Mississippi Medicaid Bulletin

Volume 12, Issue 6

June 2006

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Split-billing Claims No Longer Required for Hospital Fiscal Year End

The Medicaid fiscal year is from July 1st through June 30th of the following year. **Providers are <u>still required</u> to split bill all claims with dates of service spanning two Medicaid fiscal years, dates inclusive of June and July.** One part of the claim should be billed through June 30th, and the other part of the claim should be billed for dates of service after June 30th**.** This ensures appropriate payment for benefits as allocated within the fiscal year that the benefits were provided.

The Hospital/Federal fiscal year is from October 1st through September 30th of the following year. **Providers are <u>no longer required</u> to split bill claims with dates of service spanning two hospital fiscal years, dates inclusive of September and October.** This was previously required when reprocessing rate changes for inpatient stays for hospital providers. The system has now been corrected to allow systematic processing for dates of service that span rate segments. Instead of submitting two separate claims as required previously, this will permit a claim to be processed for payment on one claim for the entire inpatient stay.

UB92 Billing Reminder

When submitting a UB92 claim, please verify that all of the following match:

- **Bill Type and Patient Status** (Example: Bill type 111 is hospital admit through discharge – does not match a patient status of 30 – still a patient)
- **Covered days and accommodation days** (Example: Dates of service 5/1/06 – 5/5/06, covered days should be four and accommodation days should be four). As stated in the Division of Medicaid Hospital Provider Manual Policy Section 5.02 Inpatient Hospital Services and Section 5.02.1 Days of Stay, the date of discharge is not covered.

The Division of Medicaid Website Reminder

The Division of Medicaid hosts a wealth of information on the website, www.dom.state.ms.us, from Provider Manuals to phone and fax contact numbers to fee schedules. Medicaid Eligibility Guidelines can also be found on this website. Under the link entitled, "Medicaid Provider Information," Billing tips, as well as, Provider Bulletins dating back to 1995, may be found in this linkage. The Division of Medicaid's website is proven to be a very useful tool for providers.

Medicare/Medicaid Provider Number Linkage

To ensure that provider files reflect the correct information, please refer to the Provider Manual Provider Information, Section 4.06:

A Medicare provider number cannot be linked to more than one Medicaid provider number. It is imperative that the Medicare provider number is linked to the correct Medicaid provider. Medicare claims crossover to Medicaid automatically ONLY if the Medicaid provider file has the correct Medicaid provider number linked to the Medicare provider number issued by the Medicare intermediaries. The fiscal agent must be notified immediately of any changed or newly assigned Medicare provider numbers. These changes must be submitted in writing to the fiscal agent and signed by the individual provider or the authorized representative who has authority to sign on behalf of the facility. The changes must be on letterhead and contain the following information:

•Name of individual or facility to which the Medicare provider number belongs;
•The Medicaid provider number to which the Medicare provider number should be linked; and
•The date that the Medicare provider number became effective.

Linking a Medicare Provider Number to an Individual Medicaid Provider Number

A Medicare provider number should be linked to an individual's Medicaid provider number only when the individual is to be reimbursed directly for the services rendered. If an individual provider performs service(s) for a group, by which s/he is employed or with which s/he is associated and the group does not bill the service under the Mississippi Medicaid group provider number, the claims are paid to the individual provider number and reported to the IRS under the individual's tax identification number or Social Security number on file with the fiscal agent.

Linking a Hospital's Medicare Provider Number

A hospital's Medicare provider number should never be associated with an individual or group Medicaid provider number.

Multiple Medicare Provider Numbers vs. a Single Medicaid Provider Number

Medicare issues a Medicare provider number for each facility at which an individual is employed or affiliated. Medicaid issues only one Medicaid provider number to the individual provider regardless of the number of facilities to which an individual is affiliated. Therefore, if a Medicaid provider is employed at multiple facilities and has been assigned a Medicare provider number for each facility, the Medicare provider number that has been issued on behalf of each facility must be linked to each facility's Medicaid group provider number to be reimbursed by Medicaid.

Edit 0511, Authorization and Procedure Code Conflict

The Edit 0511, which is Authorization and Procedure Code Conflict, is posting to many hospital claims and denying payment. The Envision system must match the codes listed on the Prior Authorization/Treatment Authorization number with the codes listed on the claim. Presently the revenue codes on the submitted claims are being read rather than the procedure codes.

