Mississippi Medicaid Bulletin

Volume 14, Issue 12

December 2008

Inside this Issue

2009 CPT/HCPCS CODE UPDATES

The Health Insurance Portability and Accountability Act (HIPAA) requires providers to bill with current code sets. The Division of Medicaid is making every effort to have the annual update of the CPT/HCPCS codes completed by January 1, 2009. If the update is not completed, the claim lines billed with new codes will deny for Exception Code 0430. Please do not resubmit the denied claims. There will be an automatic reprocessing of these claims when the codes are correctly loaded. Remember to retain your previous books as they may be needed when reconciling older claims.

Fraud and Abuse Reminder

In accordance with the Medicaid Provider Policy Manual, General Policy, Section 7.04, Fraud and Abuse, when a provider identifies any overpayments made by Medicaid, caused by billing errors, system errors, human error, etc., he/she should notify the Division's Bureau of Program Integrity in writing, and submit an Adjustment/Void Request to the fiscal agent within 30 days of the discovery.

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.**

National Plan and Provider Enumeration System (NPPES) – Keeping It Safe and Keeping it Updated

The Centers for Medicare & Medicaid Services (CMS) recommends that each health care provider, including individual physicians and non-physician practitioners:

- Know and maintain their NPPES User IDs and passwords.
- Reset their NPPES passwords at least once a year. See the NPPES Application Help page regarding the 'Reset Password' rules. Those rules indicate the length, format, content and requirements of NPPES passwords.
- Review their NPPES records in order to ensure that the information reflects current and correct information.

Maintaining NPPES Account Information for Safety and Accessibility
Health care providers, including physicians and non-physician practitioners, should maintain their own NPPES account information (i.e., User ID, Password, and Secret Question/Answer) for safety and accessibility purposes.

Viewing NPPES Information
Health care providers, including physicians and non-physician practitioners, can view their NPPES information in one of two ways:

(1) By accessing the NPPES record at https://nppes.cms.hhs.gov/NPPES/Welcome.do and following the NPI hyperlink and selecting Login. The user will be prompted to enter the User ID and password that he/she previously created. *

* If the health care provider has forgotten the password, enter the User ID and click the "Reset Forgotten Password" button to navigate to the Reset Password Page. If the health care provider enters an incorrect User ID and Password combination three times, the User ID will be disabled. Please contact the NPI Enumerator at 1-800-465-3203 if the account is disabled or if the health care provider has forgotten the User ID.

OR

(2) By accessing the NPI Registry at https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do. The NPI Registry gives the health care provider an online view of Freedom of Information Act (FOIA)-disclosable NPPES data. The health care provider can search for its information using the name or NPI as the criterion.

Updating NPPES Information
Health care providers, including physicians and non-physician practitioners, can correct, add, or delete information in their NPPES records by accessing their NPPES records at https://nppes.cms.hhs.gov/NPPES/Welcome.do and following the NPI hyperlink and selecting Login. The user will be prompted to enter the User ID and password that he/she previously created.

Please note: Required information cannot be deleted from an NPPES record; however, required information can be changed/updated to ensure that NPPES captures the correct information. Certain information is inaccessible via the web, thus requiring the change/update to be made via paper application. The paper NPI Application/Update Form can be downloaded and printed at http://www.cms.hhs.gov/cmsforms/downloads/CMS10114.pdf.

Need More Information?

Providers can apply for an NPI online at https://nppes.cms.hhs.gov or can call the NPI enumerator to request a paper application at 1-800-465-3203. Having trouble viewing any of the URLs in this message? If so, try to cut and paste any URL in this message into your web browser to view the intended information.

Note: All current and past CMS NPI communications are available by clicking "CMS Communications" in the left column of the www.cms.hhs.gov/NationalProvIdentStand CMS webpage.

Changes in Pre-certification/Certification Requirements

Effective for dates of services on and after January 1, 2009, the Division of Medicaid (DOM) is announcing changes to pre-certification and/or certification requirements for the following services.

DOM's Utilization Management and Quality Improvement Organization (UM/QIO), HealthSystems of Mississippi (HSM), will manage the changes and conduct statewide provider workshops in December, 2008. Both HSM and DOM strongly encourage providers to participate in the workshops for the purpose of obtaining information and instructions. The dates, locations, times, and description of workshops, scheduled for hospital providers, can be found on page 13 within this Bulletin.

