Mississippi Medicaid Bulletin

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March 2008

Inside this Issue

Your Claims Will Deny Without the NPI

On February 6, 2008, final notices were sent to Medicaid providers who had not filed their NPI with the Division of Medicaid. If your NPI is not on file with the Division of Medicaid, your claims will deny without further notice. All Medicaid claims must include the provider's Medicaid number and the NPI number in the appropriate billing form locators.

In order for the fiscal agent to receive and process your claims correctly, your software vendor/clearinghouse must be transmitting the correct provider/NPI numbers. **Providers are advised to contact their vendor/clearinghouse to ensure that the appropriate billing number is transmitted correctly.**

Fax your NPI to Division of Medicaid, Provider and Beneficiary Relations at 601-359-4185. If you need more information, contact Evelyn H. Silas or Mary Randazzo at 601-359-6133.

Mississippi Medicaid/Head Start Interagency Agreement

The Mississippi Division of Medicaid has an interagency agreement with the Mississippi Head Start Association. The purpose of the agreement is to facilitate delivery of health services to Medicaid eligible children enrolled in Head Start programs. Although this agreement has been in place for many years, some providers are unaware of the collaboration between the two agencies.

All children enrolled in Head Start programs **must** receive an annual health assessment equivalent to the one offered by MS Medicaid Cool Kids (EPSDT) providers **within** forty-five (45) days of their Head Start enrollment. Cool Kids providers who currently screen Head Start children are encouraged to continue to do so and provide the screening results to the appropriate Head Start center where the child is enrolled. Cool Kids providers who screen children without prior knowledge of their Head Start status are encouraged to release Cool Kids screening results to the Head Start center in a timely manner so that they can meet the mandatory 45-day deadline.

Questions related to this article should be directed to the Bureau of Maternal and Child Health at 601-359-6150.

Vaccines for Children (VFC) Program Update

The following vaccines, Human Papillomavirus (CPT code 90649) and Haemophilus Influenzae type b (CPT code 90648), are now covered for Medicaid beneficiaries 18 years of age and under through the Vaccines for Children Program. The Division of Medicaid reimburses for the administration of the vaccines **ONLY,** when it is obtained through the Mississippi State Department of Health's Vaccines for Children Program. Detailed billing instructions can be found on the Envision website at http://msmedicaid.acs-inc.com under the Provider heading by referring to the Provider Bulletin, September 2003 issue, page 33.

Medicare Advantage Plans - Part C

The Division of Medicaid (DOM) accepts Medicare Advantage Plans - Part C claims filed for dually eligible beneficiaries, individuals enrolled in Medicare and eligible for Medicaid coverage. DOM will **not** accept any electronic Part C claims. These claims must be paper submissions only.

Instructions for Submission of Part C Claims

1. All claims should be submitted on the appropriate revised paper Medicaid Crossover Claim and attach the EOB to each claim. To access these forms, go to www.dom.state.ms.us ; select Medicaid Provider Information/Forms for Providers. Instructions should be followed for completion as indicated.

   NOTE: All claims to be processed after January 1, 2008, must include the NPI number and Medicaid provider number in the appropriate bill form locators or it will deny. Medicaid Crossover Claim forms have been revised to include this requirement.

2. Claims processed with the EOB payment date of December 1, 2007, and thereafter, will be subject to the 180-day timely filing limitation.
3. Providers should write across the bottom portion of the claim form **"Advantage Plan". The plan's name must be identified on the EOB to process for payment.**
4. Part C Claims should be sent to:

   ACS
   P.O. Box 23076
   Jackson, MS 39225

Submission of Part C Past 180 Day Filing Time Limit

1. All claims should be submitted on the appropriate revised paper Medicaid Crossover Claim form, and the EOB with the plan's name clearly identified should be attached. To access these forms, go to www.dom.state.ms.us ; select Medicaid Provider Information/Forms for Providers. Instructions should be followed for completion as indicated.
2. Claims to be processed for consideration of timely overrides **mus**t be received by April 1, 2008, and submitted to:

