Volume 18, Issue 2 June 2012

MS Medicaid Provider Bulletin

Mississippi Division Of MEDICAID

MississippiCAN Improves the Lives of Mississippians with Chronic Health Care Needs

The 2012 Mississippi Legislature took an important step toward improving the lives of Mississippians with chronic and acute health care needs by expanding the number of Medicaid beneficiaries who may participate in coordinated care programs.

"We think coordinated care is a way to improve quality and at the same time decrease costs, the emphasis being on improving quality of health care," said Dr. David Dzielak, Executive Director of the Mississippi Division of Medicaid.

The Mississippi Coordinated Access Network, known as MississippiCAN, is a coordinated care program that began January 1, 2011. MississippiCAN enrollees may choose between DOM's two Coordinated Care Organization (CCO) partners, Magnolia Health Plan and UnitedHealthcare.

The changes to Medicaid's coordinated care programs as stated in House Bill 421:

- Increases from 15% to 45% the percentage of Medicaid beneficiaries who may enroll in coordinated care programs such as MississippiCAN.
- Ensures that the medical decisions of hospital physicians or staff regarding patients admitted to a hospital cannot be overridden by the program.
- Mandates that the program may not have a prior authorization program for prescription drugs that is more stringent than the prior authorization process used by DOM.
- Requires the program to maintain a preferred drug list that is no more stringent than the mandatory preferred drug list established by DOM.
- Ensures that beneficiaries with hemophilia have access to the federally funded hemophilia treatment centers as part of the Medicaid coordinated care network of providers.

Additionally, House Bill 421:

- Authorizes implementation of All-Patient Refined-Diagnostic Related Group (APR-DRG) reimbursement methodology for inpatient hospital services.

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- Authorizes implementation of an ambulatory patient classification (APC) methodology for outpatient hospital services.
- Extends the authority of the Division of Medicaid through July 1, 2013.

Every day in every corner of the state, MississippiCAN helps people manage their acute and chronic health care conditions. UnitedHealthcare was recently able to assist a 14-year old MississippiCAN member suffering from extensive vitiligo, a skin condition that results in the loss of brown pigmentation, especially in the facial area.

The member was emotionally affected by this disorder and depressed to the point of having suicidal thoughts. The dermatologist ordered a UV light machine for prolonged home therapy to reduce the progression of the disease. UnitedHealthcare's case manager coordinated with the Durable Medical Equipment provider to obtain the UV machine for the child.

"Mississippi Medicaid participants now have unprecedented access to health professionals to provide assistance with scheduling of primary care provider appointment, locating specialists, enrolling in disease/case management, and accessing other community-based resources," said Christopher E. Johnson, M.D., interim Chief Medical Officer for Mississippi UnitedHealthcare.

By targeting high-risk, high-cost beneficiaries, DOM is attempting to better predict and manage costs by focusing on those beneficiaries who represent the greatest challenge and greatest expense to the State.

Currently, the targeted high-cost Medicaid beneficiaries covered in this program are beneficiaries in the following eligibility groups:

- SSI recipients
- Disabled child at home
- Working disabled
- Department of Human Services Foster Care
- Breast/cervical group

DOM strongly believes that coordinated care leads to improved health outcomes, and that adhering to coordinated care principles creates an environment where it is possible to make decisions about the program and about patient care that are fiscally responsible, but also in the best interests of beneficiaries.

This translates to providing the most appropriate service, at the right time and in the most appropriate location. DOM will continue monitoring to ensure that patient interventions are based on the most up-to-date industry best practices and clinical practice guidelines.

The bottom line: the CCOs and DOM share a common goal – to improve health outcomes for MississippiCAN beneficiaries.

While the program has built momentum gradually, Dr. Dzielak forecasts increased beneficiary and provider participation in the program. DOM has heard the concerns voiced by providers and is continuously working to find solutions that strengthen the program, he said.

DOM and the CCOs are working together to inform existing providers, including out-of-state providers from bordering states, about the benefits of the program for the providers and their patients.

Magnolia Health Plan Chief Medical Director Jason B. Dees, D.O., FAAFP, said his company is a proud to partner with the Division of Medicaid to improve the lives of MississippiCAN members.

Individuals enrolled in the program not only have complex medical needs, but often have other non-health care needs that affect their ability to remain healthy. This Winter, Magnolia Health Plan was contacted by a member with multiple chronic conditions who needed assistance with heating his trailer.

The oven, which had been his main source of heat, had stopped working. Magnolia's program specialist enlisted the help of United Community Action Agency, who agreed to pay for 200 gallons of propane gas which provided the member with safe and appropriate heating. However, the cost of installation and set-up remained. Magnolia paid these costs and provided the member with a Connections Plus cell phone so that Magnolia's specialist could coordinate via cell phone with the member.

"I am amazed that with just one call to Magnolia Health plan you got me heat and a phone," the member relayed to Magnolia.

"Magnolia's goal is to provide added value to the healthcare landscape in Mississippi. Our team of nurses, social workers, care managers, pharmacists, and physicians are here to help the provider community as you provide direct care to our members. If we can help you improve the lives of Magnolia members please reach out to us," Dr. Dees said.

"As of May 1, 2012, there were 49,341 individuals enrolled in the program. Legislative authority to expand the program will have far-reaching effects on quality of care and service costs for people living in the community," Dr. Dzielak said. It may allow for the expansion of new populations such as expectant mothers.

The MississippiCAN program connects the targeted beneficiaries with a medical home, increasing access to

providers and improving beneficiaries' use of primary and preventative care services. Quality of care is improved by providing systems and supportive services, including disease state management and other programs that allow beneficiaries to take increased responsibility for their health care.

