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MS Medicaid Provider Bulletin

Mississippi Division Of MEDICAID

Inpatient and Outpatient Cases Will Reward Hospitals and Curb Medicaid Cost, says Dr. Dzielak

DR. DAVID DZIELAK
Executive Director
MS Division of Medicaid

"Changes to the way hospitals are reimbursed for both inpatient and outpatient cases will reward hospitals and curb escalating Medicaid costs over the long haul associated with hospital payments," said Dr. David Dzielak, Executive Director of the Mississippi Division of Medicaid.

Allowing the same rate per procedure across hospitals for inpatient cases and a sum for outpatient cases determined by the complexity of the case will reverse a system that had been set up such that "efficient hospitals were being penalized and inefficient hospitals were being rewarded".

The new methodology for inpatient cases is based on the All Patient Refined-Diagnosis Related Groups. The new methodology for outpatient cases is based on Medicare's Outpatient Prospective Payment System. The payment method will utilize Medicare's Ambulatory Payment Classifications, Medicare fees, and Mississippi Medicaid fees.

With these changes, Dr. Dzielak said the agency is trying to make the payment methodology fairer for efficient hospitals while also "reducing the continuing escalation of costs that Medicaid has been experiencing in the last three years".

APR-DRG

Effective with first dates of service on or after October 1, 2012, Mississippi Medicaid will implement a new reimbursement methodology, which will be based on All Patient Refined-Diagnosis Related Groups (APR-DRGs). The new method will apply to inpatient care in all acute care hospitals, other than Indian Health Services, including general hospitals, freestanding mental health hospitals and freestanding rehabilitation hospitals. The following services provided by acute care hospitals are not affected by this new method: outpatient care, Medicare crossover claims, swing bed services, psychiatric residential treatment facilities and nursing facilities.

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The Division of Medicaid (DOM) will assign an APR-DRG to each Medicaid patient discharged in accordance with the APR-DRG grouper program version as developed by 3M Health Information Systems. The assignment of each APR-DRG is based on the ICD-9-CM principal diagnoses, all ICD-9-CM secondary diagnoses and all ICD-9-CM medical procedures performed during the beneficiary's hospital stay. For each APR-DRG, DOM determines a relative weight using a national scale from 3M that reflects the cost of hospital resources used to treat similar cases.

The importance of coding for APR-DRG

Severity adjusted methodologies require a comprehensive coding approach for successful implementation. The APR-DRG classification system utilizes many diagnosis and procedure codes and combinations thereof, to assign the most accurate APR-DRG and severity level to a claim. Every inpatient stay will be assigned to a single DRG that reflects the difficulty of that case. For example, a patient with pneumonia will be assigned to one DRG and a patient with pneumonia and heart failure will be assigned to a different DRG. For each stay, the DRG base payment equals:

Relative weight for that DRG x base price = DRG base payment

The first DRG would have a lower weight than the second DRG. Hospitals are, therefore, paid more for more difficult cases and less for less difficult cases. At the same time, payment does not depend on the hospital's charges or costs, so the hospital has an incentive to improve efficiency. It is important to use complete diagnosis and procedure coding on claims with first date of service on or after October 1, 2012.

Why change to APR-DRG?

The Division has five reasons.

- **Improve access to care.** Under the new method, the Medicaid payment for a particular inpatient stay will be closely tied to the acuity, or casemix, of the inpatient stay. Hospitals that take sicker patients can expect higher payments, which should improve access to care.
- **Increase fairness to hospitals.** Under the previous method, hospitals were often paid very different amounts for the care of very similar patients. Under the new method, all hospitals will be paid similarly for similar patients.
- **Reward efficiency.** Under the previous method, hospitals that became more efficient and decreased cost were penalized with lower payments. Under the new method, hospitals will receive a flat rate for each stay of a given casemix level. If they improve efficiency, they will keep the savings.
- **Improve purchasing clarity.** The new method will allow the Division clearer insight into the services being covered. Each stay is assigned to a single DRG with a single payment. DRGs are organized so that each DRG contains stays that are similar both clinically and in terms of hospital resources used.
- **Reduce administrative burden.** Under the previous method, delays and adjustments to cost reports and payment rates bedeviled financial planning for both the hospitals and the Division. After a patient was discharged, the hospital and the Division financial managers had to wait several years before payment for that specific stay was finalized. Under the new method, a hospital will receive final payment for a stay shortly after it submits a claim. In contrast, the previous method depended on the Division receiving audited hospital cost reports from Medicare contractors. These audited hospital cost reports under the APR-DRG payment methodology are no longer essential for timely final payments of hospital claims. The future accuracy and timeliness of these audits is in question because hardly any Medicare payment now depends on these audits.

Additional documents detailing the change to APR-DRGs are posted at http://www.medicaid.ms.gov.

Inpatient hospital provider WebEx training is planned for:
October 11, 2012 at 2:00 p.m.

For questions, please contact Karen Thomas, Division of Medicaid, 601-359-5186 or karen.thomas@medicaid.ms.gov.

