problems.

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(EPSDT Changes continued)

In order to administer the EPSDT program, the Division of Medicaid (DOM) and potential EPSDT providers, including but not limited to, the State Department of Health, other public and private agencies, private physicians, rural health clinics, comprehensive health clinics, and similar agencies which provide various components of EPSDT services, must sign an EPSDT specific provider agreement. Diagnostic and treatment services are primarily provided by referral to other providers.

An EPSDT provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then rebate Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by DOM.

Enrollment

Physicians, physician assistants, or nurse practitioners, who wish to become EPSDT screening providers, must complete the enrollment requirements and must sign an EPSDT specific provider agreement with DOM. If this is the first provider agreement entered into between the provider and DOM, a Medicaid provider number will be issued and a special EPSDT indicator will be added to the new Medicaid provider number. An onsite clinic inspection must be conducted, prior to receiving the EPSDT provider segment. (See Clinic Preparation: On Site).

For current Medicaid providers, a special EPSDT indicator will be added to their existing Medicaid provider number. However, the provider facility on-site review must be approved prior to finalizing the EPSDT provider agreement with the effective begin date as the date this review is completed and approved.

Registered Nurses who are employed through the Mississippi Department of Education (MDE), who have met the certification requirement, and who meet the established protocols mandated by the Mississippi State Department of Health (MSDH), Mississippi Department of Education (MDE), Mississippi School Nurse Association, and Mississippi Board of Nursing, may perform EPSDT health assessments following the protocols established by the MSDH. Those nurse-operated clinics, sponsored by medical practices/hospitals and issued provider numbers prior to 2002, will be recognized as acceptable if they conform to the above. However, after 2002, all established and new nurse-run clinics must adhere to the above-stated policy. This process assures that registered nurses have the educational basis and clinical basis needed to perform health assessments. In addition to the certification requirement, claims submitted for these services must be submitted under the school's provider number and the billing provider must have a letter of referral affiliation on file with the Division of Medicaid.

Medicaid providers who wish to become EPSDT screening providers should contact DOM Maternal and Child Health Bureau (MCH) at the following address to obtain EPSDT provider agreements:

Division of Medicaid
Maternal and Child Health Bureau
Robert E. Lee Building, Suite 801
239 North Lamar Street
Jackson, MS 39201-1399
Phone 1-800-421-2408 ext. 6150 or
Phone 601-359-6150

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Clinic Preparation: On-Site

An on-site clinic inspection must be conducted prior to receiving the EPSDT provider segment. An on-site visit is also required if the physical setting is moved to a new location or an additional satellite clinic is opened as a part of the original facility. A separate Medicaid facility number must be obtained for each clinic setting, and an on-site inspection must be conducted by an EPSDT Review Nurse from the MCH Bureau prior to EPSDT screenings and submission of Medicaid claims for screening services.

Provider Agreement

The Division of Medicaid enters into an EPSDT provider agreement with Medicaid providers who wish to participate in the EPSDT program. Participation as an EPSDT screening provider is entirely voluntary. A physician, physician assistant or nurse practitioner, who wishes to become an EPSDT screener, must complete all enrollment requirements and sign an EPSDT specific provider agreement with DOM. The provider agrees to abide by all existing laws, regulations, and procedures pursuant to the EPSDT program and Medicaid participation. This includes policies and procedures stated in the EPSDT section of the Medicaid Provider Policy Manual. The agreement may not be transferred or reassigned and may be terminated on thirty (30) days written notice by either the provider or DOM. Changes in ownership or corporate entity must be reported immediately to DOM, and failure to do so may invalidate the agreement.

Frequently asked questions concerning EPSDT

What services are covered under the Expanded EPSDT services?

Expanded EPSDT services include any necessary Medicaid reimbursable health care to correct or ameliorate illnesses and conditions found on EPSDT screening. Services not covered, or exceeding the limits set forth in the Mississippi State Plan, must be prior authorized by DOM to ensure medical necessity. Expanded services are available to children from birth to 21 years of age. Eligibility extends through the last day of the child's birth month only.

Who is eligible to participate in EPSDT?

Children and youth (birth to twenty-one years) who are on Medicaid are eligible to participate in EPSDT.

Who can provide EPSDT screenings?