Expansion of MississippiCAN is one of the primary components of DOM's efforts to increase coordinated care efforts, but it is not the only effort.

Other related programs that aim to make Mississippians healthy through coordinated care include incentives for providers who embrace electronic health records. The Medicaid Electronic Health Records (EHR) Incentive Program is a federally legislated program that provides financial incentives to eligible Medicaid health care providers who adopt, implement, or upgrade to a certified electronic health records system.

"It really complements what coordinated care organizations are trying to do," said Mr. Will Crump, DOM's Deputy Director of Health Services. "Electronic records assist case managers in making sure a patient follows directives of the medical provider and ensures that the medical record tells the whole story."

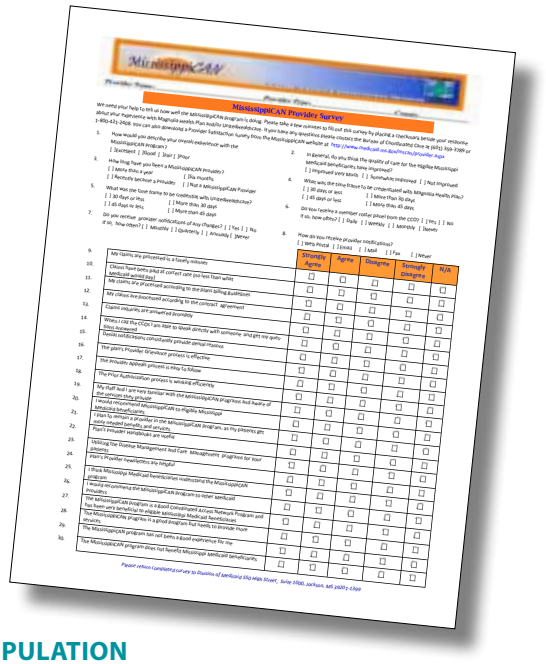
DOM also is in the process of designing a patient-centered medical home model that works for the State. The medical home concept will provide an important "whole-person" care option for people with complex medical needs, especially individuals with chronic physical conditions and mental illness.

"We cannot ignore one for the other," Dr. Dzielak said. While there are great models in other states from which we can learn, Mississippi needs a unique model to address its unique health concerns.

MississippiCAN Member Satisfaction Survey Results

The two Coordinated Care Organizations (CCOs) for the MississippiCAN program, Magnolia Health Plan and UnitedHealthcare, conducted member satisfaction surveys reflecting the first six months of the MississippiCAN program. The survey tool used by both organizations, Consumer Assessment of Healthcare Providers and Systems (CAHPS®), is a national standardized tool which allows for benchmarking across health care settings. The Agency for Healthcare Research and Quality (AHRQ) developed the tool working with a national team of public and private research organizations.

Both health plans were impressed with the number of responses received from members. Magnolia Health Plan and UnitedHealthcare are pleased to share some results of this first survey conducted August-November 2011, and would like to thank Mississippi Medicaid providers for the services provided to keep members safe and healthy.



CHILDREN-GENERAL POPULATION

Question	Magnolia Health Plan	UnitedHealthcare	Compared to Public Reporting
How Well Doctors Communicate	88.5%	88.6%	90.6%
Rating of Your Personal Doctor	84.5%	84.7%	84.7%

ADULTS

Question	Magnolia Health Plan	UnitedHealthcare	Compared to Public Reporting
How Well Doctors Communicate	88.6%	90.5%	87.7%
Rating of Your Personal Doctor	84.0%	83.2%	76.4%

FROM THE DESK OF

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

DAVID J. DZIELAK, Ph.D.
EXECUTIVE DIRECTOR

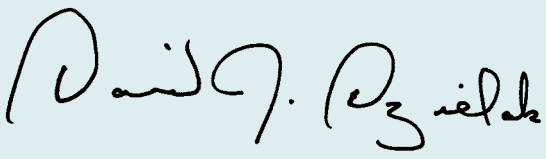
Dear Providers,

To improve quality of care and control costs, we must increase coordinated care programs for people with multiple and complex health care needs to better serve them in the community. The Division of Medicaid is seeking to expand coordinated care programs, but we cannot realize this goal without your participation. I humbly ask for your support to build a stronger, better health care system for Mississippians in need.

This is a very important time for Mississippi in regards to development of coordinated care programs. The 2012 Mississippi Legislature expanded the number of Medicaid beneficiaries who may participate in the Mississippi Coordinated Access Network program that you know as MississippiCAN. Passage of House Bill 421 expanded from 15% to 45% the percentage of overall Medicaid beneficiaries who may participate in coordinated care programs.

The Mississippi Legislature, via House Bill 421, allows for inpatient hospital service to be paid by MississippiCAN plans, while maintaining hospital physicians' final authority on decisions regarding their patients, and guaranteeing that Upper Payment Limit (UPL) payments to hospitals will not be reduced. DOM will engage affected providers in the coming months to build consensus around implementation of these important program enhancements. As you know, MississippiCAN is a new program that began January 1, 2011. We have heard your concerns, and we are continuously working to build a stronger coordinated care program that encourages provider participation.

Thank you for joining us on this important journey to better the lives of Mississippians through coordinated care initiatives. Together, we can build a healthier Mississippi.



CALLING ALL NEW PROVIDERS!!!

IT'S WORKSHOP TIME!!!

2012 PROVIDERS WORKSHOPS

xerox

The Division of Medicaid along with Xerox State Healthcare, LLC will host a series of workshops for all "New Providers." The workshops are scheduled for June 26th– June 28th and August 9th-August 23rd.