The provider may either await the correction of the system and resubmit claims or contact your provider representative regarding denial of Edit 0511. The provider representative must review the claim to determine whether Edit 0511 is posting appropriately. If it is not appropriate, then the representative will special batch to override this edit and submit to ACS for payment. The codes listed on the Prior Authorization / Treatment Authorization must match the codes listed on the claim. The units must be within limits authorized, and the dates must be consistent on the claim and the authorization.

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.

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.

Claims Modifiers

The Division of Medicaid accepts all HIPAA compliant modifiers; however, only the modifiers listed below are required for either pricing or data purposes.

Ambulance	
D	Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes
E	Residential, domiciliary, custodial facility
G	Hospital-based dialysis facility (hospital - related approved destination)
H	Hospital
I	Site of transfer (e.g. airport or helicopter pad) between types of ambulance vehicles
J	Non-hospital based dialysis facility (free-standing)
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at physician's office on the way to the hospital)
Mental Health	
HW	Funded by state mental health agency
HA	Child/Adolescent program
HB	Adult program, non-geriatric
HT	Multi-disciplinary
HC	Adult program, geriatric
AH	Clinical psychologist
AJ	Clinical social worker
Home and Community Based Service	
U1	Required on all Elderly and Disabled Waiver claims
U2	Required on all Independent Living Waiver claims
U3	Required on all MR/DD Waiver claims
U4	Required on all Assisted Living Waiver claims
U5	Required on all TBI/SCI Waiver claims
TT	Additional Patient

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Early Periodic Screening Diagnosis Treatment	
EP	EPSDT
Perinatal High Risk Management Infant Service System	
TH	Obstetrical treatment/services, prenatal and postpartum
Vaccines for Children	
EP	EPSDT
Maternity	
TH	Obstetrical treatment/services, prenatal and postpartum
Family Planning	
FP	Family Planning
Anesthesia	
AA	Anesthesia service performed personally by anesthesiologist
GC	This service has been performed in part by a resident under the direction of a teaching physician
QX	CRNA Service: With the medical direction by a physician
QZ	CRNA Service: Without the medical direction by a physician
Durable Medical Equipment	
RR	Rental (use the RR modifier when the DME is to be rented for the full month)
KR	Rental item, billing for a partial month
NU	New Equipment
RP	Replacement and Repair
UE	Used durable medical equipment
SC	Medically necessary service or supply
Surgery	
50	Bilateral procedure
51	Multiple procedure
62	Two surgeons (Co-Surgeons)
66	Surgical team
80	Assistant Surgeon
Radiology	
TC	Technical Component
26	Professional Component

Hospice Top Denials

Issue	Description of Issue	Resolution
Edit 0104/ Exact Duplicate Claim	Due to the system reprocessing on 02/28/05, providers encountered an increase in this denial.	Claims that denied for this edit on or before 02/28/05 have been reprocessed. Any current denials are appropriate. Verify through RA's, the Envision web portal or ACS Provider Beneficiary Support Call Center when the claim was previously paid.
Edit 0105/Suspect Duplicate Claim	Due to the system reprocessing on 02/28/05, providers encountered an increase in this denial.	Claims that denied for this edit on or before 02/28/05 have been reprocessed. Any current denials are appropriate. Verify through ACS Provider Beneficiary Support Call Center any other claims that may have paid for the same beneficiary, same DOS. The paid claim could have been for another provider.
Edit 0129/Beneficiary ID Is Missing/Invalid	The Medicaid number on the claim is either missing or the number is invalid.	Verify beneficiary's ID number, correct the claim, and resubmit.
Edit 0142/Beneficiary Not Eligible - Recycle	The beneficiary under the number on the claim is not eligible or not found, meaning the number is not in the Medicaid system	It is not necessary for the provider to take action on this edit, as the claim will recycle for 21 days looking for eligibility. If eligibility is not found the claim will deny after the 21-day cycle with edit 0143.
Edit 0143/ Beneficiary Not Eligible/Not Found	The beneficiary under the number on the claim is not eligible or not found, meaning the number is not in the Medicaid system	Verify the Medicaid number on the claim and resubmit the claim using the correct number. If the beneficiary is not eligible, submit the claim to the appropriate payor source.
Edit 0163/Line item DOS Outside Thru Date	The claim was submitted with a line item date of service that is after the through date on the claim. (Ex. Line item DOS is 01/01/06 -01/31/06 while the "From and Through" date on the claim is 01/01/06 – 01/20/06.	Correct the claim and resubmit

