Mississippi Medicaid Bulletin

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Payment Error Rate Measurement (PERM) Federal Fiscal Year 2011

PERM was developed by CMS to measure improper payments in the Medicaid program and the Children's Health Insurance (CHIP) Program. PERM reviews will be conducted in the following three areas:

- Beneficiary Eligibility for both the Medicaid and CHIP programs,
- Managed Care payments, and
- Fee-for-service claims payments.

The PERM reviewers/contractors examine claims to determine whether the provider:

- Responded to the request for documentation within the required time frame;
- Submitted correct supporting documentation for the procedure code that was reimbursed;
- Submitted insufficient documentation;
- Submitted an erroneous procedure code (i.e. provider performed a procedure but billed an incorrect procedure code for the service performed);
- Billed with an incorrect diagnosis;
- Billed separate components of a procedure code when one inclusive procedure code should have been billed;
- Billed for an incorrect number of units for a particular procedure or revenue code;
- Billed for a service determined to have been medically necessary based on documentation in the medical/service record about the patient's condition;
- Billed and was paid for a service that was not in agreement with a documented policy, regulation or other requirement;
- Meets all DOM, CMS, and other applicable policies, procedures and regulations

For additional information on PERM, go to the CMS website: http://www.cms.gov/PERM

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CMS has secured the services of three independent contractors to conduct the PERM review process:

- The Lewin Group – A statistical contractor to conduct sampling and calculation of error rate
- A+ Government Solutions – A review contractor to contact providers to collect medical documentation
- Health Date Insights (HDI) – A review contractor to conduct medical reviews

The initial request for documentation by contractor **A+** Government Solutions**,** for the first quarter of sampled claims, is scheduled for mailing to providers in the Fall of 2011, with subsequent mailing to follow each quarter. Providers receiving a request for documentation must submit the requested medical records to A+ Government Solutions within 75 days of date of the letter. Providers receiving a request for additional medical records must submit this documentation to A+ Government Solutions within 14 days of date of the letter of request. For additional assistance in complying with informational requests providers may call **1-301-987-1100.**

Failure to comply with the request for medical records will result is an automatic error and recoupment of paid claim. Therefore, in an effort to confirm that documentation is complete, we are requesting that providers also send a copy of the documentation to DOM's PERM Coordinator. This process will allow DOM to ensure the required documentation is provided to the contractor and avoid the assignment of an inaccurate error rate and subsequent recoupment of claim payments.

Providers may submit information to A+ Government Solutions via:

- Toll free number **(1-877-619-7850)**
- Electronic submission of medical documentation (esMD).
- Advance notification to A+ must be done before the provider submits.
- For assistance in faxing information to A+, please call 301-987-1100. For more information about esMD, see www.cms.gov/esMD.

Additional information on PERM may be found on the following websites:

- CMS: http://www.cms.gov/PERM
- DOM: http://www.medicaid.ms.gov/News/Payment%20Error%20Rate%20Measurement.pdf

Sharon Jones is the DOM PERM representative. She can be reached at 601-359-6134 or 1-800-421-2408, or email, Sharon.Jones@medicaid.ms.gov.

IMPORTANT NOTIFICATION!!!

HIPAA 5010 AND ICD-10-CM/PCS IMPLEMENTATIONS FIRST COMPLIANCE DATE IS HERE!

On January 1, 2012, standards for electronic health transactions will change from Version 4010/4010A1 to Version 5010. **Version 4010/4010A1 will no longer be accepted**. The CMS statement released on 11/17/2011 will not change the implementation date for the Mississippi Division of Medicaid.

THE COMPLIANCE DATE IS FIRM AND WILL NOT CHANGE.

After 12/31/2011, claims submitted in 4010/4010A1 format will not be accepted or paid. Prior to 1/1/12 implementation, all providers must successfully complete 5010 testing with ACS and be registered in the system to submit 5010 claims. Preparing now can help you avoid potential reimbursement issues. Providers who will not be ready to submit claims in 5010 format on 1/1/2012 are encouraged to utilize a clearinghouse vendor to assist them during the transition. "**For questions regarding 5010 implementation or to schedule testing with ACS, please email Mississippi5010@acs-inc.com or call Ernestine Dunbar (601) 206-2939**."