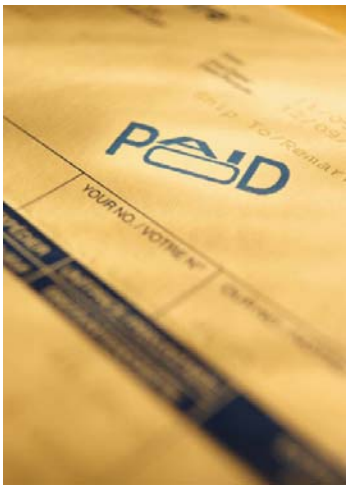
   Division of Medicaid
   Attention: Provider and Beneficiary Relations
   550 High Street, Suite 1000
   Jackson, Mississippi 39201

   NOTE: Claims that are not sent to the Bureau of Provider and Beneficiary Relations by the above required deadline **will not** be reimbursed by the Division of Medicaid.

The Division of Medicaid will not be responsible for any co-pay/co-insurance required by any Medicare Advantage Plans.

For additional assistance, contact the ACS Call center at 1-800-884-3222.

Billing Of Bilateral Procedures



Providers must bill according to the Bilateral Procedures Policy located in the Provider Policy Manual, Surgery Section 52.04. By following those policies, providers should receive prompt and correct payment. The bilateral procedure policies also apply to Assistant Surgeons, Co-Surgeons, and Team Surgeons.

The following billing tips may be helpful:

1) When bilateral procedures are billed for the same date of service, same operative setting performed on anatomically bilateral sides of the body identified by the same CPT codes, and bilateral procedures are the **ONLY** procedures performed, the claims should be billed:

- Primary bilateral procedure billed on the 1st line of claim with modifier 50 and 1 unit – procedure will be paid at 150% of the Medicaid allowable.

- Subsequent bilateral procedures billed on the 2nd line of claim (and other lines as needed) with modifier 51 and 2 units – procedure(s) will be paid at 50% of the Medicaid allowable for each unit.

EXAMPLE:

31254 – 50 (Bilateral Code)	1 Unit	Pays 150% of allowable
31256 – 51 (Bilateral Code)	2 Units	Pays 50% of allowable for each unit

2) When bilateral procedures are billed for the same date of service, same operative setting performed on anatomically bilateral sides of the body identified by the same CPT codes, and bilateral procedures are the **NOT** the only procedures performed, the claims should be billed:

- If primary procedure is a bilateral procedure, bill on the 1st line of claim with modifier 50 and 1 unit – procedure will be paid at 150% of the Medicaid allowable.

- All subsequent procedures billed on the 2nd line of claim (and other lines as needed) with modifier 51 and appropriate units (bill bilateral with 2 units; bill unilateral with appropriate units) – procedure(s) will be paid at 50% of the Medicaid allowable for each unit.

EXAMPLE:

69436 - 50 (Bilateral Code)	1 Unit	Pays 150% of allowable
42831 - 51 (Unilateral Code)	1 Unit	Pays 50% of allowable for each unit

OR

- If primary procedure is unilateral procedure, bill on 1st line of claim with no modifier and 1 unit – procedure will be paid at 100% of the Medicaid allowable.

- All subsequent procedures billed on 2nd line of claim (and other lines as needed) with modifier 51 and appropriate units (bill bilateral with 2 units; bill unilateral with appropriate units) – procedures will be paid at 50% of the Medicaid allowable for each unit.

EXAMPLE:

42820 (Unilateral Code)	1 Unit	Pays 100% of allowable
69421 - 51(Bilateral Code)	2 Units	Pays 50% of allowable for each unit

Note: CPT procedure codes with the description indicating bilateral or unilateral should be billed according to multiple surgery rules, not the bilateral rules.

Co-payments for Outpatient Settings

Effective April 1, 2008, the Division of Medicaid will require the $3.00 co-payment for all beneficiaries receiving services in an outpatient hospital setting UNLESS the beneficiary or service is exempt from the co-payment. When the beneficiary is exempt from the co-payment an exception code must be placed on the claim. **It is the provider's responsibility to bill the claim with the appropriate co-payment exception code, and to collect the co-payment from the beneficiary.** If an exception code is not billed on the claim, Medicaid will subtract the $3.00 co-payment from the claim's payment amount. However, the provider may not deny services to any eligible Medicaid individual due to the individual's inability to pay the co-payment. The individual's inability to pay the co-payment amount does not alter the Medicaid reimbursement amount for the claim, unless the beneficiary or service is excluded from the co-payment policy.