OPPS

Mississippi Medicaid will implement a new reimbursement methodology for hospitals, which will be based on Medicare's Outpatient Prospective Payment System (OPPS). This payment method will utilize Medicare's Ambulatory Payment Classifications (APC), Medicare fees, and Mississippi Medicaid fees. Implementation will take place in two phases. Phase I, a fee schedule based on CPT and HCPCS codes, will be effective for claims with dates of service on or after September 1, 2012. Phase II will include multiple procedure reductions of significant procedures (status indicator "T") effective for claims with dates of service on or after December 10, 2012. The new method will apply to outpatient care in all acute care hospitals, including general hospitals, freestanding rehabilitation hospitals and long-term care hospitals. The following services are not affected: Medicare crossover claims and Indian Health Services (IHS).

The hierarchy of payment will be as follow:

- If there is a Medicare APC assigned to the code, the fee will be the Mississippi Medicaid conversion factor times the national APC weight times 90% times number of units (when applicable).
- If there is not an APC and a Medicare fee is available, the fee will be 90% of the Medicare fee times the number of units (when applicable).
- If there is not an APC nor a Medicare fee, the fee will be the Mississippi Medicaid fee times the number of units (when applicable). If a technical component or site-of-service differential are appropriate that fee will apply, otherwise the general Mississippi Medicaid fee will apply.

The Division of Medicaid, as required by State law, reduces the rate of reimbursement to providers for any service by five percent (5%) of the allowed amount for that service.

Emergency department services provided by hospitals, except for Indian Health Services, will be reimbursed using the outpatient prospective payment methodology. The Division of Medicaid uses the two (2) lowest emergency department evaluation and management code descriptions to determine non-emergent emergency department visits.

The importance of coding for OPPS

As with Medicare, all revenue codes, except 0250-0259, 0270-0279, 0370-0379 and 0710-0719 will now require appropriate CPT or HCPCS procedure codes. Lines without valid CPT or HCPCS codes will be denied. In addition, physician administered drugs for revenue code 0636 will require a National Drug Code (NDC). Lines with revenue codes that are inappropriate for outpatient claims will be denied.

Why change to a new outpatient payment method?

The Division has five reasons.

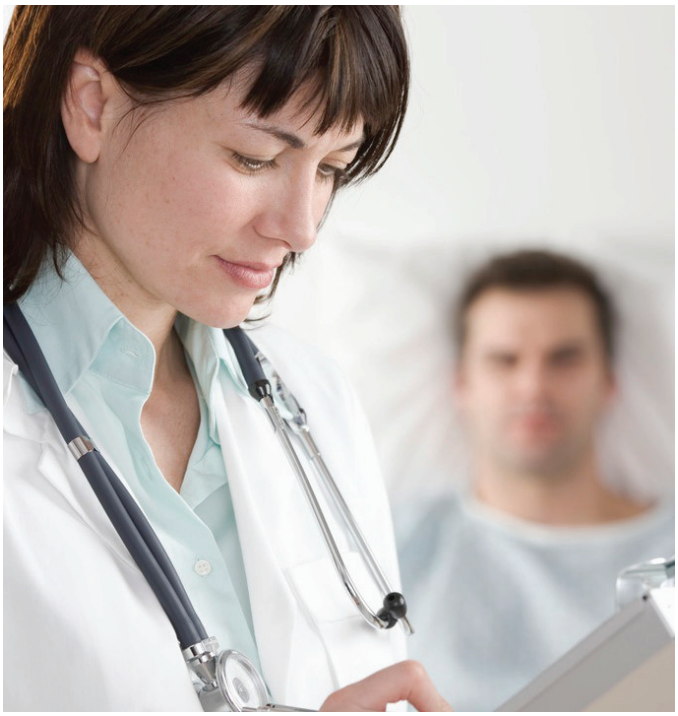
- **Reward efficiency.** Under the current method, hospitals that become more efficient and decrease their cost are penalized with lower payments. Under the new method, hospitals will receive a flat rate for each service. If they improve efficiency, they will keep the savings. (The new method, however, will continue to pay hospitals more when they increase the volume of services for a given condition.)
- **Reduce administrative burden.** Under the current method, delays and adjustments to cost reports and payment rates negatively impact financial planning for both the hospitals and the Division. Financial managers have to wait several years before outpatient payments are finalized. Under the new method, a hospital will receive final payment for a visit shortly after it submits a claim.
- **Reduce reliance on Medicare cost reports.** Under the current method, the lengthy cost report settlement process is burdensome for everyone. The current method depends on the Division receiving settled hospital cost reports from Medicare contractors. Federal contractors audit only 15% of reports, focusing on those areas that are important to Medicare payment. These areas may or may not include the cost centers that are important for Medicaid payments.

- **Improve purchasing clarity.** The new method will allow the Division clearer insight into the services being purchased. Because payment will be based on procedure codes, the Division will be better able to ensure that payment is being made for appropriate and covered services.
- **Increase fairness to hospitals.** Under the current method, hospitals are often paid very different amounts for very similar care. Under the new method, all hospitals will be paid similarly for similar care.