Listed below are links to information concerning this transition:
Centers for Medicare and Medicaid Services http://www.cms.gov/ICD10/
Centers for Disease Control and Prevention http://www.cdc.gov/nchs/icd/icd10.htm

ICD-10 TRANSITION

On January 16, 2009, the U.S. Department of Health and Human Services (HHS) released the final rule mandating that everyone covered by the Health Insurance Portability and Accountability Act (HIPAA) must implement ICD-10 for medical coding on **October 1, 2013**.

On this date medical coding in U.S. health care settings will change from ICD-9 to ICD-10. The transition will require business and systems changes throughout the health care industry. Everyone who is covered by HIPAA must make the transition, not just those who submit Medicare or Medicaid claims.

BILLING ADULT INFLUENZA AND PNEUMONIA IMMUNIZATIONS

The Division of Medicaid (DOM) is continuing efforts to educate Medicaid providers and beneficiaries on the benefits of receiving influenza and pneumonia immunizations. DOM encourages providers to assist in the effort to increase influenza and pneumonia protection in the State.

Injectable Flu and Pneumonia Immunizations for Adult Beneficiaries Age 19 and Over

Physician, nurse practitioners, and physician assistants will be reimbursed for seasonal flu and pneumonia vaccines administered to beneficiaries age 19 and over as indicated below:

- For beneficiaries receiving injectable immunizations only, the provider may be reimbursed for CPT code 99211, the seasonal flu and/or pneumonia vaccine code(s), and the appropriate vaccine administration code(s).

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- For beneficiaries who are seen for evaluation or treatment in addition to receiving these injectable immunizations, the provider should bill the appropriate CPT evaluation and management code, the flu and/or pneumonia vaccine code(s), and the appropriate vaccine administration code(s).

- Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) providers will be reimbursed according to their encounter payment method.

Intranasal Flu Immunization for Adult Beneficiaries Age 19 and Over

- Mississippi Medicaid will reimburse for the Flu Mist influenza vaccine when given to beneficiaries ages 19 through 49, but will receive no separate administration fee for administration of this vaccine.

Flu and Pneumonia Vaccine and Administration Fees

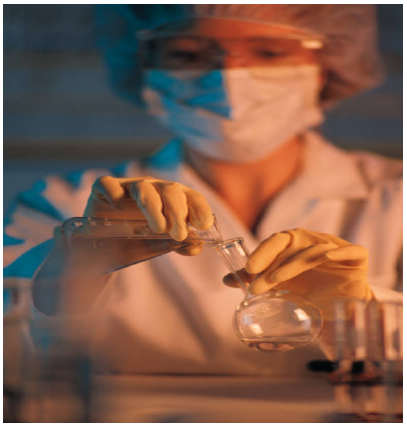
Reimbursement rates effective July 1, 2011, for vaccines and administration for beneficiaries age 19 and older are as follows:

Influenza Vaccines					Pneumonia Vaccines		Administration Fee	
Code	**Fee**		**Code**	**Fee**	**Code**	**Fee**	**Code**	**Fee**
90656	$12.38		Q2036	$8.78	90669	$95.48	90471	$19.64
90658	$11.37		Q2037	$13.65	90732	$57.19	90472	$9.94
90660	$22.32		Q2038	$13.31				

Reminder: All flu and pneumonia immunizations for children age 18 and younger must be handled through the Vaccines for Children Program (VFC) and are subject to Medicaid policies in the Provider Manual, Section 77.

INPATIENT INDEPENDENT LABORATORY SERVICES

Independent Laboratory services performed for beneficiaries during an inpatient hospital stay are not reimbursed by the Mississippi Division of Medicaid. The Inpatient Hospital Policy, Section 25.37 of the Medicaid Provider Manual, states that the per diem rate received by the hospital covers all services provided during the inpatient stay. Reimbursement for Independent Laboratory services must be obtained from the hospital. Edit 0125 has been implemented to deny these services when provided in place of service 21 (Inpatient Hospital). Claims for dates of service beginning April 1, 2010, will be reprocessed for incorrect payment. Watch for Late Breaking News on the Mississippi Envision Web Portal located at http://msmedicaid.acs-inc.com.