The Mississippi Medicaid Provider Policy Manual, Section 3.08 contains the policies regarding beneficiary cost sharing. Providers are strongly encouraged to review this policy in its entirety by accessing the DOM website at www.dom.state.ms.us, and clicking on "Provider Manuals" in the left window.

New co-payment exclusion codes specifically for outpatient hospital settings are as follows:

- Exception code O – Chemotherapy (Drug Therapy for Cancer); applicable only to facility charges for chemotherapy services performed in the outpatient department of the hospital; this exception code does not apply to the physician charges.

- Exception code T – Radiation Therapy; applicable only to facility charges for radiation therapy performed in the outpatient department of the hospital; this exception code does not apply to physician charges.

- Exception code L – Laboratory/Laboratory Pathology; applicable only to facility charges when the beneficiary is only receiving laboratory services in the outpatient department of the hospital; this exception code does not apply to physician charges.

Co-payment exception code E (Emergency Services) must be placed on the claim for services performed in a hospital, clinic, office, or other facility that is equipped to furnish the required care. The emergency service must be provided after the onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. The documentation in the medical records must justify the service as a true emergency. If the co-payment exception code E is not on the claim, Medicaid will subtract a $3.00 copayment.

Providers should utilize the information contained in this article and the Provider Policy Manual in determining beneficiary cost sharing requirements.

Web Portal Reminder

For easy access to up-to-date information, Providers are encouraged to use the **Mississippi *Envision* Web Portal**. The Web Portal is the electronic approach to rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The **Mississippi *Envision* Web Portal** is available 24 hours a day, 7 days a week, 365 days a year via the Internet at **http://msmedicaid.acs-inc.com**.

Tamper Resistant Prescription Pad/Paper Mandate

Effective April 1, 2008, all non-electronic prescriptions must be written on tamper-resistant pads/paper in order to be eligible for reimbursement by Medicaid. The tamper resistant prescription pads/paper requirement applies to all outpatient drugs, including over-the-counter drugs. It also applies whether DOM is the primary or secondary payer of the prescription being filled. This new provision impacts all DOM prescribers: physicians, dentists, optometrists, nurse practitioners and other providers who prescribe outpatient drugs.

The Centers for Medicare & Medicaid Services (CMS) has issued guidance to the States in implementing the new federal requirement. This guidance allows for compliance with the tamper-resistant prescription pad/paper requirement to occur in two phases. In the first phase, a prescription must contain at least one of the three features outlined below by April 1, 2008, to be considered "tamper-resistant." All three features are required on the prescription pads by October 1, 2008.

DOM encourages providers to implement all security features by April 1, 2008, to be in compliance with all program requirements. Note that computer generated prescriptions are not exempt from the CMS mandate.

The features listed below are recommended as best practice tamper resistant features by a national taskforce including representatives from CMS, State Medicaid agencies, and national medical and pharmacy organizations. Features listed in bold tend to be less costly and easier for prescribers to implement.

Category 1 – One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.	
Feature	**Description**
"Void" or "Illegal" Pantograph	**The word "Void" appears when the prescription is photocopied. Due to the word "Void" on faxed prescriptions, this feature requires the pharmacy to document if the prescription was faxed.**
Reverse "RX" or White Area on prescription	"Rx" symbol or white area disappears when photocopied at light setting. This feature is normally paired with the "Void" pantograph to prohibit copying on a light setting.
Coin-reactive ink	Ink that changes color when rubbed by a coin – Can be expensive and is not recommended.
Security Back print	Printed on the back of prescription form. The most popular wording for the security back print is "Security Prescription" or the security back print can include the states name.
Watermarking (forderiner)	Special paper containing "watermarking".
Diagonal lines (patented "Void")	Diagonal lines with the word "void" or "copy". Can be distracting or expensive.
Micro printing	Very small font writing, perhaps acting as a signature line. This is difficult to photocopy and difficult to implement if using computer printer. It is also difficult for a pharmacist to see.