EPSDT screenings may be performed by physicians, physician assistants, nurse practitioners and registered nurses, who are employed through the Mississippi Department of Education, who have met the certification requirement, and who meet the established protocols mandated by the Mississippi State Department of Health, Mississippi Department of Education, Mississippi School of Nursing Association, and the Mississippi Board of Nursing.

Do EPSDT screening providers need a separate Medicaid provider number?

Physicians, physician assistants or nurse practitioners, who wish to become EPSDT screening providers, must complete the enrollment requirements and must sign an EPSDT specific provider agreement with DOM. If this is the first provider agreement entered into between the provider and DOM, a Medicaid provider number will be issued and a special EPSDT indicator will be added to the new Medicaid provider number. For current Medicaid providers, a special EPSDT indicator will be added to their existing Medicaid provider number. An onsite provider facility inspection must be conducted and approved prior to finalizing the EPSDT provider agreement with the effective begin date as the date the facility on-site review is completed and approved.

Note: An EPSDT provider agreement must be on file prior to providing EPSDT screening services, billing, and being reimbursed by Medicaid for services rendered. An EPSDT provider cannot have a retroactive effective date. Also, a separate Medicaid facility number must be obtained for each clinic setting, and an on-site inspection must be conducted by an EPSDT Review Nurse from the MCH Bureau prior to EPSDT screenings and submission of Medicaid claims for screening services.

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How often can an EPSDT screening be performed?

All providers must follow the periodicity schedule. The schedule is based on the American Academy of Pediatrics "Recommendations for Preventive Pediatric Health Care." Frequency is as follows:

- 0-1month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- Yearly beginning at age 2 years, up to age 21.
- Yearly visits must occur once during the state fiscal year (July 1st- June 30th) and be scheduled the month following the child's birth month.

Where can an EPSDT screening be performed?

Local County Health Departments
Limited School Systems
Private and Public Clinics
Federally Qualified Health Clinics
Rural Health Clinics

How do I know if an EPSDT screening has not already been done?

All Medicaid providers can check Medicaid eligibility and see whether the EPSDT screening is available through the ACS Medicaid Web Portal. The web address is: http://msmedicaid.acs-inc.com. The providers that do not have internet service may call the Automated Voice Response System (AVRS). The number is: 1-866-597-2675 or 601-206-3090.

Why has Medicaid started sending out clinic EPSDT referrals?

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a mandatory service under Medicaid. Each state is required to inform all Medicaid-eligible beneficiaries under age 21 that EPSDT services are available. Each state must also report annually to the Centers for Medicare & Medicaid Services (CMS) their performance and participation in the program. As part of our initiative to inform beneficiaries about the EPSDT program and increase participation in the program, the Medicaid Regional Offices are informing beneficiaries orally and in writing about the EPSDT program. A 315 Referral Form is completed for each beneficiary that chooses to participate. The 315 Referral Form is sent to the EPSDT participating provider to schedule the EPSDT screen.

Medicaid has sent me EPSDT referrals on children that we have never seen before. What do I do with these referrals?

Many of Medicaid-eligible beneficiaries do not have a Medical Home and have not received an EPSDT screening. This is reflected on our annual Federal report that shows a low participation rate for our state. EPSDT participating providers have entered into an agreement with the Division of Medicaid to provide this service to eligible beneficiaries. The Division of Medicaid policy is that participating providers contact the parent and schedule a screening for these beneficiaries within 60 days of receiving the referral.

Will I be locked into seeing only the beneficiaries that Medicaid refers?

No. The Division of Medicaid wants every beneficiary to have a Medical Home, and we encourage them to continue seeing their Medicaid provider of choice to establish a Medical Home.

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What do I do when we schedule the EPSDT screening and the beneficiary does not show up?

Medicaid policy is that the EPSDT participating provider will make an appointment for the eligible beneficiary according to the periodicity schedule. If the family fails to keep the scheduled appointment, a second appointment letter will be sent providing the family another opportunity to participate in the EPSDT program within (30) days of the initial appointment. Failure of the family to keep the second appointment or to contact the clinic for a change in date and time will be considered a declination of services. Further attempts to contact the patient are not required for that periodic schedule.