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Issue	Description of Issue	Resolution
Edit 0221/Beneficiary Name Mismatch	The Medicaid number on the claim is a valid number but the name on the claim does not match the name associated with the Medicaid number on the beneficiary file.	Verify the name and number on the claim, correct and resubmit the claim. Remember the name must be spelled EXACTLY the way the name is spelled on the beneficiary file.
Edit 0264/Medicare Part A Eligible – W/O Attachment	The claim was submitted as a hardcopy crossover without a Medicare Explanation of Benefits (EOMB) attached.	Contact ACS Provider and Beneficiary Support Call Center to verify the attachment was not received. Re-file the claim with the appropriate EOMB attached.
Edit 0302/Attending Provider Is Not On File	The claim was submitted with an incorrect attending provider number or without an attending provider number.	This edit is for tracking purposes only. No action is required by the provider.
Edit 0336/ Billing Provider Not Authorized By Lock-in Span	The billing provider is not on the beneficiary's Hospice lock-in segment. There is a lock in just not one for the billing provider.	Contact ACS Provider and Beneficiary Support Call Center to check the beneficiary's lock in segment. Send the appropriate enrollment forms to ACS and resubmit the claim.
Edit 0357/No Hospice Lock-in Available	There is no Hospice lock in on the beneficiary file.	Contact ACS Provider and Beneficiary Support Call Center to check the beneficiary's lock in segment. Send the appropriate enrollment forms to ACS and resubmit the claim.
Edit 0381/ Rate Record Not Found	A claim was submitted with Revenue Code 659 (LTC Room and Board) and there is not a LTC provider number on the lock in segment.	Contact ACS Provider and Beneficiary Support Call Center to verify the LTC provider number is on the beneficiary lock in segment. If necessary mail corrected enrollment forms to ACS. Once the beneficiary file is updated, resubmit the claim.
Edit 0547/Revenue Code Requires Price	A claim was submitted with Revenue Code 659 (LTC Room and Board) and there is not a LTC provider number on the lock in segment.	Contact ACS Provider and Beneficiary Support Call Center to verify the LTC provider number is on the beneficiary lock in segment. If necessary mail corrected enrollment forms to ACS. Once the beneficiary file is updated, resubmit the claim.
Edit 1253/Claim DOS/DOD Conflict	The claim was submitted with a through date that is AFTER the date of death on the beneficiary file.	Verify the date of death and the date of service billed, correct the claim and resubmit.

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Issue	Description of Issue	Resolution
Edit 1255/Beneficiary Over 65 Bill Medicare	The claim was submitted for a beneficiary who is a dual eligible. (Medicare will cover Revenue Code 651 but not Revenue Code 659.)	Submit the claim to Medicare. If the claim is for a beneficiary in a LTC facility once Medicare pays, submit the claim for Revenue Code 659 to Medicaid with a copy of the EOMB.
Edit 3272/DOS Greater Than 1 Year No Timely Filing TCN	The claim is more than 12 months from the DOS and there is not a TF TCN documented on the claim	Identify the 17 digit timely filing TCN (The TCN from the FIRST time the claim adjudicated). Enter that number in the "ICN/DCN" field and resubmit the claim.
Edit 3273/Date Of Service Greater Than 2 Years From Current TCN Date	The date of service is more than 2 years from the day the claim was received.	There is nothing more that can be done with this claim as timely filing guidelines for straight Medicaid claims stipulate claims must be adjudicated within 2 years of the date of service. Additionally after the first 12 months the claim requires a timely filing TCN.
Edit 3453/Units Billed > Covered Days	The claim was submitted with units greater than the total number of covered days. (Ex: Total number of units for ALL Revenue Codes is 30 while the total covered days is only 20.)	Correct the claim and resubmit
Edit 3683/Invalid TF TCN (Timely Filing Transaction Control Number)	The claim was submitted with a TF TCN that is not valid.	Verify the TF TCN via the web portal, RA's or ACS Provider and Beneficiary Support Call Center. Correct the claim and resubmit.

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	11.02 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

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

Memorandum

To: Medicaid Orthodontic Providers

From: Robert Shaye, D.D.S.
DOM Orthodontic Consultant

Subject: New Orthodontic Authorization Request Form

First of all, I would like to thank you for agreeing to provide our Medicaid patients with orthodontic services. If not for your dedication, significantly more Mississippi children would be suffering from disfiguring malocclusions.