Date/Time	Location
June 26th, 2012 9:00am -4:00pm	Holiday Inn 280 Marathon Way Southaven, MS 38671
June 27th, 2012 9:00am -4:00pm	Hilton Garden Inn Tupelo 363 East Main St. Tupelo, MS 38804
June 28th, 2012 9:00am -4:00pm	Hilton Garden Inn Meridian/Renaissance Center 109 US Hwy 11 & 80 Meridian, MS 39301
August 9th, 2012 9:00am -4:00pm	Holiday Inn Gulfport North 9515 Highway 49 Gulfport, MS 39503
August 16th, 2012 9:00am -4:00pm	Hattiesburg Lake Terrace Convention Center One Convention Center Plaza Hattiesburg, MS 39401
August 23rd, 2012 9:00am -4:00pm	Jackson Medical Mall Foundation 350 W. Woodrow Wilson, Suite 107 Jackson, MS 39213

Registration starts at 8:30 a.m., and the workshop begins at 9:00 a.m. Space is limited. Please RSVP by June 18, 2012 & August 2, 2012 indicating which workshop you will be attending.

FAX RSVP'S TO XEROX STATE HEALTHCARE, LLC

ATTN: Provider/Beneficiary Services

At 601-206-3119

Or the Call Center
At
1-800-884-3222

You may also call or email

Amy R. Burns

at 601-206-3028

email: amy.burns@acs-inc.com

Session Topics

- **The overall Medicaid Program**
- **Mississippi Division of Medicaid Website**
- **HealthSystems of Mississippi Website**
- **Mississippi Envision Web Portal**
- **Medicaid Resources for Providers**
- **Medicaid Programs, Eligibility, & Beneficiary Responsibilities**
- **Medicaid Acronyms**
- **How to file claims to Mississippi Medicaid**
- **Claim Processing**
- **Medicaid Remittance Advice**

MISSISSIPPICAN SATISFACTION SURVEY

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

DAVID J. DZIELAK, Ph.D.
EXECUTIVE DIRECTOR

MississippiCAN Provider Satisfaction Survey
The Mississippi Coordinated Access Network (MississippiCAN) is a statewide coordinated care program designed to *improve beneficiaries access to needed medical services, improve the beneficiaries quality of care and improve efficiencies and cost effectiveness*.

Dear Medicaid Providers,

The Division of Medicaid (DOM), Bureau of Coordinated Care, is conducting a MississippiCAN provider survey. We are soliciting the input and opinion of our providers. The DOM believes your opinion and feedback can assist us with the improvement and quality of the MississippiCAN program.

We realize that this survey will take you a few minutes to complete, but each question is important. The time you invest in completing this survey will aid the DOM to identify specific areas for improvement and make positive changes, enabling both Magnolia Health Plan and UnitedHealthcare to serve you better and more efficiently regarding medical management decisions. We ask that you please complete and return the survey to us by mail or you can complete the survey on the MississippiCAN website at http://www.medicaid.ms.gov/mscan/Provider.aspx.

The DOM encourages you to complete this important survey because your feedback is valuable to us. We thank you for your time and assistance. If there are any questions, please contact the Bureau of Coordinated Care at 601- 359-3789 or 1 -800- 421-2408.

Division of Medicaid

The Bureau of Coordinated Care

MississippiCAN

Mississippi Division Of Medicaid

Mississippi Coordinated Access Network

Provider Name:_____ **Provider Type:**_____ **County**_____

MississippiCAN Provider Survey

We need your help to tell us how well the MississippiCAN program is doing. Please take a few minutes to fill out this survey by placing a checkmark beside your response about your experience with Magnolia Health Plan and/or UnitedHealthcare. If you have any questions please contact the Bureau of Coordinated Care at (601) 359-3789 or 1-800-421-2408. You can also download a Provider Satisfaction survey from the MississippiCAN website at http://www.medicaid.ms.gov/mscan/provider.aspx

1. How would you describe your overall experience with the MississippiCAN Program?
   [ ]Excellent [ ]Good [ ]Fair [ ]Poor

2. In general, do you think the quality of care for the eligible Mississippi Medicaid beneficiaries have improved?
   [ ] Improved Very Much [ ] Somewhat Improved [ ] Not Improved

3. How long have you been a MississippiCAN Provider?
   [ ] More than a year [ ]Six months
   [ ] Recently became a Provider [ ] Not a MississippiCAN Provider

4. What was the time frame to be credentialed with Magnolia Health Plan?
   [ ] 30 days or less [ ] More than 30 days
   [ ] 45 days or less [ ] More than 45 days

5. What was the time frame to be credential with UnitedHealthcare?
   [ ] 30 days or less [ ] More than 30 days
   [ ] 45 days or less [ ] More than 45 days

6. Do you receive a member roster panel from the CCO? [ ] Yes [ ] No
   If so, how often? [ ] Daily [ ] Weekly [ ] Monthly [ ]Never

7. Do you receive provider notifications of any changes? [ ] Yes [ ] No
   If so, how often? [ ] Monthly [ ] Quarterly [ ] Annually [ ]Never