Inpatient Hospital Services and MississippiCAN

Inpatient hospital services are carved out of the MississippiCAN program. Hospitals must request inpatient certification from HealthSystems of Mississippi (HSM) for inpatient hospital stays for all Medicaid beneficiaries including MississippiCAN beneficiaries. All inpatient hospital stays are reimbursed by the Division of Medicaid (DOM). However, the MississippiCAN coordinated care organizations (CCOs), Magnolia Health Plan and UnitedHealthCare, are responsible for discharge planning as well as the professional charges associated with the inpatient stays for MississippiCAN beneficiaries.

HSM provides, to the CCOs, a daily report of admissions, concurrent reviews and discharges for MississippiCAN beneficiaries. However, the only clinical information provided by HSM to the CCOs is the admitting diagnosis. DOM is requesting that hospital staff cooperate with the CCOs by providing the necessary clinical information for continuity of care for MississippiCAN beneficiaries. At a minimum, this information should include the discharge diagnosis and medications. It is not a HIPAA violation for hospitals to provide information to the CCOs.

If you have any questions regarding this article, please contact Sheila Meadows or Jakki Andrews in the Bureau of Care Coordination at 601-359-3789.

MississippiCAN Provider Networks

On January 1, 2011, the Division of Medicaid implemented a new program, MississippiCAN, and contracted with two coordinated care organizations (CCOs) – Magnolia Health Plan and UnitedHealthcare. These plans are responsible for providing services to Mississippi Medicaid beneficiaries enrolled in the program.

Both Magnolia and UnitedHealthcare are actively contracting with Mississippi Medicaid providers for their provider networks. MississippiCAN allows beneficiaries enrolled in the program to receive medically necessary enhanced Medicaid benefits. More providers in the networks allows for improved access to care. Therefore, DOM is encouraging ALL providers to participate.

Beneficiaries enrolled in MississippiCAN are required to see providers who are in the CCO networks. Out-of-network providers that treat MississippiCAN enrollees without CCO authorization may not be paid. If you have not contracted with the CCOs and are interested in participation, you may contact them at the numbers below:

Magnolia Health Plan 866-912-6285
UnitedHealthcare 877-743-8731

For more details on the MississippiCAN program, please go to the Medicaid website at www.medicaid.ms.gov and look for the MississippiCAN link. You may also contact our MississippiCAN staff at 601-359-3789.

Billing for Psychiatrists Treating MississippiCAN Beneficiaries

Psychiatrists providing services to MississippiCAN beneficiaries in an inpatient or outpatient setting should bill the Division of Medicaid, regardless of the code billed, for date of service on and after July 1, 2011. All providers should bill the appropriate code for the service provided. It is acceptable for psychiatrists to bill E&M codes if that is the service, which has been provided.

2012 CPT & HCPCS CODE UPDATE

The Health Insurance Portability and Accountability Act (HIPAA) requires providers to bill with current transaction code sets. The annual update of the CPT and HCPCS codes is scheduled to be completed by January 1, 2012. In the event that the update is not completed, claims billed with new codes will deny for Exception Code 0430. **However, please do not resubmit the denied claims.** There will be an automatic reprocessing of these claims when the update is completed. Remember to retain your previous books, as they may be needed when reconciling older claims.

Change in Open-ended Approval Dates for Orthodontic Services

Orthodontic prior authorizations are no longer approved with an open-ended date of 12/31/9999. This change became effective on October 1, 2011. Orthodontic prior authorizations are now approved for three years from the original approval date. Providers will have to provide justification of medical necessity to the Division of Medicaid for prior authorizations to extend beyond the three years.

Providers should review Section 11.18 of the Provider Manual prior to requesting prior authorization for Orthodontic services for Medicaid beneficiaries.

