Mississippi Medicaid Bulletin

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Mississippi Division of Medicaid - Uncompensated Care Program

The Mississippi Division of Medicaid has received approval of limited federal funding for uncompensated care provided to individuals from a county or parish declared a disaster area as a result of Hurricane Katrina who required medically necessary services associated with the hurricane relief effort and were without private insurance, Medicaid or SCHIP in any state, Medicare, health care vouchers from any state, federal, or charity organization, or any other method of health care coverage including patient payments even if made based on a sliding fee scale at the time the services were rendered.

Services covered by the uncompensated care program include:

- All services covered through the Mississippi Medicaid program. These services will be reimbursed according to the Mississippi Medicaid rate for each procedure in effect on the date of service. The Uncompensated Care Program may only reimburse for emergency items and services with respect to dental care, eye care, and durable medical equipment.
- In addition, the program will cover those prescription drug claims for dates of service August 27 through September 30, 2005, which **exceeded** the Mississippi Medicaid program benefit limits to those persons eligible for Mississippi Medicaid.
- Mental health services provided by the Community Mental Health Centers to eligible individuals that were medically necessary and are not covered in a Medicaid beneficiary's home state will also be covered under this program. Payment may be made for these mental health services specified only to the extent that they are not otherwise reimbursable under other funding sources including but not limited to, grant or reimbursement programs offered through the Federal Emergency Management Agency (FEMA), the Substance Abuse & Mental Health Services Administration, the Health Resources and Services Administration, National Institutes of Health, or any other Federal or State program, private insurance, Medicaid, SCHIP, Medicare or any private source.

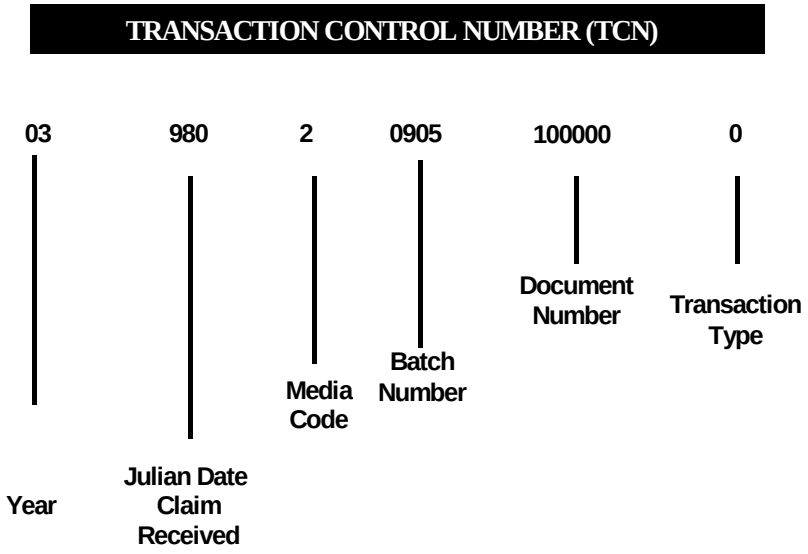
For specific details, please refer to the Medicaid web site at www.dom.state.ms.us.

The Importance of the TCN in Filing Medicaid Claims

The transaction control number is often referred to as the TCN, a 17-digit number that appears on the weekly remittance advice. When paper or electronic claims are received by ACS for processing, they are assigned a unique TCN. It is the date stamp of how and when the claim was received and processed by ACS.

The 17-digit transaction control number has meaning as follows:

EXAMPLE 17-Digit TCN – 03980209051000000



Year The last two digits of the year for which the claim was received
Julian Date The month and day in Julian date format when the claim was received
Media Code The format of the claim.

Media Codes

2=Electronic Crossover claim
3=Electronic Claims claim
4=System Generated claim
6=Special Batch claim
8=Paper claim
9=Paper claim with Attachment

Transaction Type Tells the transaction type.

Transaction Type

7=Original
8=Void/Credit
9=Debit

(Continued on the next page)

(TCN article continued from page 2)

The TCN is required when resubmitting Medicaid claims that are over one year from the date of service to prove timely filing. The TCN allows the claim to be adjudicated for payment up to two years from the date of service. Enter the TCN in Block 22 labeled "Medicaid Resubmission Code/Original Ref. No." on the CMS 1500 claim form, and enter the TCN in Block 37a (not labeled) on the UB-92 claim form.