Continued on next page

(Tamper Resistant Prescription Pad/Paper Mandate – continued)

Category 2 - One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.	
Feature	**Description**
Uniform non-white background color	**Background that consists of a solid color or consistent pattern that has been printed onto the paper. This will inhibit a forger from physically erasing written or printed information on a prescription form. If someone tries to erase or copy, the consistent background color will look altered and show the color of the underlying paper.**
Quantity check off boxes	**In addition to the written quantity on the prescription, Quantities are indicated in ranges. It is recommended that ranges be 25's with the highest being "151 and over". The range box corresponding to the quantity prescribed MUST be checked for the prescription to be valid. See illustration in Appendix 1.**
Refill Indicator (circle or check number of refills or "NR")	**Indicates the number of refills on the prescription. Refill number must be used to be a valid prescription.**
Pre-print "Rx is void if more than___ Rx's on paper" on prescription paper	**Reduces the ability to add medications to the prescription. - Line must be completed for this feature to be valid. Computer printer paper can accommodate this feature by printing "This space intentionally left blank" in an empty space or quadrant.**
Quantity Border and Fill (for computer generated prescriptions on paper only)	**Quantities are surrounded by special characters such as an asterisk to prevent alteration, e.g. QTY **50** Value may also be expressed as text, e.g. (FIFTY), (optional)**
Refill Border and Fill (for computer generated prescriptions on paper only)	**Refill quantities are surrounded by special characters such as an asterisk to prevent alteration, e.g. QTY **5** Value may also be expressed as text, e.g. (FIVE), (optional)**
Chemically reactive paper	**If exposed to chemical solvents, oxidants, acids, or alkalis to alter, the prescription paper will react and leave a mark visible to the pharmacist.**
Paper toner fuser	Special printer toner that establishes strong bond to prescription paper and is difficult to tamper.
Safety or security paper with colored pattern	White (or some other color) mark appears when erased. This is expensive paper.

Category 3 – One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.	
Feature	**Description**
Security features and descriptions listed on prescriptions	**Complete list of the security features on the prescription paper for compliance purposes. This is strongly recommended to aid pharmacists in identification of features implemented on prescription.**
Encoding techniques (bar codes)	Bar codes on prescription. Serial number or Batch number is encoded in a bar code.
Logos	Sometimes used as part of the background color or pantograph.
Metal stripe security	Metal stripe on paper, difficult to counterfeit.
Heat sensing imprint	By touching the imprint or design, the imprint will disappear.
Invisible fluorescent fibers/ink	*Visible only under black light.*
Thermo chromic ink	*Ink changes color with temperature change. This is expensive paper and problematic for storage in areas not climate controlled.*
Holograms that interfere with photocopying	*May interfere with photocopying or scanning.*

(Tamper Resistant Prescription Pad/Paper Mandate – continued)

Per CMS guidance, pharmacies that are presented with a prescription on a non-tamper-resistant prescription pad/paper may satisfy the federal requirement by calling the provider's office and verbally confirming the prescription with the physician or prescriber. The pharmacy shall document through placement on the original non-compliant prescription form that such communication and confirmation has taken place.

Prescriptions that the federal requirement does not apply to:

- E-prescriptions transmitted to the pharmacy;
- Prescriptions faxed to the pharmacy;
- Prescriptions communicated to the pharmacy by telephone by a prescriber;
- Transfer of a prescription between two pharmacies, provided that the receiving pharmacy is able to confirm by facsimile or phone call the authenticity of the tamper-resistant prescription with the original pharmacy;
- Written orders prepared in an institutional setting (which include Intermediate Care Facilities and Nursing Facilities), provided that the beneficiary does not have the opportunity to handle the written order and the order is given by licensed staff directly to the dispensing pharmacy;
- Drugs dispensed or administered directly to the beneficiary in the physician's office or clinic;
- Written prescriptions dispensed to MS Medicaid beneficiaries who become retroactively eligible after April 1, 2008, provided the prescription was filled on or after April 1, 2008, and before the beneficiary became retroactively eligible for MS Medicaid;
- Emergency fills, provided that the prescriber provides a verbal, faxed, electronic or compliant written prescription within 72 hours;
- Refills of written prescriptions presented at a pharmacy before April 1, 2008;
- Written prescriptions paid for by Medicare, a Medicare Part D plan or Medicare Advantage Plan, unless MS Medicaid fee-for-service is a secondary payer. Part D excluded drugs paid for by Medicaid must be executed on tamper-resistant pad/paper[1].