After two appointment failures, the provider shall place the child for recall for the next EPSDT screening date on the periodicity schedule. It is the responsibility of the EPSDT screening provider to document efforts made to ensure the family an opportunity to participate in the EPSDT program. In no circumstances should the child be deleted from the system, unless the family refuses the service.

Why is lead testing a requirement of the EPSDT program?

Statistics show that the prevalence of lead poisoning is greater for children who are enrolled in Medicaid. Federal law mandates that all States screen all Medicaid eligible children for lead poisoning as part of the EPSDT program requirements. A blood lead test must be used when screening Medicaid-eligible children.

At what age is lead testing required?

A blood lead test is required at 12 months and 24 months of age and anytime risk factors are identified by the risk assessment questionnaire. Additionally, children between the ages of 36 months and 72 months of age must receive a blood lead test if they have not been previously screened for lead poisoning. A blood lead test result equal to or greater than 10 mcg/dl obtained by a capillary specimen (finger stick) must be confirmed using a venous blood sample.

The verbal lead risk questionnaire reveals no environmental risk factors at the 12-month EPSDT visit. Is a blood lead test still required?

Yes. A blood lead test is required at 12 months and 24 months regardless of the responses to the lead risk questionnaire. In addition, children over age 2 but less than age 6 should receive a blood lead test if not previously tested and at anytime a risk factor is identified.

Will I receive Medicaid reimbursement for lead testing?

Billing of lead analysis (83655) is appropriate only for the lab that analyzes the lead test and for those facilities that have purchased and utilize an in-house lead analyzer. Lab slips must contain accurate information including name, address, and current Medicaid number for appropriate billing by the independent lab. All labs must report weekly the results of all lead tests to the MSDH Lead Program. Those clinics with in-house lead analyzers must report all lead results to the MSDH Lead Program utilizing the reporting tool developed by the Lead Program.

A capillary specimen came back elevated requiring a confirmatory venous test. The venous test was elevated at 12 mcg/dl. What follow-up is required?

- All venous lead test results of 10mcg/dl or greater must be reported to the State Lead Program Coordinator at 601-576-7447.

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- Provide family lead education; screen other children in the household under 6 years of age
- Provide nutritional counseling and check for iron deficiency (hct/hgb)
- Conduct a developmental assessment
- Repeat blood lead testing every 3 months until 2 venous results <10 mcg/dl. or 3 results <15 mcg/dl, then annually.

The Mississippi Childhood Lead Poisoning Prevention Guidance gives specifics on lead testing guidelines and recommended follow-up procedures. Download the guidance from the MSDH website at http://www.msdh.state.ms.us; click on preventive health services; click on environmental lead; scroll down to lead prevention guidance. For those without internet access, a copy can be obtained by calling 601-576-7447.

Where might I get patient educational materials on lead poisoning and prevention?

Contact the MSDH Childhood Lead Poisoning Prevention Program at 601-576-7447 for free literature on lead poisoning and prevention.

SPECIAL NOTICE:

BEGINNING JANUARY 1, 2006, THE NUMBER OF OFFICE VISITS AND OUTPATIENT VISITS ALLOWED FOR CHILDREN UP TO AGE 21 WILL REMAIN CONSISTENT WITH STATE LAW AND DOM STATE PLAN. FOR CHILDREN UP TO AGE 21, EXPANDED OFFICE VISITS CAN BE APPROVED AFTER THE 12TH VISIT WITH DOCUMENTED EPSDT SCREENING AND AFTER THE 6TH EMERGENCY ROOM VISIT. PLEASE REFER TO PROVIDER POLICY MANUAL SECTION 73 FOR ADDITIONAL INFORMATION.

Should you have any questions or need any additional information, please call DOM, BUREAU OF MATERNAL/CHILD HEALTH at 1-800-421-2408 or 601-359-6150.

Policy Manual Additions/ Revisions

The following policies and policy sections have been added and/or revised in 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.