8. How do you receive provider notifications?
   [ ] Web Portal [ ] Email [ ] Mail [ ] Fax [ ] Never

		Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
9.	My claims are processed in a timely manner	☐	☐	☐	☐	☐
10.	Claims have been paid at correct rate (no less than what Medicaid would pay)	☐	☐	☐	☐	☐
11.	My claims are processed according to the plans billing guidelines	☐	☐	☐	☐	☐
12.	My claims are processed according to the contract agreement	☐	☐	☐	☐	☐
13.	Claims inquiries are answered promptly	☐	☐	☐	☐	☐
14.	When I call the CCOs I am able to speak directly with someone and get my questions answered	☐	☐	☐	☐	☐
15.	Denial notifications consistently provide denial reasons	☐	☐	☐	☐	☐
16.	The plan's Provider Grievance process is effective	☐	☐	☐	☐	☐
17.	The Provider Appeals process is easy to follow	☐	☐	☐	☐	☐
18.	The Prior Authorization process is working efficiently	☐	☐	☐	☐	☐
19.	My staff and I are very familiar with the MississippiCAN programs and aware of the services they provide	☐	☐	☐	☐	☐
20.	I would recommend MississippiCAN to eligible Mississippi Medicaid beneficiaries	☐	☐	☐	☐	☐
21.	I plan to remain a provider in the MississippiCAN program, as my patients get more needed benefits and services	☐	☐	☐	☐	☐
22.	Plan's Provider Handbooks are useful	☐	☐	☐	☐	☐
23.	Utilizing the Disease Management and Care Management programs for your patients	☐	☐	☐	☐	☐
24.	Plan's Provider newsletters are helpful	☐	☐	☐	☐	☐
25.	I think Mississippi Medicaid beneficiaries understand the MississippiCAN program	☐	☐	☐	☐	☐
26.	I would recommend the MississippiCAN program to other Medicaid Providers	☐	☐	☐	☐	☐
27.	The MississippiCAN program is a good Coordinated Access Network Program and has been very beneficial to eligible Mississippi Medicaid beneficiaries	☐	☐	☐	☐	☐
28.	The MississippiCAN program is a good program but needs to provide more services	☐	☐	☐	☐	☐
29.	The MississippiCAN program has not been a good experience for me	☐	☐	☐	☐	☐
30.	The MississippiCAN program does not benefit Mississippi Medicaid beneficiaries	☐	☐	☐	☐	☐

Please return completed survey to Division of Medicaid 550 High Street, Suite 1000, Jackson, MS 39201-1399

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IN BRIEF

Family Planning Waiver Transitions to Regional Offices

Effective April 1, 2012, eligibility determination for the Family Planning Waiver transitioned from the Bureau of Medical Services, formerly the Bureau of Maternal Child Health (MCH), to the Medicaid regional offices. Family Planning Waiver applications and inquiries should be directed to the appropriate regional office for processing. Providers may request applications from ACS by calling 1-800-884-3222.

DOM Helps Kick the Habit

Tobacco use can lead to nicotine dependence and serious health problems. According to the CDC, nicotine dependence is the most common form of chemical dependence in the United States.

To help beneficiaries break free from nicotine dependence, the following smoking cessation drugs are covered:

- Over the counter nicotine products
- Legend or prescription nicotine replacement products
- Bupropion hydrochloride
- Varenicline tartrate

REMINDERS

Leave Clear Messages for Field Reps

In order to return calls in a timely manner, Provider Field Representatives request providers leave the following information in the call-back message:

- Caller's first and last name;
- Telephone number including the area code;
- Medicaid provider number; and
- A brief description of the nature of the call.

Dental Prior Authorization Request Submission Instructions

Non-orthodontic and unspecified procedures requiring prior authorization under the dental program must be submitted via the Envision web portal or on the Dental Services Authorization Request form (MA-1098).

The Dental Services Authorization Request form (MA-1098) is a four (4) part carbonless form. The provider must mail at least 2 parts of the form (DOM and provider pages marked on the bottom of the form) to the address below. DOM will retain one page and the other will be returned to the provider to be placed in the beneficiary's record.

DIVISION OF MEDICAID
Bureau of Medical Services
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201-1399

The Dental Services Authorization Request form is ordered from ACS at (601) 206-2900.

Questions and inquiries should be directed to the Mississippi Division of Medicaid, Bureau of Medical Services' Dental Program at (800) 421-2408 ext. 95139.

Bridge to Independence Referrals Can Be Made at Any Time

Bridge to Independence (B2I) is a new program operated by the Mississippi Division of Medicaid that helps qualified individuals of nursing homes and ICFs/MR move to homes in the community. Self-referrals can be made at any time. More information on program requirements and forms for making self-referrals are available at: http://www.medicaid.ms.gov/News/Bridge%20to%20Independence.pdf

Billing Tips to Avoid Duplicate Claims

The Division of Medicaid along with Xerox State Healthcare, LLC have noticed a pattern in duplicate claims submitted by providers.

"Filing claims multiple times can be considered abuse."

To ensure that each claim is paid in a timely matter, we want to give you a few simple tips to avoid needless denials.

- Bill all procedures/services provided on the same date of service on one claim.
- Bill for multiple units of the same procedure code with the appropriate modifier (if applicable) on the same claim line if more than one unit of the same procedure/service is provided on the same date of service.
- Do not bill the same procedure code on separate claim lines for the same date of service.
- Separate claims for the same date of service are only necessary if all claim lines have been used.
- Once a claim has been billed, do not re-bill the same claim.
- If all claim lines on the claim are paid, billing the same claim again will result in a denial for duplicate services and may be **considered fraud**.
- If some claim lines are paid but one or more claim lines are denied, do not re-bill the same claim or the denied claim lines. Re-billing the claim or claim lines will not reverse the denial. The claim will deny as duplicate procedures.
- The edit messages listed at the bottom of the remittance advice explains the reason the claim lines denied. Refer to Medicaid's Administrative Code, Billing Manual, and fee schedules for detailed information about what services and procedure codes are covered and applicable service limits.
- Contact the Contact the Xerox Call Center at 1-800-884-3222 if a claim line was possibly denied in error. The ACS staff will review the claim, explain the reason for the denial and, if appropriate, give instructions how to reverse the denial and receive payment.

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.