Radiographs Submitted by Dental Providers

When submitting radiographs with a request for prior authorization via mail, the films must be properly mounted, marked R (right) and L (left) and stapled to the authorization request form. The dentist's name, the beneficiary's name and the date taken must be on the film to ensure proper identification. Radiographs will be returned to the provider if they are legibly labeled with the dentist's name, address.

When submitting radiographs with a request for authorization via the web, the dentist's name, the beneficiary's name and the date taken must be on the film to ensure proper identification.

Refer to section 11.05 of the Provider Policy Manual regarding this and all Dental issues.

Dear MS Cool Kids (EPSDT) Provider:

Requests for extended visits for beneficiaries under 21 may be submitted electronically for easier processing and to save time. The processing and approval turnaround time for a Prior Authorization (PA) request is 14 days. Provider and beneficiary Medicaid ID numbers are already conveniently programmed in the system. Submission of your PA request over the web will serve as your electronic signature. The system automatically assigns a PA number once you submit your request in the system. Providers should check the Envision Web Portal within 14 days of submission for an approved or denied status.

If you are interested in submitting PAs electronically through the Web Portal, the following steps can guide you to successful submission.

- Go to the Envision website at: https://msmedicaid.acs-inc.com/msenvision
- Log on. **If you do not have a password, click on the Web registration tab below the login and register.**
- Click on the provider tab
- Click on Prior Authorization
- Click on Enter a PA request
- Click on MS Cool Kids (EPSDT)
- Enter the Provider number and Beneficiary number. (At this point, the system will automatically assign the PA number. Please retain this number, as it will be needed to check the status of the PA request.

If you are not sure if the child has had a screening, you should check service limits by calling the Automated Voice Response System (AVRS), checking the Web Portal, or calling ACS at 1-800-884-3222. A primary diagnosis code, date of service and procedure code must be entered to continue with submission of the request. If the child is scheduled for another visit, the same steps must be followed; however, an addendum should be requested. This will allow the same PA number to be used for that beneficiary. Entering the child's Medicaid number in the system will confirm if a PA already exists for the beneficiary.

If you have any questions, please call Stacey Bogan at 601-359-2046.

Preventive Screenings for Adolescents: We Need Your Help

The Division of Medicaid (DOM) is requesting your assistance in encouraging your adolescent clients to receive an annual EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) comprehensive health physical examination.

The ***Mississippi FY 2010 CMS-416: Annual EPSDT Participation Report*** revealed that the screening ratios of adolescents' age 12 – 20 years are still far below the CMS universal compliance screening ratio standard of 80%. ***Our average is a dismal 25%.*** All other ages of the state continue to either surpass the 80% universal compliance ratio requirement or were within its reach. The above age groups' screening ratios lowered the State's total overall ratio to a respectable 64%.

It is widely known that adolescents are generally healthy. However, adolescence is usually the time period that most chronic conditions manifest. It is also during this time period when significant health risks such as drug use/experimentation, unprotected sex, unhealthy eating habits, and other physically dangerous behavior may occur.

Fortunately, for all Medicaid-eligible children and adolescents 21 years and under, the federally mandated EPSDT benefit requires an annual screening examination, which includes:

- A comprehensive health and developmental history/assessment
- An unclothed physical examination
- Appropriate immunizations
- Age appropriate laboratory tests
- Adolescent counseling
- Health education, including anticipatory guidance
- Vision, hearing and dental screen

The EPSDT benefit allows early identification of health problems and the assurances that diagnostic and treatment services, which are medically necessary to treat a condition identified during the screen, must be covered by the Medicaid program to the extent that federal Medicaid law allows.

Since the EPSDT screening service is ***not mandatory***, and the majority of Medicaid–eligible adolescents only see their primary care providers when sick, 75% of them are not taking advantage of this very important preventive health service as revealed on the CMS-416 annual utilization report. Various initiatives have been implemented in past years to increase the number of eligibles receiving EPSDT screening services. These initiatives include more publicity with the statewide DOM/ACS provider educational outreach workshops, the Mississippi Cool Kids naming of the EPSDT benefit with the **Cool *Bumblebee mascot and Bee Cool slogan***, increasing of the EPSDT provider reimbursement rates, the implementation of the Mississippi Department of Education Registered Nurse School - run alternative screening facility sites located throughout the state, and the easy accessible provider website to print the Cool Kids (EPSDT) screening provider participation application, EPSDT age appropriate screening medical chart documentation forms, policy manual, periodicity and billing schedule, etc. Because of these added efforts, DOM has successfully been able to meet or surpass the CMS 80% universal screening ratios compliance standard for age groupings under 9. It is Medicaid's goal to screen all eligible beneficiaries, and with your assistance in making sure your adolescent clients are screened, we will be successful in achieving that goal.

