Mississippi Medicaid Bulletin

Volume 12, Issue 7

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X12 Mandated For Medicare Crossovers

Effective June 30, 2006, the Centers for Medicare & Medicaid Services (CMS) is mandating X12 format for all Medicare crossover claims. The Mississippi Division of Medicaid and ACS will no longer accept Medicare crossover claims from providers, billing agents, clearing houses and Medicare intermediaries in contingency formats beginning June 30, 2006 and thereafter. All claims must be in the HIPAA-mandated X12 format. To maximize processing efficiency, please submit all claims for Mississippi Medicaid beneficiaries to Medicare indicating your Mississippi Medicaid provider number in loop 2330B (other payer secondary identification and reference number).

If you are currently using a billing agent or clearinghouse to submit your claims, please contact them immediately to ensure they are submitting HIPAA compliant claims. It is imperative that you act immediately to prevent rejection of your claims. Should you have questions regarding conversion to the X12N 837 format, please contact ACS Provider Support Line at 1-800-884-3222.

Quality Assurance Calls

The Quality Management Department of ACS State Healthcare is conducting random customer service satisfaction surveys with the Medicaid provider community. These surveys are conducted monthly via telephone. Currently, the emphasis of these surveys is related to the quality of service provided by the ACS Provider and Beneficiary Services Call Center and Provider Field Representatives. If you receive one of these calls, please provide the individual conducting the survey with as much feedback as possible. Your feedback is extremely important to us as we strive to provide the best customer service that we can!

Billing for Anesthesia or Pain Management Services- Reminder

Mississippi Medicaid currently requires all anesthesiologists, CRNAs, and providers specializing in pain management services to bill modifiers –AA, -GC, -QX, or –QZ with each procedure code billed on the provider's claim. If the service is maternity-related, the provider must also bill modifier –TH. Providers who have a pain management specialty are not exempt from this policy and must bill one of these modifiers with each procedure code, including non-anesthesia codes.

IT'S TIME TO APPLY FOR YOUR NPI!

What is NPI?
The National Provider Identifier (NPI) is a unique 10-digit number used to identify health care providers. The NPI eliminates the need for health care professionals to use different numbers when conducting transactions with multiple commercial and government health plans. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all covered entities (i.e., providers, clearinghouses and large health plans) to begin using NPIs on standard health care transactions on May 23, 2007.

Who Should Obtain and Use an NPI?
All health care providers are eligible to obtain and use an NPI. Mississippi Medicaid will require an NPI on electronic transactions. Providers who do not provide health care as defined by the Centers for Medicare & Medicaid Services (CMS) are not eligible to obtain an NPI. These Atypical providers include non-emergency transportation, homemaker, respite, personal care attendant providers.

How Do I Apply for a NPI?
To apply for a NPI, providers should visit the National Plan and Provider enumeration System (NPPES) website at https://nppes.cms.hhs.gov/NPPES as soon as possible. You may request a paper application by calling 1-800-465-3203.

In addition, CMS has published the Medicare Expectations for Subpart Enumeration policy paper, describing Medicare program expectations concerning the determination of subparts for NPI assignment. This document and other NPI information are available on the CMS website at http://www.cms.hhs.gov/NationalProvIdentStand.

What are Subparts?
Subparts are components of an organization. If a subpart conducts their own standard transactions, they must obtain an NPI. It is the decision of the organization provider to determine which subparts need an NPI. For example, hospitals may determine subparts to be rehabilitation units, psychiatric units, acute care services, therapy services, renal dialysis, surgical centers, etc.

Things to Start Thinking About…
- Analyze your billing system and assess Medicare and Medicaid provider numbers currently in use.
- Do you have multiple numbers for the same payers?
- Will your practice management system or clearinghouse require changes?
- What will your billing system do with the numbers being replaced?

For More Information…
More information on NPI and how to report your NPI to Mississippi Medicaid will be published in future Provider Bulletins, banner messages, and on the Mississippi Envision Web portal http://msmedicaid.acs-inc.com. You may also call the ACS Provider and Beneficiary Support Line at 800-884-3222 with questions.

McKesson ClaimCheck Update

The Division of Medicaid and ACS have completed the review of the most recent update for the McKesson ClaimCheck software. This update includes edits for the 2006 CPT codes. The updated version was forwarded to production on May 22, 2006 and is applied to claims on the May 29, 2006 remittance advices.