> **NOTE**: If the claim is less than one year old, DO NOT enter a timely filing TCN on claim or it will deny, for invalid timely filing TCN, EOB denial 3683.

Medicare Crossovers are processed on the CMS 1500 and UB-92 claim forms with a Medicare EOMB attached to the claim. Medicaid policy states that the provider has 180 days from Medicare paid date to have the Medicaid claim processed for payment. If the claim denies for Edit 3259 (claim exceeds filing time limits), reference to a TCN will not allow additional time for consideration of claim payment. If a TCN is on the crossover claim, and the 180 days has expired from the Medicare paid date, then **crossover claims should not use a timely filing TCN**.

Please contact the ACS Provider Support Line at 1-800-884-3222 or 1-601-206-2900 if you have a question on how and when to use the TCN.

EPSDT Screening Services Billing Reminder

EPSDT providers are reminded that in order to receive Medicaid reimbursement for EPSDT screening services you must perform the well child check-ups according to the following periodic examination schedule:

*0-1 month	*9 months
*2 months	*12 months
*4 months	*15 months
*6 months	*18 months
*Every year beginning at age 2. The yearly visit must be planned to occur once during the state fiscal year (July 1st – June 30th).	

EPSDT providers are also reminded when billing for the above screening services, your name/eight digit servicing provider number and E provider type indicator must be reflected on the CMS-1500 form with the age-appropriate CPT preventive medicine code and "EP" modifier for proper payment. Please refer to the EPSDT Provider Manual, Section 73.04 for the EPSDT preventive medicine procedure codes.

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.

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.

Processing Adjustment/Void Requests

In our present environment, most providers use special software systems to bill their claims electronically. Electronic claims billing is the fastest way to file claims, whether the user is a large or small volume biller. ACS, the fiscal agent of the Division of Medicaid, provides free electronic billing software to Mississippi Medicaid providers.

WINASAP2003 is that software and is specifically designed to meet the needs of small volume claims billers. Not only can claims be filed electronically, but claims can also be voided or adjusted electronically. An electronic transaction is the fastest method of completing an adjustment or void request. Also, other software vendors have representatives available to provide technical assistance for performing electronic adjustments or voids. However, if the user is not a Mississippi Medicaid provider who processes claims electronically, then the provider must manually submit requests to adjust or void claims. Simply complete the Adjustment/Void Request Form (AVR) and mail it to ACS for processing at P. O. Box 23077, Jackson, Mississippi 39225. Please complete each field on the AVR as it directly affects the processing of the request. If additional AVR forms are needed, simply access the ACS provider web portal at http://msmedicaid.acs-inc.com, click on the "Publications" link and under "Forms", the Adjustment Void Request Form (AVR) is downloadable. The electronic billing software, WINASAP2003, is also downloadable at the internet address listed above. The Division of Medicaid appreciates this proactive measure of correcting identified claim errors.

Please contact the ACS Provider/Beneficiary Services Call Center at 1-800-884-3222. The Customer Service Representatives are available to provide assistance. Also, because more complex inquiries may require special assistance, please contact the Provider Field Representative assigned to the territory of your billing location.

Call Record Tracking Numbers

When calling the ACS Call Center, ask for the call record number (CRN) from the Call Center Associate prior to ending your call. Make a record of this number, as it will be useful if there is a need for you to follow up on an inquiry.

Co-Payments

The Division of Medicaid (DOM) and ACS have experienced a high volume of calls regarding increased co-payments. The current co-payment amounts are listed below:

Ambulance	$3.00 per trip
Dental	$3.00 per visit
Federally Qualified Health Center	$3.00 per visit
Home Health *	$3.00 per visit
Hospital Inpatient	$10.00 per day
Physician	$3.00 per visit
Prescription	$3.00 per prescription
Rural Health Clinic	$3.00 per visit
Eyeglasses	$3.00 per pair
DME, Orthotics, and Prosthetics (excludes medical supplies)	up to $3.00
MSDH (Mississippi Department of Health) Clinic	$3.00 per visit

Please note that the Home Health co-pay applies to state plan service HH visits only,* ***not* *the extended HH visits (after the first 25) covered by HCBS Elderly and Disabled (E&D) waiver.*

ADJUSTMENT/VOID Request Form

Please complete this form and attach appropriate documentation. If filing for an adjustment attach a corrected claim form.