DOM is in the process of updating appropriate policies for the Provider Policy Manual. These updates will be announced in a future bulletin.

Home Health Visits (Home Health Agency Providers)	Twenty-five home health visits are allowed per Medicaid fiscal year. For adults (beneficiaries age 21 or over), the home health visits may be a combination of skilled nurse or home health aide visits. For children (beneficiaries under age 21), the visits may be a combination of skilled nurse, home health aide, physical therapy, and speech therapy visits. Additional visits are available for children through the Expanded EPSDT Program when approved for medical necessity by the UM/QIO. Effective for dates of service on and after January 1, 2009, home health agency providers will only be required to certify visits beyond the 25th visit for beneficiaries under age 21. Beginning with the 26th visit, the provider must request certification either before or within 30 days after the service, unless Medicaid eligibility is determined after services are rendered, and made retroactive to the date of service. There will be no certification requirement for the 25 visits allowed for adults, and for the initial 25 visits for children. This change does not affect home health services provided to beneficiaries in the Elderly and Disabled Waiver program.
Inpatient Hospital Days	Hospitals will continue to pre-certify all medical/surgical, maternity, and psychiatric admissions and continued stays in an acute care facility and a freestanding psychiatric hospitals. However, the process for obtaining the Treatment Authorization Numbers (TAN) will be expanded to include an automated rule driven system-based review process. Through this process, hospital providers will be able to submit both initial and concurrent requests and clinical information for certain conditions and receive real-time approvals.
Maternity Reporting	Effective for dates of admission on and after January 1, 2009, DOM will allow hospitals to report admissions up to three days for a vaginal delivery and five days for a Cesarean Section delivery. A Treatment Authorization Number (TAN) will be issued for the respective number of days. Hospitals **must** submit a request for a continued stay for admissions exceeding three days for vaginal delivery and five days for a Cesarean Section delivery, in accordance with the UM/QIO's policy and procedures. A TAN will be issued if the continued stay is determined to be medically necessary.

Medical Supplies	Through the Durable Medical Equipment (DME) Program, benefits are provided for medically necessary durable medical equipment, orthotics, prosthetics, and medical supplies. Currently, DOM requires certification for all items supplied through the DME program. Effective for dates of service on and after January 1, 2009, DME providers will no longer be required to certify medical supplies except for underpads and diapers. DOM will continue to require certification for underpads and diapers either before the provider provides the item or within 30 days of delivery unless Medicaid eligibility is determined after services are rendered, and made retroactive to the date of service. DME providers must continue to certify all durable medical equipment, orthotics, and prosthetics.
Outpatient Hospital Mental Health Services	Effective for dates of service on and after January 1, 2009, hospitals must pre-certify all mental health services provided through outpatient hospital departments. The services must be pre-certified prior to the service, unless Medicaid eligibility is determined after services are rendered, and made retroactive to the date of service.
Therapy Services (Outpatient Physical, Occupational, and Speech Therapy)	Effective for dates of service on and after January 1, 2009, the following services will no longer be exempt from pre-certification requirements for outpatient physical, occupational, and speech therapy services: • Therapy services provided to beneficiaries in nursing facilities. • Therapy services covered under regular State Plan benefits and provided to beneficiaries also enrolled in a Home and Community Based (HCBS) waiver program. Pre-certification will be required for the above services when provided by therapists (individual or groups) or therapy clinics and billed directly to Medicaid. Pre-certification is not required, regardless of the CPT codes used, when the services fall into one of the following categories: • Therapy services billed by school providers. • Therapy services provided to beneficiaries in an ICF/MR. • Therapy services provided to beneficiaries enrolled in a hospice program. • Therapy services provided to beneficiaries covered under both Medicare and Medicaid if Medicare benefits have not been exhausted.

Questions relating to the following changes should be directed to the Division of Medicaid's Provider Relations Division at telephone 601- 359-6133 or 1-800-421-2408.

Billing Tip – Bilateral and Multiple Surgery Claims

To prevent claim denials for Edit 1001 – BILL 1 UNIT ONLY ON BILATERAL PROCEDURES or Edit 3251 – BILLING OF SECONDARY SURGERY REQUIRES MODIFIER 51, be sure to remember the following rules:

1. Modifier 50 will ONLY be billed on the 1st line of the claim with 1 unit for bilateral procedures and NEVER on the 2nd or subsequent lines.