The Mississippi Childhood Lead Poisoning Prevention Program (CLPPP) revises the Blood Lead Screening Summary

The Mississippi State Department of Health's Childhood Lead Poisoning Prevention Program (CLPPP) has revised the Blood Lead Screening Summary and it is now referred to as the Blood Lead Screening and Healthy Homes Summary. The revised summary, will not only identify children ages 6 to 72 months that may be at high risk for lead poisoning, but additionally, serves as a risk screening tool for identifying hazards within the child's home that may affect his/her health.

Medicaid providers should utilize the revised summary focusing on questions 1 – 7 for blood lead risk screening and testing. Questions 8 – 11 pertain to Healthy Housing issues only and will determine if there are hazards in the child's home that may affect the child's health. The particular responses to questions 8 - 11 should guide the provider regarding health education and anticipatory guidance.

The Blood Lead Screening and Healthy Homes Summary can be obtained by calling the Mississippi State Department of Health Lead Program at 601-576-7447. It is also available on the Division of Medicaid's website at www.medicaid.ms.gov. Once on the homepage click on providers then click on forms. Scroll down to Blood Lead Screening and Healthy Homes Summary.

Mississippi Ranked Number One in Vaccine Rates!!! July 2009-June 2010

Mississippi received the award for the highest estimated vaccine coverage for children aged 19-35 months based on a recent National Immunization Survey (NIS) sponsored by the Centers for Disease Control and Prevention (CDC). The NIS is a telephone survey that began data collection in April 1994 to monitor childhood immunization coverage. In the survey conducted from July 2009 to June 2010, Mississippi had an estimated vaccine coverage rate of 81.1% (compared to the national average of 71.5%) for the 4:3:1:0:3:1:4 series (*Haemophilus influenzae* type b (Hib) vaccine is excluded from the estimate due to a recent shortage). The 4:3:1:0:3:1:4 series includes: four or more doses of DTaP vaccine, three or more doses of poliovirus vaccine, one or more doses of MMR, three or more doses of hepatitis B vaccine, one or more doses of varicella vaccine, and four or more doses of pneumococcal vaccine. Mississippi was also recognized as being the state with the most improved vaccine rates. In the NIS for the same time period in 2008-2009, Mississippi ranked 18th with an estimated rate of 72.5% (compared to the national average of 70.9%). The full 2009-2010 survey is available on the NIS website month at: http://www.cdc.gov/vaccines/stats-surv/nis/default.htm#nis. Previous surveys dating back to 1994 are also available at the same website.

This article was written courtesy of Dr. Byers, State Epidemiologist

Bridge to Independence: *The pathway to supported community living*
Division of Medicaid ramps up outreach efforts

The Division of Medicaid kicked off its outreach campaign on Oct. 1, 2011, to educate consumers, providers, caregivers, facility staff, agency partners, policymakers, and others about **Bridge to Independence**, a program designed to enhance community-living options for older adults (65+) and persons with disabilities.

Medicaid is committed to engaging stakeholders and ensuring that information about the program is communicated to interested parties across the state. Bridge to Independence staff have visited consumer groups, providers, and facilities and hosted a conference call Nov. 1, 2011, with nursing facilities. The purpose of the outreach campaign is to provide education, answer questions and collect feedback and suggestions that will lead to a stronger program.

To schedule a visit with Bridge to Independence staff or for more information call 601-359-5241 or e-mail B2I@medicaid.ms.gov.

What is Bridge to Independence?

Bridge to Independence is Mississippi's six-year Money Follows the Person initiative, a federal grant funded by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). Bridge to Independence seeks to remove barriers to community living and rebalance Mississippi's long-term care delivery system.