Mail to: **Mississippi Medicaid Program**
P.O. Box 23077
Jackson, Mississippi 39225

1 Provider Information	2 Beneficiary Information
1a Provider Number	***2a Name***
1b Provider Name	***2b Recipient ID Number***
	2c Date(s) of Service
1c Provider Address	***2d Transaction Control Number (TCN)***
	2e Line Numbers
	2f RA Date

3 Adjustment or Void *(Please check one of the following options)*

- ☐ 3a Adjustment
- ☐ 3b Void

4 Overpayment *(Please check one of the following, 4a is preferred option)*

- ☐ 4a Please deduct the overpayment from the future claims payments.
- ☐ 4b I have attached my personal check in the amount of the overpayment.
- ☐ 4c I have returned the State Warrant.

5 Description of Request *(Please check one of the following if applicable, if not please explain in the space below)*

- ☐ 5a Third Party Liability Recovery (Attach EOB)
- ☐ 5b Provider Corrections
- ☐ 5c Fiscal Agent Error
- ☐ 5d Claim Paid for Wrong Recipient
- ☐ 5e Claim Paid to Wrong Provider
- ☐ 5f LTC Medicaid Income Change

Other Explanation:

6 Signature Block

6a Signature of Sender	***6b Mailing Date***

Mississippi Medicaid Use Only

Reason Code		***Initials***	***Date Stamp***
FCN		***Date***	
Claim Type	***TXN Code***	***COS***	

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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
10.0 Durable Medical Equipment	10.02 Reimbursement		X	05/01/06
	10.10 Apnea Monitor		X	
	10.14 Bi-level Positive Airway Pressure Device (BIPAP) With or Without an In-Line Heated Humidifier		X	
	10.27 Continuous Positive Airway Pressure Device (BIPAP) With or Without an In-Line Heated Humidifier		X	
	10.42 Humidifier		X	
	10.73 Suction Pump (Respiratory/ Gastric)		X	
	10.91 DME-Related Supplies		X	
	10.96 Combination Positive Expiratory Pressure Device, Airway Oscillation Device, and Intermittent Flow Acceleration Device	X		
	10.101 Hip Abductor Pillow/ Wedge	X		
	10.103 Cranial Molding Helmet	X		
	10.104 Urinary Tract Infection Kits	X		
	10.105 Height Adjustable Crawler	X		
	10.106 Combination Head Float with Mini Stabilizer Bar	X		
	10.107 Weighted Blanket	X		
	10.108 Custom Wedge Seat Insert	X		

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(Policy Manual continued)

Manual Section	Policy Section	New	Revised	Effective Date
18.0 Psychiatric Residential Treatment Facility (PRTF)	18.12 Discharge/Aftercare		X	05/01/06
32.0 Beneficiary Health Management	All (32.01-32.05)	X		05/01/06
36.0 Nursing Facility	36.12 Case Mix Guidelines		X	05/01/06
37.0 Laboratory	37.04 Qualitative Drug Screens	X		05/01/06
55.0 Physician	55.07 Removal of Impacted Cerumen	X		05/01/06
11.0 Dental	11.02 Dental Programs 11.09 Restorative Services 11.20 Authorization (Prior Authorization/ Authorization Prior to Billing)		X X X	06/01/06
68.0 HCBS/ Assisted Living	All (68.01- 68.10)	X		06/01/06