2. Modifier 51 will ONLY be billed on the 2nd or subsequent lines of the claim and NEVER on the 1st line.

3. Modifier 50 and 51 will NEVER be billed together on the same line.

Bilateral procedures billed on the 1st line will require the 50 modifier and 1 unit paying 150%. Bilateral procedures billed on the 2nd and subsequent lines will require the 51 modifier and 2 units paying 50% for each unit.

Example: 31254 – 50 x 1 Unit Pays 150% of allowable
31256 – 51 x 2 Units Pays 50% of allowable for each unit

Bilateral procedures billed on the 1st line will require the 50 modifier and 1 unit paying 150%. Unilateral procedures billed on the 2nd and subsequent lines will require the 51 modifier and appropriate units.

Example: 69436 – 50 x 1 Unit Pays 150% of allowable
42831 – 51 x 1 Unit Pays 50% of allowable for each unit

Unilateral procedures billed on the 1st line with 1 unit do not require a modifier. Bilateral procedure billed on the 2nd and subsequent lines will require the 51 modifier.

Example: 42820 x 1 Unit Pays 100% of allowable
69421 – 51 x 2 Units Pays 50% of allowable for each unit

Unilateral procedures that may be billed with multiple units should be billed on 2 lines. The 1st line will be billed with 1 unit and no modifier. The second line will be billed with the remainder of the units with the 51 modifier.

Example: 22520 x 1 Unit Pays 100% of allowable
22520 - 51 x 2 Units Pays 50% of allowable for each unit
22521 – 51 x 3 Units Pays 50% of allowable for each unit

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.

Web Portal Submission of Plans of Care for Children

The Bureau of Maternal/Child Health encourages all providers who submit the ***MS Cool Kids (EPSDT) Plans of Care*** for children to do so using the Mississippi Envision Web Portal. Using the Web Portal to submit plans of care is quick and simple. The great thing is you receive your approval electronically, which is better than waiting for it to come in the mail.

If you need assistance in learning how to use the Web Portal, please call the Bureau of Maternal/Child Health at 601-359-6150 or 1-800-421-2408.

Rates for Adult Immunizations

Reimbursement rates, effective July 1, 2008, for vaccines and administration for beneficiaries age 19 and older are as follows:

Influenza Vaccines		Pneumonia Vaccine		Administration Fees	
90656	$17.37	90732	$29.73	90471	$16.43
90658	$13.22			90472	$8.49
90660	$22.03				

Cool Kids Lead Reporting Protocol

All Cool Kids (EPSDT) providers who have purchased and/or utilize the ESA Leadcare machine (in-house lead analyzer) must report **ALL** blood lead levels to the Mississippi State Department of Health's (MSDH) Childhood Lead Poisoning Prevention Program (CLPPP). There are standard reporting requirements that must be followed as part of the lead screening and testing process.

Effective May 2008, MSDH and the Division of Medicaid required reporting of all venous blood lead levels ≥10µg/dL to the CLPPP within one week of diagnosis (Class II). Laboratories and clinics utilizing the in-house lead analyzer must report **ALL** blood lead test results to the CLPPP within one week of completion (Class III).

The standard reporting tool must be completed in its entirety for each child tested. If the form is not legible or is incomplete it will be returned to the clinic for completion. A copy of the standard reporting tool is included on the following page for your convenience.

The MSDH CLPPP maintains the blood lead surveillance system and is the point of contact for any questions regarding testing, follow-up, case management, and education. Educational materials are available upon request. Additional information can be found on the MSDH website at www.msdh.state.ms.us.

Any questions should be directed to the CLPPP at (601) 576-7447.

MISSISSIPPI STATE DEPARTMENT OF HEALTH

Report of Lead Levels

Child's Name _____Date of Birth_____

Sex_____ Race_____ Phone Number_____ Medicaid # _____

Mailing Address _____

Physical Address_____

County _____ Social Security #_____

Parent/Guardian Name_____

Lead Reports:
Date of Tests:_____ Lead Level_____ Venous__ Capillary_____

Date of Tests:_____ Lead Level_____ Venous__ Capillary_____

Date of Tests:_____ Lead Level_____ Venous__ Capillary_____

Follow Up Care:
Next scheduled Testing Date:_____
Is the Child on WIC? Yes_____ No_____
Have the parents received nutritional information? Yes____ No_____
Have the parents received educational information? Yes_____ No_____

Clinic Information:
Name of Clinic_____
Address_____ Phone#_____
Physician_____

** Feel free to use a stamp to fill in the clinic information**

Please print legibly in black ink. The CLPPP will return if unable to read the information.