NEWS

Vaccines for Children Claims Processing Procedure Changes

In compliance with the 2011 Code Update American Medical Association (AMA), DOM's claims processing procedures were recently modified for immunization administration (IA) codes:

- 90460
- 90461

This change allows reporting of each vaccine antigen/component separately. Codes 90460 and 90461 may now be reported in addition to vaccine/toxoid code(s) 90474-90749. The aforementioned codes may now be billed multiple times by the Vaccines for Children (VFC) provider for a beneficiary on a single date of service without resulting in a duplicate edit or denial of the claim. The DOM claims system allows IA code 90460 (with EP modifier) to be reported for the first antigen/component of each vaccine administered (single or combination) with a payment of $10.00. CPT code 90461 (with EP modifier) may be reported for each additional antigen/component in a given vaccine with a payment of $0.00.

The DOM claims processing procedures for the IA codes 90471 and 90473 were also modified to be in compliance with the 2009 Code Update AMA changes. The mandate indicates the two codes should no longer be billed together. The National Correct Coding Initiative (NCCI) edits recent mutually exclusive ruling, also mandated certain codes cannot be billed simultaneously by a provider for a beneficiary on a single date of service.

The NCCI edits also impacted the maximum number of units of service allowable by a provider for a beneficiary on a single date of service. As a result of these mandates, IA code 90472 when billed with five (5) or greater units will post NCCI Exception Edit 6560 (MUE Limit Exceeded) with a maximum of four (4) units for the code.

Although the VFC program permits payment for both immunization administration code sets at the same dollar amount, VFC providers are encouraged to use IA codes 90460 and 90461 in lieu of 90471-90474 to avoid posting of the NCCI edits causing the denial of the claim(s).

DOM Posts Administrative Code/ Provider Policy Manual Crosswalk

Effective April 1, 2012, in compliance with the Secretary of State mandate (Title 1, Part 1, Chapter 3, Rule 3.2) of the Administrative Procedures Act, the policies in the Division of Medicaid Provider Policy Manual were reformatted with no substantive changes.

All forms, tables, charts, contact information, web addresses, etc., were removed according to the reformatting requirements. An Administrative Code/Provider Policy Manual Crosswalk is available at http://www.medicaid.ms.gov/AdminCode.aspx referencing the sections of the old Provider Policy Manual to the Parts and Chapters of the Administrative Code Title 23.

A Provider Reference Guide will be posted on DOM's website which will include operating procedures such as billing instructions, office contacts, and deadlines. Providers are encouraged to download pertinent sections of the old Provider Policy Manual as it will be no longer be accessible via the website.

For more information, please call the Division of Medicaid Policy, Planning and Development at 601-359-5241.

Guidelines for Billing Mental Health/Psychiatric Services for Group Therapy and Other 908XX Codes

Group Therapy:

Effective January 1, 2012, two (2) services in group psychotherapy may be eligible for reimbursement on any given day when the following criteria are met:

- Two (2) distinct sessions, each having mutually exclusive goals and objectives, are provided, **AND**
- Two (2) sessions per day are medically necessary, **AND**
- Two (2) sessions per day are appropriate and in accordance with the standards of medical practice, **AND**
- Documentation in the clinical record substantiates that the above criteria were met.

When billing for two (2) distinct group therapy sessions, use modifier 59 on the line.

Correct Billing: Group Psychotherapy (90853) + Interactive Group Psychotherapy (90857)
Line item # 1: 90853 Modifier 59 1 Unit/Service
Line item # 2: 90857 Modifier 59 1 Unit/Service

or

Two (2) Group Psychotherapy sessions provided on same day by the same billing provider.
Line item # 1: 90853 Modifier 59 2 Unit/Service

Other 908XX Codes:

When more than one (1) psychotherapeutic service (908XX) is being billed by the same provider on the same date of service, claims that are submitted with two separate encounters of psychotherapy may deny because of National Correct Coding Initiative (NCCI) edits that are in place. In order to bypass these edits the provider is instructed to use modifier-59. Modifier-59 should not be used to bypass an NCCI edit unless the proper criteria are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier used.

Example: Individual Therapy (90804) and Family Therapy (90846) billed on the same day.

Line item # 1: 90804 Modifier 59
Line item # 2: 90846 Modifier 59

When billing the following code sets together for the same date of service modifier-59 is not required. These are:

90801 with 90804	90862 with 90808
90801 with 90806	90862 with 90847
90801 with 90808	90862 with 90849
90862 with 90804	90862 with 90853
90862 with 90806	90862 with 90857

If you have additional questions or concerns, please contact the Bureau of Mental Health Programs at 601-359-6630 or 601-359-6122.

PHARMACY

Notice about Pharmacy PA Forms

Approved PA Forms: Providers must use current pharmacy PA forms located on the DOM website at http://www.medicaid.ms.gov/PharmacyForms.aspx and fax to the pharmacy PA unit at 1-877-537-0720.

Since January 1, 2011, DOM's Pharmacy Prior Authorization (PA) program has been a function of DOM's Pharmacy Bureau. However, many providers continue to use former vendor's PA forms and submit PAs to obsolete fax numbers. PA submissions on unapproved DOM forms are no longer accepted.

Prescriber signature required: All PA and appeal/reconsideration forms must be signed by the ordering physician, nurse practitioner, or physician assistant. Submission of forms without the prescriber's signature will automatically void and deny the PA or appeal.

Prescribers are strongly encouraged to submit PA requests via the Envision Web Portal. Prescribers may designate office personnel as their surrogate to submit PA requests through the Web Portal. Web Portal instructions are located at https://msmedicaid.acs-inc.com/msenvision/pharmacyPriorAuthInstructionAction.do. If assistance is needed, contact ACS at 1-800-884-3222, select option 2 for Provider, then option 2 for Pharmacy.