Claims processed prior to May 22, 2006 may be submitted for review; however, decisions will not be reversed solely based on a change in the updated version. Policies applicable prior to the May 22, 2006 update will be applied. Providers must not resubmit previously denied claims for reprocessing by new ClaimCheck edits.

To review the ClaimCheck edits and the process for submitting a claim for reconsideration, please refer to pages 3 and 4 of the August, 2005 Mississippi Medicaid Bulletin.

Common Pharmacy Billing Errors

	Drug Name	Correct Billing/ Quantity	Common Incorrect Billing	Other Information
64116-0011-01	Actimmune 2MMI Units/.5ml	0.5ml	1	
00085-1341-01	Asmanex Twisthalr 220 MCG (120)	0.24gm	120 (doses)	
00085-1341-03	Asmanex Twisthalr 220 MCG (30)	0.24gm	30 (doses)	
00085-1341-02	Asmanex Twisthalr 220 MCG (60)	0.24gm	60 (doses)	
00037-0241-30	Astelin 137 MCG Nasal Spray (New Ready-Spray Bottle)	30ml	34 (prior formulation)	
52268-0502-01	Halflytely Bowel Prep Kit	1	2000 ml	
00173-0633-10	Lamictal 25MG Tab Starter	35	1	
00173-0594-01	Lamictal Tablet Starter Kit	98	1	
00173-0594-02	Lamictal Tablet Starter Kit	49	1	
00075-0620-40	Lovenox 40mg Prefilled Syringe	.4ml	1	1carton (10 syringes) = 4 ml
00085-1288-01	Nasonex 50 MCG Nasal Spray	17gm	34 (days supply)	
00300-1546-07	Prevacid Naprapac 500 (weekly blister card)	21 (14 Naproxen + 7 Prevacid)	28, 90	7 days supply should be billed
00300-1546-30	Prevacid Naprapac 500 (one month administration pack)	84	28, 90	28 days supply should be billed
00186-0915-42	Pulmicort 200 mcg Turbuhaler	1	200	
50242-0100-40	Pulmozyme 1mg/ml ampule (30 x 2.5ml amps per carton)	75ml	90	30 ampules at 2.5mls=75mls; must bill exact metric quantity dispensed.
00023-9163-32	Restasis .05% Ophth. Emulsion (32 x 0.4ml vials per Tray)	32 (vials)	30, 31 (days supply)	A 'bid' dose should be billed as 64
60574-4111-01	Synagis 100 mg Vial	1	100 mg	

(Continued on next page)

(Pharmacy Information continued from page 3)

New Additions to DOM's Preferred Drug List*

The Division of Medicaid's Preferred Drug List, or PDL, will be updated effective July 1, 2006. The following agents are added to Preferred Status:

(1) ADHD Agents: Adderall XR, Concerta, Focalin XR, Metadate CD, Methylin chewable, Methylin solution, Strattera

(2) Digestive Health: Asacol, Canasa, Dipentum, Entocort EC, Pentasa

(3) Osteoporosis Agents: Boniva, Fosamax

**for comprehensive PDL list, refer to DOM's website at www.dom.state.ms.us, select Pharmacy Services, and go to Preferred Drug List*

Pharmacy FAQs

Question: What are the advantages of using drugs on the Preferred Drug List?
Response: 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, safety, and cost effectiveness for Medicaid beneficiaries. Most generic agents are preferred, do not require prior authorization, and are not individually listed. The PDL is routinely updated. For a current copy of DOM's PDL, refer to our website at www.dom.state.ms.us, select Pharmacy Services, and select Preferred Drug List.

Question: What drugs are reimbursed by Hospice?
Response: Medicaid beneficiaries enrolled in Hospice Services are covered under a per diem rate which covers all services for that beneficiary. For those beneficiaries receiving Medicaid Hospice Services, all palliative therapy, or drugs used to treat beneficiary's terminal illness, is to be billed to the Hospice provider. Medicaid will only pay for drugs used for an indication not directly related to the beneficiary's terminal illness and are within the applicable Medicaid prescription service limits. Since plans of care are specific for beneficiaries, it is the responsibility of the dispensing pharmacy to bill the Hospice Provider or Medicaid appropriately. Medicaid's policies, prior authorizations, and limits are still applicable. The dispensing pharmacy must retain documentation regarding Hospice Services drug coverage for beneficiaries which is easily retrievable for auditing purposes. A listing of medications generally considered the responsibility of Hospice may be referenced on DOM's website at www.dom.state.ms.us, select Pharmacy Services, and select Pharmacy Billing for Hospice Patients. **Medicaid is always the payer of last resort**.