CLPPP Program: Crystal Veazey (601)-576-7447, Fax **(601)-576-7498**.

Thank You!

Correction to Vaccines for Children Update Article

There was a typo error in the CPT vaccine codes range printed in the article, *Vaccines for Children Update* in the October and November 2008 Provider Bulletins. The correct CPT vaccine codes range is **90476 through 90749** for the Vaccines for Children (VFC) Program (beneficiaries age 18 and under).

REMINDER – In billing for oral or intranasal administration of the immunizations provided in the VFC Program, providers must bill CPT code 90473, with an EP modifier, and one unit for the single oral or intranasal administration of one vaccine; and bill CPT code 90471, with an EP modifier, and one unit for a single subcutaneous or intramuscular administration of one vaccine. If more than one subcutaneous or intramuscular is administered, providers must also bill CPT code 90472, with an EP modifier, and indicate the appropriate number of units, based on the number of additional subcutaneous or intramuscular vaccines administered to the beneficiary. Mississippi Medicaid allows $10 for each vaccine administered.

Preferred Drug List Reminder: Update on January 1, 2009

The Division of Medicaid's Preferred Drug List (PDL) will be revised on January 1, 2009. For a comprehensive list of the PDL, go to the Agency's website at www.medicaid.ms.gov, select Pharmacy Services and PDL.

Drug Reference Database File

There are over 9,000 active national drug code (NDC) numbers in the Division's Drug Reference database file, which is updated weekly. Changes to the Drug Reference file can impact pharmacy claims. There are thousands of updates each week, which may include, but are not limited to pricing changes, orange book rating, DEA class, DESI standing, whether or not the drug is rebated, NDA/ANDA status, daily dose ranges, and age/gender/pregnancy restrictions, if applicable.

Pharmacy Changes for Beneficiaries Enrolled in the Family Planning Waiver Program

Effective November 1, 2008, Division of Medicaid beneficiaries in the Family Planning Waiver Program (Yellow Medicaid Card) can now get the following contraceptives at their local Medicaid participating pharmacy:

- ***Contraceptive Patches***
- ***Self-inserted contraceptive products (like NuvaRing)***
- ***Oral contraceptive agents***
- ***Injectable contraceptives (e.g. Depo-Provera)***

Also, Depo-Provera will continue to be *available* through the prescriber's office. Contraceptive drug coverage for Medicaid beneficiaries (green card) has not changed.

Beneficiaries enrolled in the Family Planning Waiver are eligible for Medicaid coverage of family planning services only and ***are not eligible for any other Medicaid pharmacy services.*** The only pharmacy services reimbursed for this beneficiary population are contraceptive oral agents, self inserted products (i.e. Nuva Ring) , injectable contraceptives (i.e. Depo Provera) and patches.

If there are questions, contact the Bureau of Maternal/Child Health (MCH) at 601-359-6150 or 1-800-421-2408.

Frequently Asked Question Received in the Pharmacy Bureau

Question: My claim denies for incorrect date of birth. How can I find the correct DOB?
Response: To obtain the beneficiary's correct date of birth,

- check for DOB on the Medicaid card; or
- ask beneficiary and/or family member for correct date of birth; or
- contact ACS's Pharmacy Help Desk at 1-866-759-4108; or
- go to the web portal "Mississippi Envision" at https://msmedicaid.acs-inc.com/msenvision/userLogin.do ; log in; and go to "Provider", "Inquiry Options", "Eligibility Inquiry"; and enter the Beneficiary's ID number or Last Name, First Name, and Social Security Number. A response will appear showing both beneficiary's personal and eligibility information, including the date of birth.

If additional information is needed in response to the above questions, or if there is an error with a beneficiary's date of birth on file with the Division of Medicaid, refer the beneficiary and/or responsible party to the Division's Provider and Beneficiary Bureau at 1-800-421-2408.