Manual Section	Policy Section	New	Revised	Effective Date
11.0 Dental	11.12 Prosthodontics (Removable) 11.17 Orthodontics: Prior Authorization/ Treatment		X X	01/01/06 01/01/06
53.0 General Medical	53.19 Failed Sterilization Procedures 53.22 Medically Necessary	X X		01/01/06 01/01/06
25.0 Hospital Inpatient	25.29 Sterilization		X	01/01/06
38.0 Maternity	38.06 Delivery and Sterilization		X	01/01/06
53.0 General Medical	53.21 Blepharoplasty	X		02/01/06
15.0 MH/ Community Mental Health	15.30 Billing Guidelines		X	02/01/06

Medicaid Program Changes that Impact the Non-Emergency Transportation Program

On January 1, 2006, some beneficiaries who are currently eligible for Medicaid through the Poverty Level Aged or Disabled (PLAD) category will have their eligibility end. This change is based on Mississippi House Bill 1104, passed by the Mississippi Legislature during 2005, which ends the PLAD group on January 1, 2006.

The Division of Medicaid has reassigned persons in the PLAD group to other categories of eligibility, the Healthier Mississippi Waiver for those non-Medicare persons, or to a Medicare Savings Program. Most PLAD beneficiaries qualify for a Medicare Savings Program that helps pay their premiums, deductibles, and copayments for Medicare covered services only. Non-Medicare eligible PLADS will remain Medicaid eligible in the Healthier Mississippi Waiver.

Non-emergency transportation (NET) is not a Medicare covered service and will no longer be provided by the Division of Medicaid for these individuals who qualify for a Medicare Savings Program. In order to assist current PLAD beneficiaries with transportation needs, the Division of Medicaid worked with the Mississippi Department of Transportation to provide a listing of public transit agencies that may be able to assist. Each of these agencies receives funding from the Federal Transit Authority to provide transportation to the elderly and disabled. Each transit agency has different service areas, available capacities, and hours of operation including fare amounts charged to riders. The affected beneficiaries must call the transit agency directly to arrange transportation. The list of public transit agencies is available on our web site at www.dom.state.ms.us.

If you have any questions, please call 1-800-421-2408 or 601-359-6050 and ask to speak with someone in the NET division.

2006 New Bed Values for Nursing Facilities, ICF-MR's and PRTF's

The new bed values for 2006 for nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR's) and psychiatric residential treatment facilities (PRTF's) have been determined by using the R.S. Means Construction Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

Facility Class	2006 New Bed Value
Nursing Facility	$38,174
ICF-MR	$45,809
PRTF	$45,809

Dental Providers

There is a $1200 limit per fiscal year (July 1 – June 30) on restorative services for beneficiaries under the age of 21. This limit is exclusive of charges made for extractions. Exceptions to the $1200 limit may be made if a prior authorization (PA) is requested and is approved by DOM **prior** to rendering services. Please refer to sections 11.02 and 11.21 of the Provider Policy Manual which can be accessed at www.dom.state.ms.us.

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.

Sanctioned/Excluded Providers

In order to meet Federal requirements regarding public notification of sanctioned Medicare/Medicaid providers, as provided in 42 CFR Section 1002.212, the Mississippi Division of Medicaid has posted on its website at www.dom.state.ms.us a list of providers that have been excluded from participation in the Medicaid programs.

PRTF Discharge Medication Clarification

The current policy in Section 18.11 states upon discharge from a PRTF, the child is to be given a one week supply of medication. The Division of Medicaid would like to clarify that upon discharge, the child and/or his/her parent/guardian will be provided a supply of all current medications prescribed for the child, equal to the amount already stocked for that child by the PRTF but not less than a seven (7) day supply or more than a thirty (30) day supply.

Pharmacy Updates

Medicare Part D and B :

The Division of Medicaid has received phone calls regarding confusion about the coverage of Medicare Part B drugs in relationship to Medicare Part D drug coverage. For more information on Medicare Part B in regard to Part D, refer to CMS web site at www.cms.gov, and Prescription D coverage, or directly at http://www.cms.hhs.gov/medicarereform/drugcoveragefaqs.asp.

Maximum Quantity Limits Changes*:

Effective February 1, 2006, the Division of Medicaid will implement new maximum quantities per prescription (a month's supply is the maximum Mississippi Medicaid-covered days' supply per prescription) resultant from the Drug Utilization Board's recommendations on November 17, 2005.

Drug categories included are controlled substances, such as hydrocodone or codeine combination drugs, propoyphene and acetaminophen combinations, tramadol preparations, oxycodone or morphine single agents and/or combination agents. Monthly quantity limits will be no more than 62 cumulative units per 30 rolling days effective February 1, 2006. For beneficiaries requiring more than 62 cumulative units, a maximum dose override should be faxed to Health Information Designs (HID) at 1-800-459-2135. Maximum dose override forms may be found at www.dom.state.ms.us, Pharmacy Services, and forms.