Long Term Care
Quick Tips

WINASAP

- Creating a revenue code data base allows claim charges to automatically calculate
- Create only one template per resident
- Always use the "Build Nursing Facility Claims" feature to create monthly billing
- To correct and bill denied claims, copy the claim, make corrections, then transmit
- Statement covered period should represent the days billed
- Covered days should equal the days represented in the statement covered period and the total line item units
- Status Code should reflect the status of the resident on the through date in the statement covered period
- When billing for a resident who had both room and board days as well as leave days, always bill revenue code 101 (room and board) on line one of the claim
- Claims can only have one revenue code 101 but multiple entries for revenue code 181 and 183
- Hospital leave days can be grouped on one line if the total days billed do not exceed 15
- Therapeutic leave days can be grouped on one line
- Only the first line item on the claim requires "from and to" service dates
- Two hours after claim submission, run a "**Receive Response File**." If claims reject, contact EDI 1-866-225-2502.
- When claims submission is paid, purge claims from data base
- Prior to downloading new versions of WINASAP, always back up data base
- MS Medicaid does not pay for date of discharge

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(Quick Tips continued)

Long Term Care
Quick Tips

Edit	Explanation	Resolution
142	Beneficiary not eligible - recycle	The beneficiary is not eligible on date of service. The claim will be recycled for 21 days in order to check for eligibility updates.
163	Line date of service outside of service dates	The date of service on the claim line item is greater than the service dates on the claim header.
188	Patient status invalid	Check patient status on claim. Make sure the patient status correlates with bill type and covered days
331	No LTC span available for first date of service	Check most recent 317. If necessary, contact Provider and Beneficiary Services to confirm 317 data.
1274	Patient Status/Beneficiary Date of Death Conflict	Check beneficiary's date of death against claim data. If necessary, contact ACS Provider and Beneficiary Services to confirm date of death.
3157	Leave days greater than total days billed	There is a discrepancy between leave days billed and total covered days. Always check line item units against total covered days on claim header.
3159	Patient has no approved LTC days	Patient is not locked into the LTC facility. Check 317 and contact Provider and Beneficiary Services to cross reference beneficiary file.
3175	Invalid covered days	Check covered days in WINASAP. Covered days should ALWAYS equal statement covered period and total line item units.
3334	No patient liability in effect for date of service	Check most recent 317. If necessary, contact Provider and Beneficiary Services to confirm 317 data.
3344	No Patient liability in effect for date of service/Verify with Regional Office	Check most recent 317. If necessary, contact Provider and Beneficiary Services to confirm 317 data.

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.

Medicaid Requires Blood Lead and Follow up Test for Elevated Blood Lead Levels for Children

The only way to determine if a child is exposed to lead or needs follow-up testing and/or treatment for elevated blood lead levels is with a blood lead screening. Blood lead levels as low as 10 mcg/dl can have adverse health effects such as decreased IQ, shortened attention span, hyperactivity, and other learning disabilities. The CDC requires screening, using a blood lead test, for all children at ages 12 and 24 months. Children between the ages of 36 and 72 months with no record of prior screening must receive a screening blood lead test. Also, the federal government requires follow-up on all blood lead levels 10mcg/dl or greater following the protocol of the Childhood Lead Poisoning Prevention Guidance document found on the MSDH website at http://www.msdh.state.ms.us

REMINDER: Crossovers Can Be Submitted on CMS 1500 and UB-92 Claim Forms

The Mississippi Division of Medicaid and ACS accept hardcopy CMS 1500 claim forms and UB-92s, with a copy of the Medicare EOMB attached for crossover claims. This started as a pilot program last year and has since been implemented to allow all providers the opportunity to submit crossover claims on both types of hardcopy claim forms. Helpful hints on how to complete both types of forms (CMS 1500 and UB-92) are located on page 2 of the February 2005 Mississippi Medicaid Provider Bulletin.

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 ACS 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.

"Web Wise"

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.

Inpatient Psychiatric Facility and PRTF Services – Not Covered for Adults

Inpatient psychiatric facility (POS 51) services must be provided before the beneficiary reaches age 21, or if the beneficiary was receiving the services immediately before age 21, before the earlier of the following: date of age 22 or date services are no longer required. The Psychiatric Residential Treatment Facility (PRTF) (POS 56) services are for children under age 21, which is full-time psychiatric treatment for mental/emotional/behavioral problems not requiring supervision/intervention on a 24-hour basis. (Sec 18.01) Inpatient acute care general hospital (POS 21) psychiatric services are provided to adults (with limitations).