Drug Quantity Limits and OTC Updates

The Division of Medicaid's list of products with quantity limits and Over the Counter (OTC) updates and will be revised effective January 1, 2009. For the complete lists, go to the Agency's website at www.medicaid.ms.gov, select Pharmacy Services, Products with Quantity Limits and/or OTC updates.

2008 Owner Salary Limits for Long-Term Care Facilities

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for the mentally retarded, and psychiatric residential treatment facilities as owner's salaries for 2008, are based on 150% of the average salaries paid to non-owner administrators in 2007, in accordance with the Medicaid State Plan. These limits apply to all owners and owner/administrators that receive payment for services related to patient care; and to salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2008 are as follows:

• Small Nursing Facilities (1-60 Beds)	$104,783
• Large Nursing Facilities (61 + Beds)	$137,640
• Intermediate Care Facilities for the Mentally Retarded (ICF-MR)	$111,107
• Psychiatric Residential Treatment Facilities (PRTF)	$183,855

Allowable Board of Directors Fees for Nursing Facilities, ICF/MR's and PRTF's 2008 Cost Reports

The allowable Board of Directors fees that will be used in the desk reviews and audits of 2008 cost reports, filed by nursing facilities (NF's), intermediate care facilities for the mentally retarded (ICF/MR's), and psychiatric residential treatment facilities (PRTF's), have been computed. The computations were made in accordance with the Medicaid State Plan, by indexing the amounts in the plan, using the Consumer Price Index for All Urban Consumers - All Items. The amounts listed below are the 'per meeting' maximum, with a limit of four meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2008 are as follows:

Category	Maximum Allowable Cost for 2008
0 - 99 Beds	$ 3,681
100 - 199 Beds	$ 5,522
200 - 299 Beds	$ 7,362
300 - 499 Beds	$ 9,203
500 Beds or More	$11,044

Reminders Regarding Medicaid Ambulance Billing and Policy

- For Medicaid coverage of non-emergency ground ambulance transport, the beneficiary must be totally bed confined. Bed confined is defined as:
  1. The inability to get up from bed without assistance, AND
  2. Inability to ambulate, AND
  3. Inability to sit in a chair, including a wheelchair.

- For Mississippi Medicaid emergency and non-emergency ground ambulance transport, the initial patient loaded 25 miles are ALWAYS included in the base rate, and must NOT be billed separately. Code A0380 or A0390 may be billed beginning with the 26th patient loaded mile. For example, if mileage is 35 patient loaded miles from the point of pick up to the point of destination, the provider may bill only 10 miles (units) with the appropriate mileage code.

- Modifiers are required for ambulance procedure codes.

- Remember to use the appropriate 'Place of Service' code when filing your claims:
  - 41-Ambulance Land
  - 42-Ambulance Air or Water

- Be sure to use the correct NPI number on claims.

- If more than one patient is transported in the same ambulance, submit a separate claim for each Medicaid beneficiary; and the submitted charge should reflect the usual charge for one patient divided by the number of patients on board. For example, if a pregnant mother delivers her baby before arrival at the hospital, submit separate claims for the Medicaid eligible mother and baby; and the submitted

charge for each separate claim should reflect the usual charge for one patient divided by two. This is applicable to both the base and mileage charges, as stated in Section 8.16 of the Provider Policy Manual.

- The 'Servicing Provider' should only be an ambulance provider. It is not appropriate to bill another provider, e.g., a physician, as the servicing provider on an ambulance claim.

- In filing a claim with Medicaid for non-emergency ambulance services for dual eligibles, the ambulance provider must first file a claim with Medicare, and obtain an Explanation of Benefits (EOB). The ambulance provider may then submit a hard copy of the CMS-1500 using Medicaid specific codes, a copy of the Medicare EOB, a copy of the Ambulance Trip report, and the Certificate of Medical Necessity for Non-Emergency Ambulance Transportation. This documentation must be mailed to the Division of Medicaid, Ambulance Program, Bureau of Medical Services, 550 High Street, Suite 1000, Jackson, MS 39201.

- The Ambulance Fee Schedule can be found on the Division's website at www.medicaid.ms.gov.

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.medicaid.ms.gov and clicking on Provider Manuals, under Publications.