Bridge to Independence offers 365-day transitional services such as housing start-up costs, transportation, extended pharmacy benefits, and safety planning to qualified individuals who transfer out of a nursing home or intermediate care facility for persons with intellectual and developmental disabilities.

Bridge to Independence is for older adults (65+) and persons with intellectual and development disabilities or mental illness who have lived at least 90 days in a qualified facility. At least one of those days must be Medicaid paid.

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 quarterly Mississippi Medicaid Bulletins

PHARMACY PERMIT RENEWAL UPDATE

The Division of Medicaid (DOM) has been notified that the Board of Pharmacy is encountering delays processing bi-annual pharmacy permit renewals. Pharmacies enrolled in the MS Medicaid program must be in good standing with their regulatory authority to be a Medicaid provider. Due to the delay with the permit renewal process at the Board of Pharmacy, DOM will extend the deadline for submission of updated permit renewals from December 31, 2011, to January 31, 2012. This extension will allow MS Medicaid pharmacy providers to continue to provide services for MS Medicaid beneficiaries.

Please note that once the Board of Pharmacy is current in issuing permits, DOM will verify that all Medicaid enrolled pharmacies have provided a copy of their updated pharmacy permits to update their files. DOM will recoup monies paid during this grace period for those pharmacy providers without a valid pharmacy permit during January 2012.

To ensure your MS Medicaid provider file is updated; please follow the instructions below as soon as you get your updated Board of Pharmacy permit.

Fax the following to ACS' Provider Enrollment at 601-206-3015:

- Cover sheet to include the following:
  - Provider name
  - MS Medicaid provider number(s)
  - NPI(S)
  - Servicing pharmacy location email address
  - Telephone number
  - Facsimile number

- Copy of the renewed license/permit for the Board of Pharmacy

If you encounter problems faxing documents, please call ACS at 1-800-884-3222. Do not fax these documents to DOM as they will be returned to you and not ACS.

Preferred Drug List for January 1, 2012

The Division of Medicaid's Preferred Drug List (PDL) is updated twice annually on January 1st and July 1st. Changes to DOM's PDL will be effective on January 1, 2012. To view the PDL changes, please refer to the Provider Notice posted on under Pharmacy News on the Pharmacy Services' webpage. For a comprehensive list of the PDL including the January 2012 changes, go to DOM's website at http://www.medicaid.ms.gov/, next select Pharmacy Services and then go to the menu on the right-hand side of the page and select PDL.

Additions to the PDL include the class of prenatal vitamins. Please refer to the Pharmacy Services' webpage and PDL for specific preferred products.

Pharmacy Prior Authorizations

Many prior authorizations received by the Pharmacy PA Unit are for a product on the Preferred Drug List where the preferred agent is a brand name and the generic alternative is being billed. Some examples are:

Drug class	Preferred Agent	Non-preferred generic
Acne medications (Limited to up to age 21 only)	BenzaClin® Retin A-Micro®	Clindamycin/benzoyl peroxide Tretinoin
Alzheimer's agents	Aricept®	donepezil
Low molecular weight heparins	Lovenox®	Enoxaparin
Ophth. Allergic Conjunctivitis	Optivar®	azelastine
PPI	Prevacid® SoluTab	Lansoprazole solutab
Stimulants	Adderall XR®	Amphetamine salt combo. ER

SYNAGIS SEASON, 2011-2012

The Mississippi Division of Medicaid supports the administration of Synagis® for children meeting the American Academy of Pediatrics Redbook 2009 criteria for RSV immunoprophylaxis. Up to a total of five doses will be allowed per beneficiary. In accordance with AAP revised guidelines, some beneficiaries may be approved for a maximum of three doses, depending upon gestational and/or chronological age. Synagis® prior authorization criteria and forms may be found at www.medicaid.ms.gov/pharmacy.aspx, go to Prior Authorization, and select Synagis® 2011-2012 PA form and criteria. These procedures are the same as the 2010-2011 season. PA requests for beneficiaries enrolled in MississippiCAN are to be submitted to the respective PBM and not to the Division of Medicaid.