[1] Prescriber may not know when Medicaid is the primary or secondary payer for MS Medicaid beneficiaries; therefore, the Division of Medicaid (DOM) recommends that prescribers use tamper-resistant prescription pads/paper for all DOM beneficiaries.

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.

Preferred Drug List Clarification

Effective April 1, 2008, all strengths and formulations of generic cetirizine are preferred, and brand name Zyrtec® requires prior authorization. Prescription Zyrtec® was discontinued by the manufacturer in January 2008 and remaining legend formulations of Zyrtec® will continue to be covered by DOM with prior authorization. Generic formulations must be rebated to be Medicaid reimbursable.

Common Pharmacy Billing Problems

NDC	Drug Name	Correct Billing Unit	Common Incorrect Billing
63032-0031-00	OLUX 0.05% FOAM	100 grams	1 unit
68032-0124-20	LIDOCAINE-HC 3-0.5% CREAM K	140 grams per kit	Increments of 20 grams
68032-0128-20	LIDOCAINE-HC 3-1% CREAM	140 grams per kit	Increments of 20 grams
68032-0193-20	LIDOCAINE 3%-HC 2.5% GEL KI	140 grams per kit	Increments of 20 grams
00944-2700-04	Gammagard Liquid	grams	mL
00944-2700-05	Gammagard Liquid	grams	mL
00944-2700-06	Gammagard Liquid	grams	mL
00456-3200-14	NAMENDA 5-10 MG TITRATION P	tablets	One unit per package
00078-0340-84	SANDOSTATIN LAR 10 MG KIT	per unit	mg
00004-0352-39	PEGASYS 180 MCG/0.5 ML CONV	per kit	per syringe
58281-0562-01	Lioresal Intrathecal (Baclofen Injection) 50 mcg/ml	Unit (each unit equals 10mg)	mg or mL
58281-0560-01	Lioresal Intrathecal (Baclofen Injection) 500 mcg/ml	Unit (each unit equals 10mg)	mg or mL
58281-0561-02	Lioresal Intrathecal (Baclofen Injection) 2000 mcg/ml	Unit (each unit equals 10mg)	mg or mL
58281-0563-01	Lioresal Intrathecal (Baclofen Injection) 2000 mcg/ml	Unit (each unit equals 10mg)	mg or mL
58281-0560-02	Lioresal Intrathecal (Baclofen Injection) 500 mcg/ml	Unit (each unit equals 10mg)	mg or mL
58281-0563-02	Lioresal Intrathecal (Baclofen Injection) 2000 mcg/ml	Unit (each unit equals 10mg)	mg or mL
00085-1235-01	Intron A 30 MIU	per Kit (each)	mL or by syringe
00085-1242-01	Intron A 18 MIU	per Kit (each)	mL or by syringe
00085-1254-01	Intron A 60 MIU	per Kit (each)	mL or by syringe
63395-0101-11	FLOXIN OTIC SINGLES	0.25 mls (increments)	per dropperette

Ophthalmologists and Optometrists – Contact Lenses

In submitting prior authorization requests for contact lenses, remember that the request must properly document at least one of the diagnoses listed under the coverage criteria in the Provider Policy Manual, Section 29.08. Documentation must include the diagnosis, appropriate ICD-9 diagnosis code, and diopters, if required by the policy. Submitting requests without the required information/documentation will cause a delay in the processing of your claim, and may result in payment denial.