By now most of you should have received the new authorization form. You will notice it is much more straightforward and simpler to complete than the previous form, which first appeared in 1992.The new form is patterned after current international standards for grading malocclusions. It follows the Index of Treatment Need (IOTN) developed in the United Kingdom. You might have seen it referred to in orthodontic journals or in Proffit's *Contemporary Orthodontics.* A more detailed explanation of the criteria can be found in Section 11.17 and 11.18 of the Provider Policy Manual, available online at the Division of Medicaid website: www.dom.state.ms.us

The simplification of the form should help to make the authorization procedure more efficient and expedite the processing of your requests. In order to make the turnaround for review as short as possible, I urge you to send for review only those cases that fit the criteria. By submitting cases that clearly do not qualify, you overburden the system, thereby slowing down the turnaround time for everyone. Of course, in "borderline" cases where it might not be clear as to whether they meet the criteria, I will be happy to review them. The new form is a vast improvement but it is not perfect. In situations where beneficiaries request that you submit the case even though it will obviously be denied, you are encouraged to explain the reality of the process to them so that a submission will not have to be processed.

On behalf of Mrs. Bertha Williams and myself, thank you for your cooperation and understanding.

Inpatient Psychiatric Facility and PRTF Services – Not Covered for Adults

Services provided in an inpatient psychiatric facility (place of service 51) or a psychiatric residential treatment facility (PRTF) (place of service 56) are limited to beneficiaries under age 21. Any services provided by any provider with place of service 51 or 56 for beneficiaries age 21 and over will be denied. Providers who have been paid for claims to adult beneficiaries age 21 and over with POS 51 or POS 56 with dates of service from October 1, 2003 to present should expect those payments to be recouped

Psychiatric services provided to adults are covered, with limitations, when provided in the Inpatient Hospital (place of service 21).

Notice to Outpatient Hospital Providers

The State of Mississippi Division of Medicaid is planning to implement an Outpatient Prospective Payment System (OPPS) in January 2008. The payment system will be based on the Ambulatory Patient Classification system, which requires detailed HCPCS coding at the line level. In preparation for that change, hospitals will be required to make certain changes in billing practices. This requirement applies to all hospitals serving Mississippi Medicaid recipients. This requirement applies to electronically submitted claims and to paper claims.

Effective with dates of service August 1, 2006 or later, the following billing changes are required when billing for outpatient hospital services for a Mississippi Medicaid recipient:

- Bill for all services provided on the same date on the same claim (no split billing)
- Bill for each day of service as a separate line item
- Record HCPCS codes at the line level for most revenue codes (see table below)

It is also strongly recommended that hospitals prepare for the advent of OPPS by taking the following additional steps:

- Record all appropriate modifiers in accordance with CPT or HCPCS coding policies although the recording of modifiers may not currently impact reimbursement
- Use the most current and most specific diagnosis codes.
- Record units of service appropriate to the listed CPT/HCPCS code.

These steps will help assure that your claims are paid correctly under OPPS. These changes will have NO impact on your payment under the current payment method. You will be aiding in a smoother transition to OPPS by providing the detailed billing information.

- A number of revenue codes already require detailed coding. This notice expands the list of revenue codes requiring HCPCS codes to include all those listed in the table on the following page.

Policy Manual Reminder

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

Mississippi Medicaid Hospitals Revenue Codes Requiring Procedure Codes Effective August 1, 2006					
274 (when pass through devices are billed)	Prosthetics/ orthotics	42x	Physical Therapy	634	EPO<10,000 units
275(when pass through devices are billed)	Pacemakers	43x	Occupational therapy	635	EPO 10,000+ units
276 (when pass through devices are billed)	Intraocular lenses	44x	Speech pathology	73x	EKG
278 (when pass through devices are billed)	Other implants	45x	Emergency room	74x	EEG
30x	Laboratory	46x	Pulmonary	75x	GI services
31x	Lab/Pathology	47x	Audiology	761	Treatment room
32x	Radiology Diagnostic	48x	Cardiology	762	Observation room
331	Chemotherapy	49x	Ambulatory Surgery	79x	ESWL
34x	CT scan	51x	Clinic	900	Behavioral Health Services
36x	Operating room	52x	Freestanding clinic	91x	Psych Services
38x	Blood	54x	Ambulance	92x	Other diagnostic services
40x	Imaging	61x	MRI	94x	Other Rx service
41x	Respiratory				

If you have questions regarding billing requirements, please contact the Provider and Beneficiary Services call center at 800-884-3222.