A comprehensive listing of all products with quantity limits is available on the DOM website at www.dom.state.ms.us, Pharmacy Services, What's New, and Products with Quantity Limits. Note that this listing is subject to change.

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Brand Name	Maximum Quantity Limitation Per 31 Days	Generic Drug Name
ANALGESICS		
NARCOTIC ANALGESIC COMBINATIONS*		
Anexsia	62	Hydrocodone/Acet 5/325
Anexsia	62	Hydrocodone/Acet 5/500
Anexsia	62	Hydrocodone/Acet 7.5/325
Anexsia	62	Hydrocodone/Acet 7.5/650
Combunox	28	Oxycodone/Ibuprofen 5/400
Darvocet N-50	62	PropoxypheneNap/Acet 50/325
Darvocet N-100	62	PropoxypheneNap/Acet 100/325
Darvocet A500	62	PropoxypheneNap/Acet 100/500
Darvon Compound-32	62	PropoxypheneHCl/ASA/Caff 32/389/32.4
Darvon Compound-65	62	PropoxypheneHCl/ASA/Caff 65/389/32.4
Empirin No.3	62	Codeine/Aspirin 30/325
Empirin No.4	62	Codeine/Aspirin 60/325
Fioricet w/Codeine	62	Butalbital/Acet/Codeine/Caf 50/325/30/40
Fiorinal w/Codeine	62	Butalbital/ASA/Codeine/Caf 50/325/30/40
Lorcet HD	62	Hydrocodone/Acet 5/500
Lorcet Plus	62	Hydrocodone/Acet 7.5/650
Lorcet 10/650	62	Hydrocodone/Acet 10/650
Lortab 2.5	62	Hydrocodone/Acet2.5/500
Lortab 5	62	Hydrocodone/Acet 5/500
Lortab 7.5	62	Hydrocodone/Acet 7.5/500
Lortab 10	62	Hydrocodone/Acet 10/500
Maxidone	62	Hydrocodone/Acet 10/750
Norco 5	62	Hydrocodone/Acet 5/325
Norco 7.5	62	Hydrocodone/Acet 7.5/325
Norco 10	62	Hydrocodone/Acet 10/325
Panlor DC	62	Dihydrocodeine/Acet/Caff 16/356.4/30
Panlor SS	62	Dihydrocodeine/Acet/Caff 32/712.8/60
Percocet	62	Oxycodone/Acet 2.5,5,7.5,10mg / 325 mg-7.5/500mg, 10/650mg Tabs
Percodan	62	Oxycodone/ASA 4.88/325mg
Suboxone	62	Buprenorphine/Naloxone- 2-0.5 & 8-2 mg
Synalgos-DC	62	Dihydrocodeine/ASA/Caf 16/356.4/30
Talacin	62	Pentazocine/Acet 25/650mg
Talwin NX	62	Pentazocine/Naloxone
Tylenol w/Codeine No.2	62	Codeine /Acet 15/300
Tylenol w/Codeine No.3	62	Codeine /Acet 30/300
Tylenol w/Codeine No.4	62	Codeine/Acet 60/300
Tylox	62	Oxycodone/Acet 5/500 mg
Vicodin	62	Hydrocodone/Acet 5/500
Vicodin ES	62	Hydrocodone/Acet 7.5/750
Vicodin HP	62	Hydrocodone/Acet 10/660
Vicoprofen (7.5/200mg)	62	Hydrocodone/Ibuprofen
Wygesic	62	PropoxypheneHCl/Acet 65/650
Xodol	62	Hydrocodone/Acet 10/300
Zydone 5/400mg	62	Hydrocodone/Acet 5/400
Zydone 7.5/400	62	Hydrocodone/Acet 7.5/400
Zydone 10/400	62	Hydrocodone/Acet 10/400