Question: Why does 'other insurance' have to be billed first before Medicaid?
Response: Effective October 1, 2004, when beneficiaries are covered by both Medicaid and other third party insurance, pharmacy providers are required to bill prescription drug claims to private third party insurance carriers before billing Medicaid. All Medicaid policies and procedures such as prior authorization requirements and limits are still applicable. **Medicaid is always the payer of last resort**.

Question: What prescriber identification numbers can be used for pharmacy claims?
Response: Pharmacy claims must include the **eight digit** MS Medicaid provider identification number or the prescriber's DEA number. To receive a current Prescribing Providers list, contact the fiscal agent or ACS at 1-800-884-3222. Ms Medicaid Provider List is also available on DOM's web site at www.dom.state.ms.us, select Pharmacy Services, and scroll down to Prescribing Providers. Pharmacy claims using default provider numbers 00099999 or 00019999 will deny. For more information regarding prescriber numbers for pharmacy claims, refer to DOM's July 2005 Provider Bulletin.

(Continued on next page)

Items of Interest from National Institutes of Health

Inhaled Corticosteroids Benefit Young Children with Frequent Wheezing but Do Not Prevent Development of Chronic Asthma

Daily treatment with inhaled corticosteroids can reduce breathing problems in pre-school-aged children at high risk for asthma but they do not prevent the development of persistent asthma in these children, according to new results from the Childhood Asthma Research and Education (CARE) Network supported by the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health. For detailed article, refer to the National Institutes of Health website at http://www.nhlbi.nih.gov/index.htm or go directly to http:nhlbi//www.nih.gov/new/press/06-05-10.htm.

NHLBI Media Availability: Diuretics Better than Other High Blood Pressure Medications in Preventing Heart Failure

Diuretic medications are more effective than other high blood pressure medications in preventing heart failure, at least in the short term, according to new data from a National Heart, Lung, and Blood Institute clinical study. High blood pressure is the leading risk factor for heart failure, a condition where the heart is weakened and does not effectively pump blood throughout the body. For detailed article, refer to National Institutes of Health website site at http://www.nhlbi.nih.gov/index.htm or go directly to http://www.nhlbi.nih.gov/new/press/06-05-01.htm.

Medication Adjustment vs. Pharmacological Restraint in a PRTF

The following information is a clarification to Mental Health policy section 18 (Psychiatric Residential Treatment Facility) regarding the non-routine use of medication in the treatment of a PRTF resident.

The term **medication adjustment** is used to describe *the use of a resident's routine medication in a non-routine way* to help the child through a period of heightened stress or agitation. This might involve ordering the administration of an extra dose (usually in a lower amount) of the same (or a similar, from the same class) medication that is already part of the child's treatment program, or ordering that the regular medication be administered sooner than the routine time, without making a permanent change in the child's treatment plan. Medication adjustment is not considered a special procedure. Unlike medications administered for the purpose of pharmacological restraint, medication adjustments are not sedative, are only administered orally, and must be taken voluntarily by the resident (and in some cases may be requested by the resident). Standing PRN orders for medication adjustments are acceptable.

Pharmacological restraint refers to the use of a medication which is not a standard part of the child's treatment regimen to control or alter the child's mood or behavior or to restrict his/her freedom of movement. Pharmacological restraint is considered to be a special procedure. Standing PRN orders for pharmacological restraint are prohibited.

Private Providers of EPSDT Mental Health Services

Rate changes for Licensed Certified Social Workers and Psychologists effective July 1, 2006 are located on the Mississippi Medicaid website at www.dom.state.ms.us under "Fee Schedules for Medicaid Provider Services" subsection "Billing Guidelines for Community-based Mental Health Services.