How Do You Feel About the Mississippi Medicaid Provider Bulletin?

DOM and ACS would like to solicit feedback from the provider community on the monthly bulletins. Your feedback is very important to us. In order to effectively assist you with your needs, please take the time to complete the attached survey. Please make a copy of the form on the following page and fax it to (601) 206-3119 or mail it to the following address:

ACS Publications Coordinator
385 B Highland Colony Parkway
Suite 300
Ridgeland, MS 39157

Provider Bulletin Survey

	Yes	No	N/A
Are you satisfied with the overall quality of the Provider Bulletin?	☐	☐	☐
Are you satisfied with the scope of the information presented?	☐	☐	☐
Do you find the information in the bulletin useful and understandable?	☐	☐	☐
Is there a topic of interest you would like included in future bulletins? Please list topics below.	☐	☐	☐
What would make the monthly bulletin more effective for you? Explain below.			
Do all appropriate staff members receive a bulletin? If not, please note that the Envision web portal has all bulletins from July 1995 to current for your convenience. The Envision web portal can be accessed at http://msmedicaid.acs-inc.com. Once the home page is accessed, click on the Publications link on the left hand side under "Provider Information." Then, click on the link entitled "Provider Bulletins."	☐	☐	☐

Additional Comments:

Optional:

Contact Name:	
Contact Number:	
Provider Name:	
Provider Number:	
Email Address:	

Mississippi Medicaid Benefits and Categories of Eligibility

Please refer to the Provider Manual Benefits Section 2.02 for services covered under the Mississippi Medicaid program. Also, providers may verify eligibility of beneficiaries through the Automated Voice Response System (AVRS), the point of service eligibility verification system, and the call center of the fiscal agent ACS. The chart below is for your assistance.

Medicaid Categories of Eligibility

001	SSI Individual via SDX	Full Medicaid Benefits	
002	SSI Retro Eligibility	Full Medicaid Benefits	
003	IV-E Foster Care/ Adoption Assistance Related	Full Medicaid Benefits	
005	SSI in Institution	Full Medicaid Benefits	
006	Protected SSI Child	Full Medicaid Benefits	
007	Protected Foster Care Child	Full Medicaid Benefits	
010	Nursing Home,under 300%	Full Medicaid Benefits	
011	Long Term Hospital, under 300%	Full Medicaid Benefits	
012	Swing Bed, under 300%	Full Medicaid Benefits	
013	NH, Eligible at Home	Full Medicaid Benefits	
014	Long Term Hospital, SSI Eligible at Home	Full Medicaid Benefits	
015	Swing Bed, SSI Eligible at Home	Full Medicaid Benefits	
019	Disabled Child at Home	Full Medicaid Benefits	
020	Emergency SSI Limitations Case	Full Medicaid Benefits	
021	Emergency Immigrant	Medicaid Benefits for Date of Service Only	Exclusions – All dates other than Date of Service
025	Working Disabled	Full Medicaid Benefits	
026	CWS Foster Care/ Adoption Assistance Child	Full Medicaid Benefits	
027	Breast/Cervical Group	Full Medicaid Benefits (Limited to Women identified to DOM by the State Health Dept, screened and diagnosed with breast/cervical cancer)	