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NARCOTIC ANALGESICS-SINGLE ENTITY AGENTS*		
Actiq Lozenge	62	Fentanyl Citrate 200,400,600,800,1200,1600mcg
Avinza Cap	31	Morphine Sulfate 30, 60, 90 120 mg
Codeine Phospate	62	Codeine Phosphate 15, 30 & 60 mg Tabs
Demerol	62	Meperidine HCl 50, 100 mg Tabs
Dilaudid	62	Hydromorphone HCl 2, 4, 8 mg Tabs
Dolophine	62	Methadone HCl 5, 10, 40 mg Tabs
Kadian Cap	62	Morphine Sulfate 20, 30, 50, 60, 100 mg
Levorphanol 2 mg	62	Levorphanol 2 mg Tabs
Morphine SO4 Soluble Tab for Injection	62	Morphine Sulfate 10, 15, 30 mg
MS Contin	62	Morphine Sulfate 15, 30, 60, 100, 200 mg Tabs
MSIR	62	Morphine Sulfate 15, 30 mg Tabs
OxyContin	62	Oxycodone HCl 10, 20, 40, 80 mg Tabs
OxyIR Cap	62	Oxycodone HCl 5 mg
Roxicodone	62	Oxycodone HCL 5, 15, 30 mg Tab
Subutex	62	Buprenorphine HCl 2, 8 mg Tabs
All Sustained Release Opioid Agonists except generic MS Contin require Prior Authorization		
CENTRAL ANALGESICS*		
Ultracet	62	Tramadol/Acetaminophen 37.5mg/325mg
Ultram 50 mg	62	Tramadol

New limits recommended by DUR Board on 11-17-05

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.

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.

"Helpful Hints"

1. All hard copy claims should be submitted on red "drop out" CMS-1500 or UB-92 claim forms. Photocopied claims are not acceptable.
2. All claims should be coded appropriately. Consult your ICD-9 and CPT-4 manuals for code definitions.
3. All place of service codes should be two digits. See September 2003 bulletin for the one to two digit place of service crosswalk.
4. If Medicare is the primary payor, timely filing guidelines state that providers have 180 days from Medicare's payment date to file the claim with Medicaid.
5. Remember to utilize the AVRS and web portal for eligibility inquiries!

Internet Access Is A Must!

In keeping up with the rapidly growing pace of business technology, Internet access is a must. Convenience is one of the many benefits the Internet provides. ACS encourages all providers to take advantage of the Mississippi Medicaid website.

The Mississippi Medicaid website is available 24 hours a day, 7 days a week. Over a period of time, using the website will result in tremendous cost and staff savings by the quick and easy access to Medicaid information.

The Mississippi Medicaid site was designed to assist the Mississippi Medicaid Provider with the ability to search and retrieve information immediately. The website is divided into two main areas: the public site and the data exchange site.

The public site contains provider support information such as:

- Manuals, provider enrollment applications, and enrollment forms
- Medicaid information, such as EDI service information
- Frequently asked questions
- Electronic claims submission software

The Data Exchange site is a secured site that contains Electronic Remittance Advices (ERAs) and Claim Rejection Reports. Providers are assigned a logon and password that will allow secure access to only that particular provider's Remittance Advice and/or Claim Rejection Report.

Providers can gain access to all of the above information by simply visiting the Division of Medicaid's website at www.dom.state.ms.us or ACS's EDI website at www.acs-gcro.com.

We encourage providers without Internet access in their offices to obtain it now. The Mississippi Medicaid site can save staff resources and money with instant information at no cost to the provider. The Internet is the avenue of choice for receiving current and immediate information.

Completing the Adjustment/Void Request Form

In order for provider requests for adjustments and voids of claims to be processed appropriately, it is extremely important that the Adjustment/Void Request Form is filled out completely. The Adjustment/Void Request Form is a one-page document used by the provider community to give direction regarding requests to adjust or void claims already submitted and processed. There are several sections on the form that identify the type of request and additional fields that help to supply the necessary details required to adjust or void the indicated claim(s). All fields must be completed in order for ACS to process the provider's request. Additionally, there is an "other explanation" field that is made available to allow for further details regarding the request.

If an Adjustment/Void Request Form (AVR) is received by ACS and it is not filled out completely, it will be returned to the provider for clarification. If you need assistance completing the Adjustment/Void Request Form, please contact Provider Services at 800-884-3222 and ask a Service Associate for assistance, or contact your assigned Provider Field Representative.

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

January

January 2006

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

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.