Pharmacy Changes Effective July 1, 2012

Injectable Mental Health Drugs and Billing Changes
Since the following agents are administered in a clinical setting, effective July 1, 2012, injectable mental health drugs, including but not limited to antipsychotics and benzodiazepines, become solely a medical benefit and are to be billed as such. ***As of July 1, 2012, these drugs will be closed to Pharmacy Point of Sale (POS).***

The only exceptions are for Medicaid only beneficiaries residing in long-term care facilities such as nursing facilities (NF), intermediate-care facilities for the mentally retarded (ICFs/MR), and/or psychiatric residential facilities (PRTF). ***All pre-existing pharmacy prior authorizations for injectable antipsychotics and/or benzodiazepines, except for the aforementioned exceptions, become null and void as of close of business on June 30, 2012.***

Injectable antipsychotics include, but are not limited to:
- Abilify (aripiprazole),
- Compazine (prochlorperazine edisylate)
- Geodon (ziprasidone),
- Haldol Lactate and Haldol Deconate Decanoate (compare to haloperidol lactate and haloperidol decanoate),
- Invega Sustenna (paliperidone palmitate),
- Prolixin decanoate (fluphenazine Decanoate)
- Risperdal Consta(risperidone microspheres),
- Thorazine (chlorpromazine HCL),
- Zyprexa (olanzapine), and
- Zyprexa Relprevv (olanzapine pamoate).

Injectable benzodiazepines include, but are not limited to:
- Lorazepam (compare to Ativan), and
- Diazepam (compare to Valium).

ICD-9 Codes at Pharmacy Point of Sale (POS)
Effective July 1, 2012, the Division of Medicaid will accept specific ICD9 codes in the pharmacy point of sale (POS) system for:
- Xarelto—limited to ***hip replacement***
- Effient—limited to ***unstable angina***; ***STEMI*** (Segment Elevation Myocardial Infarction or heart attack), ***NSTEMI*** (Non-ST Segment Elevation Myocardial Infarction)
- Brilintia—limited to unstable angina; STEMI (Segment Elevation Myocardial Infarction or heart attack), or ***NSTEMI*** (Non-ST Segment Elevation Myocardial Infarction)

Prescriber must write the ICD code on the prescription. For the comprehensive list of validating ICD codes at POS, refer to Pharmacy Services' webpage at http://www.medicaid.ms.gov/Pharmacy.aspx, and select POS ICD-9 Codes. For other indications for the aforementioned drugs, please submit a PDL Exception Request or prior authorization.

To process a claim, the pharmacy is to use the following procedure:
(1) Submit the diagnosis code **(on RX)** in the field **Diagnosis Code (492-DO)**
(2) Submit qualifier **Diagnosis Code Qualifier (492-WE) = 01**

Field	Field Name	Values Supported
492- WE	Diagnosis Code Qualifier	Required when Diagnosis used. **01** = ICD9
492-DO	Diagnosis Code	Required when diagnosis is needed for designated drug coverage.

Preferred Drug List (PDL) Update

The Division of Medicaid's Preferred Drug List (PDL) is updated two times annually on January 1st and July 1st. The following changes will be made to the Preferred Drug List (PDL), effective July 1, 2012, following recommendation and/or approval by the P&T Committee, DOM, and DOM's Executive Director:

For a comprehensive list of the PDL including the July 2012 changes, go to http://www.medicaid.ms.gov/Pharmacy.aspx. DOM encourages providers to print a copy of the PDL and/or save to your desktop for easy reference.

NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	**RECOMMENDED for PREFERRED STATUS**
Anticoagulants	XARELTO (rivaroxaban)
Anticonvulsants	DIASTAT (diazepam rectal gel)
Anticonvulsants	VIMPAT (lacosamide)
Antiparasitics (Topical)	NATROBA (spinosad)
Bladder Relaxant Preparations	ENABLEX (darifenacin)
Bronchodilators, Beta Agonist	PROAIR HFA (albuterol)
Erythropoiesis Stimulating Proteins	ARANESP (darbepoetin)
Growth Hormone	NORDITROPIN (somatropin)
Hypoglycemics, Incretin Mimetics/Enhancers	TRADJENTA (linagliptin)
Hypoglycemics, Insulins and Related Agents	HUMALOG VIAL (insulin lispro)
Hypoglycemics, Insulins and Related Agents	HUMALOG MIX VIAL (insulin lispro/lispro protamine)
Hypoglycemics, Insulins and Related Agents	HUMULIN VIAL (insulin)
Intranasal Rhinitis Agents	ASTEPRO (azelastine)
Lipotropics, Statins	atorvastatin/amlodipine
Ulcerative Colitis Agents	mesalamine

NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	**RECOMMENDED for NON-PREFERRED STATUS**
Androgenic Agents	ANDRODERM (testosterone patch)
Angiotensin Modulators	COZAAR (losartan)
Angiotensin Modulators	EDARBYCLOR (azilsartan/chlorthalidone)
Antibiotics (GI)	DIFICID (fidaxomicin)
Anticonvulsants	diazepam rectal gel
Anticonvulsants	GRALISE (gabapentin)
Anticonvulsants	HORIZANT (gabapentin)
Anticonvulsants	LAMICTAL ODT (lamotrigine)
Anticonvulsants	LAMICTAL XR (lamotrigine)#
Anticonvulsants	ONFI (clobazam)