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028	DMIE Project Demonstration to Maintain Independent Employment (HIV Grant)	Full Medicaid Benefits	
029	Family Planning	Limited Medicaid Benefits Family Planning Benefits Only	Exclusions – All other benefits
031	**QMB - Qualified Medicare Beneficiary**	**Medicaid payment of Medicare Parts A and B Premiums, deductibles, and coinsurance**	**Exclusions – Non-covered Medicare Services non-emergency transportation**
035	**QWDI – Qualified Working Disabled Individual**	**Medicaid payment of Medicare Parts A Premium**	**Exclusions – Non-covered Medicare Services non-emergency transportation**
041	PLAD <100% FPL Poverty Level Aged or Disabled	Full Medicaid Benefits to 12-31-2005	No Benefits from 1-1-2006
042	PLAD <120% FPL Poverty Level Aged or Disabled	Full Medicaid Benefits to 12-31-2005	No Benefits from 1-1-2006
043	PLAD <135% FPL Poverty Level Aged or Disabled	Full Medicaid Benefits to 12-31-2005	No Benefits from 1-1-2006
044	PLAD Kidney Disease Poverty Level Aged or Disabled	Full Medicaid Benefits to 12-31-2005	No Benefits from 1-1-2006
045	**PLAD Healthier MS Waiver - No Medicare**	**Limited Medicaid Benefits Does include NET service**	**Exclusions – Long term care, hospice, dental, eyeglasses, chiropractic, podiatry, therapy at free-standing clinic.**
046	Healthier MS Waiver - Cancer	Full Medicaid Benefits to 12-31-2005	No Benefits from 1-1-2006
047	Healthier MS Waiver – Renal Disease	Full Medicaid Benefits to 12-31-2005	No Benefits from 1-1-2006
048	Healthier MS Waiver – Transplant	Full Medicaid Benefits to 12-31-2005	No Benefits from 1-1-2006
049	Healthier MS Waiver – Anti-Psychotic	Full Medicaid Benefits to 12-31-2005	No Benefits from 1-1-2006

051	**SLMB - Specified Low-Income Medicare**	**Medicaid payment of Medicare Part B Premium**	Exclusions–All other Medicaid Benefits
054	**QI1 – Qualified Individual**	**Medicaid payment of Medicare Part B Premium**	Exclusions–All other Medicaid Benefits
057	**QI2 – Qualified Individual**	**Medicaid payment of Medicare Part B Premium to 12-31-2002**	No Benefits from 1-1-2003
061	Hospice	Category ended 5-1-2005	
062	HCBS Assisted Living	Full Medicaid Benefits	
063	HCBS Elderly/Disabled	Full Medicaid Benefits	
064	HCBS MR/DD	Full Medicaid Benefits	
065	HCBS Independent Living	Full Medicaid Benefits	
066	TBI/SCI Waiver (Traumatic Brain Injury)	Full Medicaid Benefits	
085	Medical Assistance – Intact Family	Full Medicaid Benefits	
087	Children up to Age 6	Full Medicaid Benefits	
088	Pregnant Women and children under Age 1, under 185%	Full Medicaid Benefits, Except beneficiaries Age 21 and older	Exclusions – Eyeglasses and Dental for beneficiaries Age 21 and older
090	1973 Grandfathered Case	Full Medicaid Benefits	
091	Child Under Age 19, under 100%	Full Medicaid Benefits	
092	HR-1 Hurricane Relief	Full Medicaid Benefits For 5 months from elig. date	HR Waiver application deadline 1-1-2006
093	Cost of Living	Full Medicaid Benefits	
094	Disabled Adult Child-DAC	Full Medicaid Benefits	
095	Widow(er) 60+yrs	Full Medicaid Benefits	
096	Widow(er) 50+yrs	Full Medicaid Benefits	
099	CHIP, under 200%	No Medicaid Benefits. Administered by BCBS 1-877-870-3110	All
999	Converted record only-not enough information		
KK	K-Baby – Newborns, under 1yr old	Full Medicaid Benefits To 1yr Birthday	No Benefits After 1yr Birthday

***If Medicare-eligible with full Medicaid benefits:** Pharmacy coverage is thru Medicare Part D. Medicaid only covers Medicare excluded drugs.

MISSISSIPPI DIVISION OF MEDICAID
PREFERRED DRUG LIST

The agents listed below are preferred products on the Mississippi Medicaid Preferred Drug List (PDL). The preferred drug list is a medication list recommended to the Division of Medicaid by the Pharmacy and Therapeutics Committee and approved by the Executive Director of the Division of Medicaid. These drugs have been selected for their efficaciousness, clinical significance, cost effectiveness and safety for Medicaid beneficiaries. Most generic agents are preferred, do not require prior authorization, and are not individually listed below. Unless otherwise specified, the listing of a particular brand or generic name includes all dosage forms of that drug. For more information concerning the PDL including non-preferred agents, the OTC formulary and other specifics please visit our website at www.dom.state.ms.us.