Dental Providers – Coverage of Crowns

Dental Providers should refer to the following information in filing claims for crowns.

- Crowns are covered for beneficiaries under twenty-one (21) years of age, when medically necessary.
- Porcelain fused to metal crowns will be allowed on secondary anterior teeth for the older child.
- Stainless steel crowns are indicated for restoration of primary or young permanent teeth.
- Porcelain or cast crowns may be covered if approval is granted after submission of a **prior authorization request,** and supporting radiograph(s).

The prior authorization request must be submitted for approval using the dental services authorization request form (MA-1098). The provider should mail the form along with the radiograph to:

Division of Medicaid
Walter Sillers Bldg
550 High Street, Suite 1000
Jackson, MS 39201

The prior authorization request may also be submitted via the web portal; however, the radiographs are still required and must be provided as indicated above. The request will be denied if the radiograph is not received in the DOM Bureau of Medical Services within 5 working days of the receipt of the request. Please refer to Section 11 of the Mississippi Medicaid Provider Policy Manual for additional information regarding crowns and prior authorizations.

2008 New Bed Values for Nursing Facilities, ICF/MR's and PRTF's

The new bed values for 2008 for nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR's) and psychiatric residential treatment facilities (PRTF's) have been determined using the R.S. Means Construction Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

Facility Class	2008 New Bed Value
Nursing Facility	$47,552
ICF-MR	$57,062
PRTF	$57,062

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
7.0 General Policy	7.04 Fraud and Abuse		X	03/01/08
10.0 Durable Medical Equipment	10.02 Reimbursement 10.87 Custom Wheelchairs: Drivers and Seating Systems		X X	03/01/08
20.0 Mental Health/Pre-Admission Screening and Resident Review (PASRR)	All (20.01-20.30)	X		03/01/08
26.0 Hospital Outpatient	26.31 Trauma Team Activation/Response* *(Cross reference to section 25.36 Hospital Inpatient)	X		03/01/08
31.0 Pharmacy	31.07 Non-Covered Pharmacy Services 31.13 Over the Counter (OTC) Drugs 31.15 Tobacco Cessation 31.16 Medicare-Covered Drugs		X X X X	03/01/08
38.0 Maternity	38.08 Terbutaline Therapy	X		03/01/08
53.0 General Medical Policy	53.12 Cochlear Implant 53.13 Tobacco Cessation 53.42 Consent for Minors	 X	X X	03/01/08
55.0 Physician	55.16 Terbutaline Therapy* *(Cross reference to section 38.08)	X		03/01/08
76.0 EPSDT School Health Related Services	76.09 Psychotherapy Services		X	03/01/08
1.0 Introduction	1.02 Reserved for Future Use 1.05 DOM Addresses and Telephone Numbers		X X	04/01/08
3.0 Beneficiary Information	3.08 Beneficiary Cost Sharing		X	04/01/08
8.0 Ambulance	8.06 Co-Payment* *(Cross reference to section 3.08)		X	04/01/08
9.0 Chiropractic Services	9.03 Co-Payment* *(Cross reference to section 3.08)		X	04/01/08
10.0 Durable Medical Equipment	10.01 Introduction 10.02 Reimbursement 10.03 Co-Payment 10.11 Augmentative Communication Device 10.47 Insulin Pump		X X X X X	04/01/08
25.0 Hospital Inpatient	25.14 Co-Payment* *(Cross reference to section 3.08)		X	04/01/08

Manual Section	Policy Section	New	Revised	Effective Date
26.0 Hospital Outpatient	26.09 Co-Payment* *(Cross reference to section 3.08)		X	04/01/08
31.0 Pharmacy	31.03 Co-Payment* *(Cross reference to section 3.08)		X	04/01/08
40.0 Home Health	40.07 Co-Payment* *(Cross reference to section 3.08)		X	04/01/08
73.0 Mississippi Cool Kids (EPSDT) Program	All (73.01- 73.09)		X	04/01/08

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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

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

March

March 2008

Sunday	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*
						1
2	3 CHECKWRITE	4	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 **EDI Cut Off 5:00 p.m.**	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 while funds are not transferred until the following Thursday.