Providers must not bill for any service with place of service 51 (POS 51) Inpatient Psychiatric Facility or place of service 56 (POS 56) Psychiatric Residential Treatment Facility for beneficiaries age 21 and over. Any claims that have already been paid with dates of service beginning October 1, 2003, through the present, should expect those payments to be recouped.

Division of Medicaid	**New:**		**Date:**
State of Mississippi Provider Policy Manual	**Revised:**	**X**	**Date: 10/01/00**
	Current:		

Section: Mental Health/Psychiatric Residential Treatment Facility (PRTF) Subject: Introduction **Section: 18.01 Pages: 1 Cross Reference:**

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 purpose of a Psychiatric Residential Treatment Facility ***(PRTF) is to provide full-time psychiatric treatment for children under age 21 with mental/emotional/behavioral problems who do not require emergency or acute psychiatric care but whose symptoms are severe enough to require supervision/intervention on a 24-hour basis. Inpatient psychiatric services for beneficiaries under age 21 must be provided before the beneficiary*** reaches age 21 or, if the beneficiary was receiving the services immediately before he/she reached age 21, before the earlier of the following: the date he/she no longer requires the services or the date he/she reaches age 22. (42 CFR 441.151 (c)(1)(2)). The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible. (42 CFR 441.152 (a)(3)) The Division of Medicaid (DOM) is responsible for determining whether a Psychiatric Residential Treatment Facility (PRTF) meets the Medicaid requirements for authorized reimbursement. A facility requesting certification as a Medicaid-authorized PRTF must complete and submit a provider enrollment packet. All enrollment forms must be signed and returned to the fiscal agent along with all requested documentation. When all information is received, it will be reviewed for completeness and, if complete, submitted to the Executive Director of DOM for approval or disapproval. If approved, the enrollment forms will be sent to the fiscal agent so that a Medicaid provider number may be assigned. If the Executive Director disapproves, the facility will be notified in writing and the reasons for the disapproval will be clearly stated. Out-of-state facility applications will be considered ONLY IF they can justify to DOM that a need exists for their services which cannot be met by the same or similar services within the state of Mississippi. A PRTF 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 refund 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. 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.

Assistance from Provider Representatives

Please call the ACS Provider/Beneficiary Support Line at 1-800-884-3222 or 1-601-206-2900 for assistance on individual claims or billing issues. This is the most efficient way to get help on your claims.

Provider representatives are available to assist you with complex billing and claims issues. You may also contact your provider representative to arrange for Medicaid billing education. A provider visit may be scheduled at a time that is convenient for you. Please leave a voice mail message for your provider representatives if they are in the field or otherwise not available. Allow the representative an opportunity to return your call. You should receive a prompt response within two business days.

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Prior to scheduled provider visits, you should submit a list of issues to your provider representative to be covered during the visit. This will allow the provider representative an opportunity to research the issues and be prepared to provide the needed assistance.

These representatives may be reached by contacting them at the phone numbers listed on the chart below. Contact the provider representative for the county of your billing address if it is different from your service address where you see your patients.

County	Provider Representative	Telephone #
Adams	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Alcorn	Machelle Dorman	601.206.3025
Amite	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Attala	Kwanza Price	601.206.2928
Benton	Machelle Dorman	601.206.3025
Bolivar	Clint Gee	662.459.9753
Calhoun	Rhonda Evans	601.359.1370
Carroll	Clint Gee	662.459.9753
Chickasaw	Rhonda Evans	601.359.1370
Choctaw	Rhonda Evans	601.359.1370
Claiborne	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Clarke	Pamela Williams Joyce Diane Wilson	601.359.9575 601.359.4293
Clay	Rhonda Evans	601.359.1370
Coahoma	Clint Gee	662.459.9753
Copiah	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Covington	Pamela Williams Joyce Diane Wilson	601.359.9575 601.359.4293
Desoto	Machelle Dorman	601.206.3025
Forrest	Pamela Williams Joyce Diane Wilson	601.359.9575 601.359.4293
Franklin	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
George	Pamela Williams Joyce Diane Wilson	601.359.9575 601.359.4293
Greene	Pamela Williams Joyce Diane Wilson	601.359.9575 601.359.4293
Grenada	Rhonda Evans	601.359.1370
Hancock	Ashlyn Booker Barbara Weed	601.359.6045 601.359.6127
Harrison	Ashlyn Booker Barbara Weed	601.359.6045 601.359.6127
Hinds Zip codes 39041 - 39215 Zip codes 39216 - 39629	 Randy Ponder Cindy Brown	 601.206.3026 601.206.2981
Holmes	Loretta Green	601.359.6129
Humphreys	Loretta Green	601.359.6129
Issaquena	Loretta Green	601.359.6129