List Effective 7-1-2006

ALLERGY
Antihistamines & Antihistamine Decongestant Combos.
First Generation
Pediatex™, Pediatex™ D
Pediatex™ 12 & 12 D
Vazol™, Vazol™ D
Second Generation
Astelin Nasal Spray®
Clarinex®
Loratadine
Zyrtec®

ANALGESICS
Cox- 2
None
NSAIDS
Generics only
Narcotics
Avinza®
Kadian®

ANTIBIOTICS (Oral)
Cephalosporins
Omnicef®
Suprax® Suspension
Macrolides
Biaxin XL®
Zithromax® Suspension
Miscellaneous
Cleocin Ped.Soln®
Penicillins
Generics only
Penicillin Combinations
Augmentin (versions not available generically)
Quinolones
Avelox®
Sulfonamides
Gantrisin® Susp
Tetracyclines
Generics only

ANTIFUNGALS (Oral)
Grifulvin V ®
Gris-PEG®
Lamisil®

ANTIPROTOZOAL
Alinia®

ANTIVIRAL
Copegus®Tabs
Hepsera®
Rebetol® Syrup
Valcyte®
Valtrex®

BPH AGENTS
Avodart®
Flomax®
Uroxatral®

CARDIOVASCULAR
ACE Inhibitors
Altace®
ACE Inhibitor/Diuretics
Generics Only
ACEI/CCB Combinations
Lexxel®
Lotrel®
Tarka®
ARBs&Combinations
Avapro®, Avalide®
Diovan®,Diovan HCT
Beta-Blockers
Coreg ®
Toprol XL®
Beta-Blocker/Diuretics
Generics Only
Calcium Channel Blockers
Norvasc®
CCB/Antihyperlipidemic
Caduet®
Diuretics& Aldosterone Receptor Antagonists
Generics Only
Platelet Aggregation Inhibitors
Aggrenox™
clopidogrel

CENTRAL NERVOUS SYSTEM AGENTS
ADHD
Adderall®-XR
Concerta™
Focalin™ XR
Metadate® CD
Strattera®
Alzheimer's Agents
Aricept®
Exelon®
Namenda®
Anti-anxiety
Generics only
Antidepressants
Effexor XR®
Wellbutrin XL®
Sedative/Hypnotics
Ambien® CR
Lunesta™
Rozerem™
Skeletal Muscle Relaxants
Generics only
5-HT3 Receptor Antagonists
Zofran®

DIABETES
Incretin Mimetics
Byetta™
INSULINS
ALL Novo Nordisk products
Lantus® (Vial)
Oral Agents
Actos®
ACTOplus met™
Avandamet®
Avandaryl™
Avandia®
Prandin®
Starlix®

DIGESTIVE HEALTH AGENTS
Asacol®
Canasa®
Dipentum®
Entocort EC®
Pentasa®

ELECTROLYTE DEPLETERS
Magnebind® Rx
Renagel®

ESTROGENS-PROGESTINS
Premarin®
Premphase®
Prempro®

GASTRO-INTEST. AGENTS
H-2 Blockers
Axid® Solution
Zantac® Syrup
PPIs
Prevacid®
Zegerid®
Misc.
Zelnorm®

G-U RELAXANTS
Enablex®

HEMATOPOIETIC
Aranesp®
Procrit®

LAXATIVES(Rx)
Generics Only

LIPIDS
Advicor®
Crestor®
Lipitor®
Niaspan®
Tricor®
Vytorin®
Zetia®

MIGRAINE
Imitrex®
Maxalt®

OSTEOPOROSIS
Boniva®
Evista®
Fosamax®
Miacalcin®

RESPIRATORY AGENTS
Advair®
Asmanex®
Azmacort®
Combivent®
Intal ® Aerosol Inhaler
Pulmicort Respules®
Serevent Diskus®
Singulair®
Spiriva®
Tilade®
QVAR®
Xopenex HFA™
Xopenex® Inhalation Sol.
Smooth Muscle Relaxants&Combinations
Generics Only
Nasal Corticosteroids
Flonase®
Nasonex®

THYROID/ANTI-THYROID AGENTS
All Brands & Generics

TOPICAL AGENTS
Anti-inflammatory Agents
Locoid Lipocream®
Antibacterial Agents
MetroGel® Vaginal
Antifungals
Naftin®
Antipruritic
None
Antiviral
None
Miscellaneous-Skin and Mucous Membrane Agents
Aldara®
Elidel ®

PRSRT STD
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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
6Hwww.dom.state.ms.us
And
Medicaid Bulletins are on the Web Portal
7Hhttp://msmedicaid.acs-inc.com

June

June 2006

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

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