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
25.0 Hospital Inpatient	25.27 Inpatient Per Diem Rates		X	07/01/06
26.0 Hospital Outpatient	26.23 Outpatient Rates		X	07/01/06
28.0 Transplants	28.15 Reimbursement		X	07/01/06
47.0 Outpatient Physical Therapy	47.03 Exclusions 47.04 General Coverage Criteria 47.09 Prior Authorization/ Pre-Certification 47.10 Prescribing Orders/Responsibilities 47.12 Plan of Care		X X X X X	07/01/06
48.0 Outpatient Occupational Therapy	48.03 Exclusions 48.04 General Coverage Criteria 48.09 Prior Authorization/Pre-Certification 48.10 Prescribing Orders/ Responsibilities 48.12 Plan of Care		X X X X X	07/01/06
49.0 Outpatient Speech-Language Pathology (Speech Therapy)	49.03 Exclusions 49.04 General Coverage Criteria 49.09 Prior Authorization/Pre-Certification 49.10 Prescribing Orders/ Responsibilities 49.12 Plan of Care		X X X X X	07/01/06
70.0 Family Planning (Non-Waiver)	70.01-70.06	X		07/01/06
50.0 Anesthesia	51.02 Anesthesia Services		X	08/01/06

Community Mental Health Centers

Billing guidelines and fee schedules which have been removed from Section 15.30 of the Medicaid Provider Policy Manual can now be found at www.dom.state.ms.us under "Fee Schedules for Medicaid Provider Services" titled "Community Mental Health Center (Section 15) Billing Guidelines".

Private Duty Nursing (PDN) Providers

Beginning July 1, 2006, the following procedure codes billed by private duty nursing agencies for EPSDT private duty nursing services will be reimbursed at a higher rate:

S9123 billed with the "EP" modifier will be reimbursed at $28.00, an increase from $24.00.
S9124 billed with the "EP" modifier will be reimbursed at $23.00, an increase from $17.00. The 5% assessment fee still applies.

Freedom of Choice in Selecting Providers

The Division of Medicaid has received complaints from beneficiaries regarding freedom of choice when selecting a Medicaid provider. The Medicaid policy regarding the right of freedom of choice of providers for the beneficiary may be located in the Division of Medicaid Provider Policy Manual, Section 3.07, page 1, or the website address:
http://www.dom.state.ms.us/Provider/Provider_Manuals/Section_3_Beneficiary_Information.pdf.

Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Section 1902(a) (23) of the Social Security Act provides that "any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person qualified to perform the service or services required."

Providers of Medicaid services agree to comply with this section of the Act in the Provider Agreement. This means that providers may not take any action to deny freedom of choice to individuals eligible for Medicaid by using systems, methods, or devices which would require persons eligible for Medicaid to obtain a service from a particular provider.

This also means that providers may not require any individuals eligible for Medicaid to sign a statement of waiver, if such statement would, in any manner, deny or restrict that individual's free choice of a provider of any services for which the individual may be eligible. Providers cannot use any method of inducement (including free transportation, refreshments, cash or gifts) to influence a beneficiary to select a certain provider.

Exception: Under a federal waiver or approved State Plan amendment, freedom of choice may be restricted for individuals enrolled in a managed care program. These individuals are required to receive primary care from a primary care provider (PCP) and have specialty care prior authorized by the PCP.

Violation of a beneficiary's right for freedom of choice for a provider may result in termination of your provider agreement.

Hospital Workshops in July

The Division of Medicaid, ACS, and the Mississippi Hospital Association (MHA) will jointly host three workshops for hospital providers on the future change to the hospital inpatient payment methodology using All Patient Refined Diagnosis Related Groups (APR-DRG). Workshop times, dates, and locations are as follows:

July 12, 2006	10:00 – 2:00	Country Inn and Suites, 255 SW Frontage Road Grenada, MS 38901
July 14, 2006	10:00 – 2:00	MHA, 116 Woodgreen Place, Madison, MS 39110
July 18, 2006	10:00 – 2:00	Hattiesburg Lake Terrace Convention Center, 1 Convention Center Plaza, 39401

This is an introductory workshop on the payment changes that is geared to CEOs, CFOs, Inpatient Billing Managers, and Utilization Review Managers. A nominal registration fee will be charged. Lunch will be provided. MHA members, Non-MHA members, in-state and out-of-state hospital providers are encouraged to attend. Please register online at http://www.mhanet.org. Click on the MHA Education Calendar icon to register.

Submission of Minimum Data Set (MDS) Quarterly Assessment

The current Division of Medicaid policy for Quarterly Assessment states:

Full Assessment or MPAF Set of MDS items, mandated by State (contains at least CMS established subset of MDS items).	Must be completed every **ninety (90) days.**

The above named assessment types may be used for the quarterly submission as required. However, the quarterly assessment is for the full 90 days from the previously submitted assessment as required under OBRA '97. There cannot be a substitution for this type of assessment for Medicaid purposes. If you have any questions, please contact Evelyn Silas at 601-359-6750 or the Case Mix Hotline at 601-359-5191.