Manual Section	Policy Section	New	Revised	Effective Date
4.0 Provider Enrollment	All (Sections 4.01-4.08) (Sections 4.09-4.41)	 X	X	12/01/08
10.0 Durable Medical Equipment	10.02 Reimbursement 10.03 DME Co-Payments 10.07 Documentation 10.32 Diapers and Underpads 10.90 Medical Supplies 10.91 Medical Supplies List		X X X X X X	01/01/09
25.0 Hospital Inpatient	25.25 Prior Authorization of Inpatient Hospital Services		X	01/01/09
26.0 Hospital Outpatient	26.12 Mental Health Services	X		01/01/09
36.0 Nursing Facility	36.07 Per Diem/Covered Services 36.18 Therapy Services		X X	01/01/09
38.0 Maternity	38.09 17 Alpha-Hydroxyprogesterone (17-P)	X		01/01/09
40.0 Home Health	40.02 Criteria for Coverage 40.03 Covered Services 40.05 Certification Requirements 40.06 Physician Responsibilities 40.08 Documentation Requirements 40.09 Home Health Services Provided in Another State 40.12 Reimbursement 40.13 Dual Eligibles		X X X X X X X	01/01/09
47.0 Outpatient Physical Therapy	47.09 Prior Authorization/Pre-Certification		X	01/01/09
48.0 Outpatient Occupational Therapy	48.09 Prior Authorization/Pre-Certification		X	01/01/09
49.0 Outpatient Speech-Language Pathology (Speech Therapy)	49.09 Prior Authorization/Pre-Certification		X	01/01/09
56.0 Injectables/Physician Office	56.05 17 Alpha-Hydroxyprogesterone (17-P)	X		01/01/09
57.0 Indian Health Services	All (Sections 57.01-57.05)	X		01/01/09

HOSPITAL PROVIDERS -
Changes to Precertification/Certification Requirements Workshops

The following workshops are designed to help hospital providers become more familiar with several 'new' changes to the Mississippi Medicaid Precertification and/or Certification Requirements. The changes will be effective for dates of services on and after January 1, 2009. All workshops will be conducted by staff from HealthSystems of Mississippi (HSM). More information can be found on the HSM web site at www.hsom.org or by contacting them at 601-360-4961. The dates for the workshops are as follows:

DATE	LOCATION	TIME	WORKSHOP DESCRIPTION
December 1, 2008	Regency Hotel Jackson, MS	9:00 a.m. - 12:00 p.m.	Outpatient Hospital Mental Health
December 1, 2008	Regency Hotel Jackson, MS	1:00 p.m. – 4:00 p.m.	Inpatient Acute Care Facilities
December 3, 2008	Vicksburg Convention Center Vicksburg, MS	9:00 a.m. – 12:00 p.m.	Outpatient Hospital Mental Health
December 3, 2008	Vicksburg Convention Center Vicksburg, MS	1:00 p.m. – 4:00 p.m.	Inpatient Acute Care Facilities
December 10, 2008	Hattiesburg Lake Terrace Convention Center Hattiesburg, MS	9:00a.m. – 12:00 p.m.	Outpatient Hospital Mental Health
December 10, 2008	Hattiesburg Lake Terrace Convention Center Hattiesburg, MS	1:00 p.m. – 4:00 p.m.	Inpatient Acute Care Facilities
December 11, 2008	Marriott Hotel Gulfport, MS	9:00 a.m. – 12:00 p.m.	Outpatient Hospital Mental Health
December 11, 2008	Marriott Hotel Gulfport, MS	1:00 p.m. – 4:00 p.m.	Inpatient Acute Care Facilities
December 16, 2008	DeSoto county Civic Center Southaven, MS	9:00 a.m. – 12:00 p.m.	Outpatient Hospital Mental Health
December 16, 2008	DeSoto county Civic Center Southaven, MS	1:00 p.m. – 4:00 p.m.	Inpatient Acute Care Facilities
December 17, 2008	Bancorp South Center Tupelo, MS	9:00 a.m. – 12:00 p.m.	Outpatient Hospital Mental Health
December 17, 2008	Bancorp South Center Tupelo, MS	1:00 p.m. – 4:00 p.m.	Inpatient Acute Care Facilities

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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

December

December 2008

Sunday	*Monday*	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*
	1	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 CHECKWRITE	30	31			

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.