Medicaid and MississippiCAN Pharmacy PA contact information

Payer	Provider Phone number	Beneficiary contact information
MS Medicaid Pharmacy PA	**1-877-537-0722; 601-359-6685; Fax 1-877-537-0720**	**1-800-421-2408; 601-359-6050**
MSCAN: Magnolia Pharmacy Help Desk	PBM is US Script, Inc. **1-800-460-8988**	**1-866-912-6285 or 601-863-0700**
MSCAN: UnitedHealthcare Pharmacy Help Desk	PBM is Prescription Solutions **1-877-305-8952**	**1-877-743-8731**

***Keep in mind that MississippiCAN claims and PA requests must be submitted to the respective PBM. Submitting claims and/or prior authorization requests to MS Medicaid, rather than to the respective plan, delays the process for providers, beneficiaries and Medicaid.

OVER THE COUNTER (OTC) FORMULARY

Some former preferred legend prescription products have moved from legend to OTC status. ***If an OTC product is not listed on DOM's OTC formulary, it is not covered.*** For a comprehensive listing of the OTC formulary, go to www.medicaid.ms.gov/Pharmacy.aspx and select OTC formulary.

The HIPAA NCPDP Version D.0 Compliance Date Is Fast Approaching!

The mandatory compliance date for National Council for Prescription Drug Programs (NCPDP) version D.0 for retail pharmacies is January 1, 2012. HIPAA Version D.0 is the new NCPDP standard for Interactive Pharmacy Claims, and will replace Version 5.1. According to the Centers for Medicare & Medicaid Services (CMS) guidelines, NCPDP 5.1 transactions submitted on and/or after January 1, 2012 will reject. Be mindful that since non-D.0 claims are not in a HIPAA compliant format, such claims will not be processed and/or paid.

Mississippi Medicaid's claims processor, ACS, began NCPDP D.0 testing with pilot test pharmacies in June 2011, and implemented a pilot program of dual processing with both 5.1 and D.0 production claims August 2011. Dual processing was opened up for all pharmacies November 2011.

Pharmacy providers are not required to test and do not require certification. If a provider wishes to test, please contact your switch vendor, or Mississippi Medicaid's claims processor, ACS, at 800-884-3222.

Payer Sheets for NCPDP version D.0 are available on the Mississippi Division of Medicaid website ***http://www.medicaid.ms.gov/Pharmacy.asp.***

Medicaid Cough and Cold Quick List

Medicaid covers these over-the-counter (OTC) drugs pursuant to a written/verbal/electronic prescription