Adjusting Denied Claims

Over the last several months, many Mississippi Medicaid Providers have received denials for edit 0177-"Void/Adjustment of denied claim". Whether billed electronically or manually on CMS-1500 or UB-92 claim forms, denied claims can NOT be adjusted. Only paid claims may be adjusted.

Keep in mind that if the policy changes between the time that a claim was originally paid and an adjustment is made, the amended payment will be made according to the most recent billing policies. (i.e. If a PA was not required when the claim was originally paid but is required now, then the new PA must be on the claim in order for the claim to properly adjudicate.)

If a claim that is older than 1 year from the date of service (and not a crossover*) is being adjusted, please ensure that the original TCN is on the claim in order to over-ride the 1 year timely filing edit.

If a claim is adjusted that is older than 2 years old, Mississippi Medicaid will take the prior payment and the claim will then deny for a two year timely filing edit. Hence, no payment will be reimbursed for claims greater than two years, including adjustments.

*Crossover claims have 180 days from the Medicare EOMB paid date to be properly adjudicated and paid. No special batching is permitted for crossovers that exceed 180 days.

Billing Tip for Hospice Providers: How to Bill A Continuous Care Claim

When billing for Continuous Care hours, please bill with Revenue Codes 651(Routine Home Care) and 652 (Continuous Care). You are allowed to list multiple lines of each of these codes.

Note: Revenue Code 651 does not have to be billed in consecutive days.

The example on the following page indicates one month of billing for a Continuous Care patient who has multiple lines of both Rev Code 651 and 652.

Scenario #1

- Enter your statement covers period.
- Use bill type 812 and patient status code 30.
- The first revenue code on your claim should be 651 (Routine Home Care).
- The second line should start your 652 rev codes (Continuous Care); if there are not any consecutive days of rev code 651.
- After entering ALL lines of 652 and any additional 651 lines, your Rev Code 001 which is your total line should be entered.

*Please note that Continuous Care and Routine Home Care cannot be billed for same date of service.

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
			812

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	1/10/06	1/31/06	21				

12 PATIENT NAME	13 PATIENT ADDRESS

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
			1/10/06					30			

32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE CODE	DATE	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37
											A
											B
											C

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
651	Routine Home Care		1-10-06	1	$xxx.xx		
652	Continuous Home Care		1-11-06	24	$xxx.xx		
652	Continuous Home Care		1-12-06	24	$xxx.xx		
652	Continuous Home Care		1-13-06	16	$xxx.xx		
652	Continuous Home Care		1-14-06	9	$xxx.xx		
652	Continuous Home Care		1-15-06	16	$xxx.xx		
652	Continuous Home Care		1-16-06	16	$xxx.xx		
652	Continuous Home Care		1-17-06	16	$xxx.xx		
652	Continuous Home Care		1-18-06	16	$xxx.xx		
652	Continuous Home Care		1-19-06	16	$xxx.xx		
652	Continuous Home Care		1-20-06	18	$xxx.xx		
652	Continuous Home Care		1-21-06	17	$xxx.xx		
652	Continuous Home Care		1-22-06	18	$xxx.xx		
652	Continuous Home Care		1-23-06	24	$xxx.xx		
652	Continuous Home Care		1-24-06	8	$xxx.xx		
652	Continuous Home Care		1-25-06	16	$xxx.xx		
652	Continuous Home Care		1-26-06	24	$xxx.xx		
652	Continuous Home Care		1-27-06	16	$xxx.xx		
652	Continuous Home Care		1-28-06	16	$xxx.xx		
652	Continuous Home Care		1-29-06	17	$xxx.xx		
652	Continuous Home Care		1-30-06	16	$xxx.xx		
651	Routine Home Care		1-31-06	1	$xxx.xx		
001	Total			345	$xxx.xx		

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56

57 **DUE FROM PATIENT ▶**

58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION

67 PRIN. DIAG. CD.	68 CODE	69 CODE	OTHER DIAG. CODES 70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
	C		D		E		

84 REMARKS	OTHER PHYS. ID	85 PROVIDER REPRESENTATIVE	86 DATE
		X	

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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

July

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

Checkwrites and Remittance Advices are dated every Monday. The Remittance Advice is available for download each Monday morning at http://msmedicaid.acs-inc.com will funds are not transferred until the following Thursday.