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(Provider Representative Assistance continued)

County	Provider Representative	Telephone #
Itawamba	Rhonda Evans	601.359.1370
Jackson	Ashlyn Booker Barbara Weed	601.359.6045 601.359.6127
Jasper	Kwanza Price	601.206.2928
Jefferson	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Jefferson Davis	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Jones	Kwanza Price	601.206.2928
Kemper	Kwanza Price	601.206.2928
Lafayette	Machelle Dorman	601.206.3025
Lamar	Pamela Williams Joyce Diane Wilson	601.359.9575 601.359.4293
Lauderdale	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Lawrence	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Leake	Kwanza Price	601.206.2928
Lee	Randy Ponder	601.206.3026
Leflore	Clint Gee	662.459.9753
Lincoln	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Lowndes	Rhonda Evans	601.359.1370
Madison	Loretta Green	601.359.6129
Marion	Pamela Williams Joyce Diane Wilson	601.359.9575 601.359.4293
Marshall	Machelle Dorman	601.206.3025
Monroe	Rhonda Evans	601.359.1370
Montgomery	Rhonda Evans	601.359.1370
Neshoba	Kwanza Price	601.206.2928
Newton	Kwanza Price	601.206.2928
Noxubee	Rhonda Evans	601.359.1370
Oktibbeha	Rhonda Evans	601.359.1370
Panola	Clint Gee	662.459.9753
Pearl River	Pamela Williams Joyce Diane Wilson	601.359.9575 601.359.4293
Perry	Pamela Williams Joyce Diane Wilson	601.359.9575 601.359.4293
Pike	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Pontotoc	Rhonda Evans	601.359.1370
Prentiss	Machelle Dorman	601.206.3025

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(Provider Representative Assistance continued)

County	Provider Representative	Telephone #
Quitman	Clint Gee	662.459.9753
Rankin	Loretta Green	601.359.6129
Scott	Kwanza Price	601.206.2928
Sharkey	Loretta Green	601.359.6129
Simpson	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Smith	Kwanza Price	601.206.2928
Stone	Pamela Williams Joyce Diane Wilson	601.359.9575 601.359.4293
Sunflower	Clint Gee	662.459.9753
Tallahatchie	Clint Gee	662.459.9753
Tate	Clint Gee	662.459.9753
Tippah	Machelle Dorman	601.206.3025
Tishomingo	Machelle Dorman	601.206.3025
Tunica	Clint Gee	662.459.9753
Union	Randy Ponder	601.206.3026
Walthall	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Warren	Loretta Green	601.359.6129
Washington	Clint Gee	662.459.9753
Wayne	Pamela Williams Joyce Diane Wilson	601.359.9575 601.359.4293
Webster	Rhonda Evans	601.359.1370
Wilkinson	Charleston Green Kimberly M. Collins	601.359.9804 601.359.6841
Winston	Kwanza Price	601.206.2928
Yalobusha	Rhonda Evans	601.359.1370
Yazoo	Loretta Green	601.359.6129

Out of State Assignments		
Alabama	Randy Ponder	601.206.3026
Louisiana East of I-55 West of I-55	 Cindy Brown Kwanza Price	 601.206.2981 601.206.2928.
Tennessee	Machelle Dorman	601.206.3025

Timely Filing Guideline Tip

When filing for regular Medicaid, claims must be filed within one year from the date of service. For Medicaid claims that have Medicare as primary payer, claims must be filed within 180 days from the Medicare payment date.

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**
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**

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.

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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

May

May 2006

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