This list is subject to revision

Class	Generic	Strength	Common Brand Names	Dosage Form	Age				Rx/OTC Status
					<2	2-<6	6-<12	>12	
1st Generation Antihistamines and Combinations	Brompheniramine/Phenylephrine	1-2.5mg/ 5mL	Dimetapp Cold & Allergy Elixir	Liquid		✓	✓	✓	OTC
	Brompheniramine/Phenylephrine/ DM	1-2.5-5mg/ 5mL	Dimetapp DM Cold & Cough Elixir	Liquid		✓	✓	✓	OTC
	Brompheniramine/ Pseudoephedrine†	1-15mg/5mL	Q-Tapp	Liquid		✓	✓	✓	OTC
	Brompheniramine/ Pseudoephedrine/ DM†	1-15-5mg/ 5mL	Q-Tapp DM	Liquid		✓	✓	✓	OTC
	Chlorpheniramine	2mg/5mL, 4mg	Aller-Chlor Syrup, Tabs	Syrup, Tablets		✓	✓	✓	OTC
	Clemastine Fumarate	1.34mg	Tavist	Tablet			✓	✓	OTC
	Diphenhydramine	12.5mg/5mL,25mg, 50mg	Benadryl	Capsule, Elixir, Liquid, Solution		✓	✓	✓	OTC
	Triprolidine/ Pseudoephedrine†	1.25-30mg/ 5mL, 2.5-60mg	Aprodine	Syrup, Tablet		✓	✓	✓	OTC
2nd Generation Antihistamine Combinations	Cetirizine	1mg/mL, 5mg, 10mg	Zyrtec	Chewable Tab, Tablets, Syrup	✓	✓	✓	✓	OTC/Rx
	Cetirizine/ Pseudoephedrine†	5mg/120mg	Zyrtec-D 12 hour	Extended Release Tab				✓	OTC
	Loratadine	5mg/5mL, 5mg, 10mg	Claritin	Chewable Tab, Syrup, Reditab, Tablet		✓	✓	✓	OTC
	Loratadine/ Pseudoephedrine†	5-120mg, 10-240mg	Claritin-D 12 & 24 hour	Extended Release Tab				✓	OTC
Antitussives & Combinations	Benzonatate	100mg, 200mg	Tessalon	Capsules			**>10**	✓	Rx
	Dextromethorphan HBr	7.5mg/5mL, 15mg/5mL	Robitussin Pediatric Cough, Tussin Liquid	Liquid		✓	✓	✓	OTC
	Dextromethorphan HBr/ Phenylephrine	5-2.5mg/5mL	Triaminic Cold & Cough Liquid	Liquid		✓	✓	✓	OTC
	Dextromethorphan HBr/ Pseudoephedrine†	7.5-15mg/5mL	Triaminic Cough-Nasal Congestion	Syrup		✓	✓	✓	OTC
	Dextromethorphan Polystirex	30mg/ 5mL	Delsym	Suspension		✓	✓	✓	OTC
Expectorants & combination	Guaifenesin	100mg/5mL, 200mg/5mL	Robitussin, Diabetic Tussin Mucous Relief	Liquid	✓	✓	✓	✓	OTC
	Guaifenesin/ Codeine‡	100mg/10mg/5mL	Guaifenesin AC Cough Syrup	Liquid		✓	✓	✓	OTC
	Guaifenesin/ Dextromethorphan	100-10mg, 200-10mg/5mL	Robitussin DM, Robitussin DM Max	Liquid		✓	✓	✓	OTC
	Guaifenesin/ Phenylephrine	50-2.5, 100-5mg/5mL	Rescon GG, Triaminic Chest-Nasal Congestion	Liquid		✓	✓	✓	OTC
	Guaifenesin/ Pseudoephedrine/ Codeine†	100-30-10mg/5mL	Cheratussin DAC Syrup	Liquid		✓	✓	✓	OTC
Decongestants	Phenylephrine Oral	2.5mg/5mL, 10mg	Children's Sudafed PE, Contact D Cold	Liquid, Tablet		✓	✓	✓	OTC
	Pseudoephedrine†	15mg/5mL, 30mg/5mL, 30mg	Children's Sudafed Syrup, Sudagest, Sudafed	Syrup, Tablet		✓	✓	✓	OTC
Nasal Solutions	Oxymetazoline Nasal Solution	0.05%	Afrin, Sinex 12 hour Decongestant	Spray			✓	✓	OTC
	Phenylephrine Nasal Solution	0.125%, 0.25%, 0.5%, 1%	Little Noses Decongestant, Neo-Synephrine Mild Nasal, 4 Way	Drops, Spray	✓	✓	✓	✓	OTC
	Sodium Chloride Nasal Solution	0.2%, 0.65%, 0.9%	Ayr, Ocean	Drops, Spray	✓	✓	✓	✓	OTC

† Classified as Schedule III controlled substance in MS. Federally classified as OTC product and remains covered, pursuant to a prescription.
‡ Classified as Schedule V controlled substance in MS. Federally classified as OTC product and remains covered, pursuant to a prescription.

Last Revised: November 15, 2011

Reflects medically-accepted indications as determined by drug compendia and clinical literature, and not exclusively for FDA-approved ages. Use clinical judgment. www.msdur.org

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http://msmedicaid.acs-inc.com

Happy Holidays from ACS, A Xerox Company…

December 2011

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 *"ACS & DOM closed"*	24
25 *"Merry Christmas"*	26 *"ACS & DOM closed"* CHECKWRITE	27	28	29 **EDI Cut Off 5:00 p.m**	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.