Antihistamines, Minimally Sedating and Combinations	XYZAL Tablets (levocetirizine)
Antiparasitics (Topical)	malathion
Antiparkinson's Agents	LODOSYN (carbidopa)
Beta Blockers	BYSTOLIC (nebivolol)*
Beta Blockers	DUTOPROL (metoprolol/HCTZ)
Bladder Relaxant Preparations	DETROL LA (tolterodine)
Bladder Relaxant Preparations	GELNIQUE (oxybutynin)
Bone Resorption Suppression and Related Agents	calcitonin salmon
BPH Agents	CIALIS (tadalafil)
BPH Agents	JALYN (dutasteride/tamsulosin)*
BPH Agents	tamsulosin
Glucocorticoids (Inhaled)	AEROBID (flunisolide)
Glucocorticoids (Inhaled)	AEROBID-M (fluisolide)
Glucocorticoids (Inhaled)	budesonide nebulizer solution
Glucocorticoids (Inhaled)	PULMICORT (budesonide) Flexhaler*
Hypoglycemics, Incretin Mimetics/Enhancers	BYDUREON (exenatide)
Hypoglycemics, Incretin Mimetics/Enhancers	JANUMET XR (sitagliptin/metformin)
Hypoglycemics, Incretin Mimetics/Enhancers	JENTADUETO (linagliptin/metformin)
Hypoglycemics, Incretin Mimetics/Enhancers	JUVISYNC (sitagliptin/simvastatin)
Intranasal Rhinitis Agents	VERAMYST (fluticasone)
Leukotriene Modifiers	ZYFLO CR (zileuton)
Lipotropics, Others	ANTARA (fenofibrate)
Lipotropics, Statins	CADUET (atorvastatin/amlodipine)
NSAIDs	DUEXIS (ibuprofen/famotidine)
Pancreatic Enzymes	PANCRELIPASE
PAH Agents – PDE5s	REVATIO (sildenafil)*
Phosphate Binders	calcium acetate
Phosphate Binders	PHOSLYRA (calcium acetate)
Platelet Aggregation Inhibitors	BRILINTA (ticagrelor)
Proton Pump Inhibitors	PREVACID SOLU-TAB (lansoprazole)**
Ulcerative Colitis Agents	PENTASA 500mg (mesalamine)
Ulcerative Colitis Agents	SFROWASA (mesalamine)

NEW THERAPUTIC CLASSES/DRUGS	
PREFERRED STATUS	**RECOMMENDED for NEW THERAPEUTIC CLASS**
NONE	

** Existing users will be grandfathered*
 # Grandfathered for seizure patients only
*** No PA required for age 12 and under*

PROVIDER COMPLIANCE

Reminders for Providers Submitting Paper Claims

Providers who submit paper claims are still encouraged to use the Envision Web Portal to access up-to-date information including eligibility verification, electronic report retrieval, and the latest provider updates.

"Paper clips and staples are prohibited when submitting paper claims."

The Web Portal is available at http://msmedicaid.acs-inc.com.

If claims must be submitted on paper, the CMS-1500 and UB04 claim forms must be:

- Submitted on the original red CMS-1500 or UB04 claim forms. No black and white or photocopied forms are accepted. This does not apply to Dental Claims, Crossover Claims, or UB Continuation Claims.
- Completed in blue or black ink without highlighting or use of correction fluid or correction tape.
- Clearly legible.
- Properly aligned with the required data printed in the designated fields.
- Signed. (Rubber stamps are acceptable)
- Submitted without medical record and other documentation unless specifically requested. (This does not apply to EOBs)

Failure to adhere to these guidelines may result in delays to claim payment or claim returns.

For more information, refer to section 2.0, 3.0, and 4.0 of the Medicaid Provider Billing Manual located at http://www.medicaid.ms.gov/BillingManuals.aspx.

DOM Initiates Overpayment Recovery Audit Program

On May 1, 2012, DOM initiated Mississippi's first centralized Overpayment Recovery Audit Program, a crucial step in promoting the continuance of a cost-effective and efficient Medicaid program.

Recovery audits will be performed on healthcare claims submitted by providers to the DOM for payment of healthcare services. All recovery audits will be performed in accordance with Mississippi's Medicaid billing policies and procedures as well as other applicable state and federal regulations that govern Medicaid billing.

DOM has contracted with PRGX USA, Inc., headquartered in Atlanta, GA. PRGX has over 40 years of audit experience in 39 states and more than 30 countries worldwide, serving various industries. This firm specializes in identifying overpayments and underpayments by utilizing their proven data mining tools and experienced audit professionals.

As a provider, you may receive medical record requests or other correspondence from PRGX Global, Inc. indicating that you are the subject of an audit. In the event you receive a letter, specific instructions on how to respond and who to contact will be contained in the body of the letter. We encourage providers to communicate the existence of this overpayment recovery program to affected staff to establish a better understanding of the importance of responding to requests and other correspondences in a time manner.

PERM Review Contractor Contacting Providers

The PERM Review Contractor, A+ Government Solutions, is in the process of contacting providers via telephone, fax, and/or mail requesting medical documentation for review to substantiate **claims paid in the federal fiscal year 2011 (October 1, 2010 to September 30, 2011)**.

CMS developed PERM to measure improper payments in the Medicaid and Children's Health Insurance Program (CHIP) by calculating error rates based on the reviews of

- Beneficiary Eligibility for both the Medicaid and CHIP programs,
- Coordinated Care payments, and
- Fee-for-service claim payments which includes medical review and data processing.

Health Data Insights (HDI), review contractor for A+ Government Solutions, is responsible for medical reviews but will not contact providers. Providers must submit to A+:

- Medical records within 75 days of the date of the request letter, and
- Additional medical documentation within 14 days of the date of the request letter.

Failure to comply within these time constraints will result is an automatic error and recoupment of paid claims.

Submit requested medical documentation to A+ via the toll free fax number 1-877-619-7850. If assistance is needed call 1-301-987-1100. For electronic submission of medical documentation (esMD), notify A+ prior to submission. For more information about esMD, refer to www.cms.gov/esMD.

Providers must also forward a copy of the requested medical information to DOM, attention Sharon Jones, to confirm documentation is complete to avoid error assignment and subsequent claims recoupment or repayment.

Sharon Jones is DOM's PERM representative and can be contacted at 601-359-6134, 1-800-421-2408 or Sharon.Jones@medicaid.ms.gov. For additional assistance please refer to http://www.medicaid.ms.gov/News/Payment%20Error%20Rate%20Measurement.pdf.

For more information about CMS's PERM program, refer to http://www.cms.gov/PERM.

ELECTRONIC HEALTH RECORDS (EHR)

EHR Accomplishments

Mississippi Medicaid has paid out over $56 million in Medicaid EHR incentive payments to eligible providers.

Provider Type	Provider Count	Payments Paid
Acute Care Hospitals	53	$37,490,025.52
Certified Nurse Midwife	6	$148,750.00
Dentist	26	$637,500.00
Nurse Practitioner	266	$6,672,500.00
Pediatrician	1	$14,167.00
Physician	593	$14,931,667.00
Physician Assistant practicing in an FQHC or RHC led by a PA	1	$21,250.00
TOTAL	**946**	**$59,915,859.52**

Data Reported 5/25/12

To date, more than 900 Eligible Physicians and Eligible Hospitals have received Medicaid EHR incentive payments by successfully adopting, implementing, or upgrading to a certified EHR system.

There is still time and opportunity for healthcare providers to apply for the EHR Incentive program for Year 2012 and begin the implementation of electronic health records. Start the process today. For more information on how you can receive EHR Incentive Payments go to http://ms.arraincentive.com.

EHR Meaningful Use

Are you a MEANINGFUL User of Electronic Health Records?

- Do you use certified EHR in a meaningful manner, such as e-prescribing?
- Do you use certified EHR technology for electronic exchange of health information to improve quality of health care?
- Do you use certified EHR technology to submit quality and other measures?

Then yes, you are a MEANINGFUL User of Electronic Health Records. **"Meaningful Use"** simply means eligible professional and eligible hospitals are using certified EHR technology to:

- Improve quality, safety, efficiency, and reduce health disparities

- Engage patients and family
- Improve care coordination, and population and public health
- Maintain privacy and security of patient health information

Please visit www.cms.gov for an overview of EHR Meaningful Use.

NEW Provider Enrollment Screening Regulations for Enrolling and Currently Active Medicaid Providers

The Division of Medicaid is in the process of implementing required enrollment and screening provisions of the Affordable Care Act (ACA) in an effort to prevent fraud, waste and abuse. The specific screenings to be conducted on enrolling and re-validating providers based on the assigned risk category will include but are not limited to:

- Fingerprinting
- Criminal background checks
- Unscheduled on-site visits
- Integrated database checks with state and federal agencies

Additionally, this Rule allows:

- An application fee be imposed on institutional providers and suppliers at initial enrollment
- A temporary moratoria be imposed if necessary, on high risk provider types,
- A provider maybe terminated if the provider has been terminated by Medicare, another Medicaid State program or the Children Health Insurance Program (CHIP), and
- A Provider's payments may be suspended during an investigation of pending credible allegations of fraud in the Medicare and/or Medicaid programs.

The Division of Medicaid's Provider Enrollment Division is working diligently to implement the required guidelines of this Final Rule. Please watch for upcoming communications on the DOM website and the Envision Web Portal concerning implementation of processes and policies relating to these guidelines. For in-depth details on this CMS Final Rule, please refer to the CMS website at www.cms.hhs.gov.

Newborn K-baby Temporary Medicaid ID

Beginning July 1, 2012, temporary Medicaid identification numbers will not be generated from a newborn's medical claims. Newborns medical claims with dates of service on or after July 1, 2012 that are billed with "K" after the mother's ID will be denied. Please see the Medicaid Provider Policy Manual, Section 25.08 for procedures on obtaining and completing the Application for Newborn Health Benefits Identification Number form. The provider should continue to verify a newborn's eligibility by using the mother's swipe card (enter mother's ID with "K" and baby's date of birth) or by calling 1-800-884-3222.

Note: This change does not apply to Pharmacy claims. Pharmacy claims will continue to process K-baby claims as they currently do.

EHR Workshops

The Medicaid EHR Team will be hosting a series of EHR Workshop in July. More information regarding the upcoming EHR workshops will posted on "Late Breaking News" at https://msmedicaid.acs-inc.com.

REMINDER TO ALL PROVIDERS

All providers are held accountable for information contained in the Mississippi Medicaid Provider Bulletins in accordance with Medicaid's Administrative Code.

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If you have any questions related to the topics in this bulletin, please contact Xerox at 1-800 -884 -3222

Mississippi Medicaid Administrative Code and Billing Manuals are on the Web
www.dom.state.ms.us

And Medicaid Bulletins are on the Web Portal
http://msmedicaid.acs-inc.com

DOM & Xerox State Healthcare, LLC., welcomes summertime…

JUNE 2012

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
				EDI Cut Off 5:00 p.m.	1	2
3	4 CHECKWRITE	5	6	7 EDI Cut Off 5:00 p.m.	8	9
10	11 CHECKWRITE	12	13	14 EDI Cut Off 5:00 p.m.	15	16
17	18 CHECKWRITE	19	20	21 EDI Cut Off 5:00 p.m.	22	23
24	25 CHECKWRITE	26 Provider Workshop Holiday Inn Southaven, MS	27 Provider Workshop Hilton Garden Inn Tupelo, MS	EDI Cut Off 5:00 p.m. 28 Provider Workshop Hilton Garden Inn Meridian, MS	29	30

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.