Additional documents detailing the change to outpatient payment methods are posted at http://www.medicaid.ms.gov.

Outpatient hospital provider WebEx training is planned for:
December 6-7, 2012 1st session at 10:00 a.m.
2nd session at 2:00 p.m.

For questions, please contact Zeddie Parker, Division of Medicaid, 601-359-6021, or zeddie.parker@medicaid.ms.gov.



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.

FROM THE DESK OF

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

DAVID J. DZIELAK, Ph.D.
EXECUTIVE DIRECTOR

How the Affordable Care Act can impact the DOM in Mississippi

What can the Patient Protection and Affordable Care Act, or ACA, mean for Mississippi Medicaid? Here's my take on it.

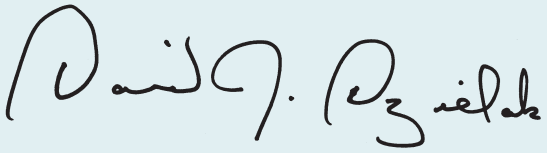
During fiscal year 2012, the DOM required $3.62 billion in federal funds and $763 million in state funds to directly administer our program. These figures don't include $210 million in funds used by other agencies, like the Department of Mental Health and the Department of Rehabilitation Services to meet their own Medicaid program responsibilities.

That means the conservative total cost to operate our Medicaid program in Mississippi during SFY 2012 was more than $4.38 billion as of July of this year. That is at least $3.62 billion in federal dollars, plus at least $973 million of state dollars for one year of DOM funding.

According to a report requested by the DOM, the total cost to the state to implement the ACA would be between $850 million and $1.6 billion over seven years, depending on participation.

This expansion could result in the state adding a projected 400,000 beneficiaries to the Medicaid rolls, resulting in one in three Mississippians being enrolled in Medicaid. As you would guess, there would be an increase in administrative costs estimated at $81 million over three years.

You will be the "front line" of this potential expansion, and I know you are aware of the impacts this expansion could have on Mississippi's health care system. So especially now, I am asking providers to continue to do what you do best. That is to stay focused on providing quality Medicaid services to our beneficiaries. The fluidity of the ACA situation will be successfully navigated by all of us if we remain focused on our primary purpose for being here.



ATTENTION: ALL PROVIDERS!!!

The MississippiCAN Workshops are coming your way….

SEPTEMBER 5, 2012 – OCTOBER 2, 2012 – FREE OF CHARGE

The Division of Medicaid, Bureau of Coordinated Care, in conjunction with Magnolia Health Plan and UnitedHealthcare, will conduct MississippiCAN Provider Workshops from **September 5, 2012 through October 2, 2012**. It is very important for you to attend these workshops as the following topics will be covered:

- Expansion of the MississippiCAN Program beginning December, 2012
- New Categories of Eligibility *(some are now mandatory)*
- Provider Enrollment and Service Limits
- Prior Authorizations and Claims Submission
- Pharmacy
- Covered and Non-Covered Services for MississippiCAN

The specific dates and times are as follows:

DATE/TIME	LOCATION
WEDNESDAY, SEPTEMBER 5, 2012 2:30 PM	NATCHEZ, MS – NATCHEZ CONVENTION CENTER 211 MAIN STREET NATCHEZ, MS 39120
MONDAY, SEPTEMBER 10, 2012 10:00 AM	GRENADA, MS – TAYLOR HALL 600 BUTLER STREET GRENADA, MS 38901
WEDNESDAY, SEPTEMBER 12, 2012 9:30 AM	SOUTHAVEN, MS – THE LANDER'S CENTER 4560 VENTURE DRIVE SOUTHAVEN, MS 38671
FRIDAY, SEPTEMBER 14, 2012 10:00 AM	GREENVILLE, MS – WILLIAM PERCY MEMORIAL LIBRARY 341 MAIN STREET GREENVILLE, MS 38701
TUESDAY, SEPTEMBER 18, 2012 9:30 AM	PASCAGOULA, MS – JACKSON COUNTY CIVIC CENTER 2902 SHORTCUT RD. PASCAGOULA, MS 39567
WEDNESDAY, SEPTEMBER 19, 2012 9:30 AM	GULFPORT, MS – HANDSBORO COMMUNITY CENTER 1890 SWITZER RD. GULFPORT, MS 39507
MONDAY, SEPTEMBER 24, 2012 2:30 PM	CORINTH, MS – CROSSROADS ARENA 2800 SOUTH HARPER ROAD CORINTH, MS 38834
WEDNESDAY, SEPTEMBER 26, 2012 9:00 AM	TUPELO, MS – BANCORPSOUTH ARENA 375 EAST MAIN STREET TUPELO, MS 38804
WEDNESDAY, SEPTEMBER 26, 2012 2:30 PM	STARKVILLE, MS – STARKVILLE SPORTSPLEX ACTIVITIES ROOM 405 LYNN LANE STARKVILLE, MS 39759
FRIDAY, SEPTEMBER 28, 2012 2:30 PM	MERIDIAN, MS – HOLIDAY INN 100 NORTH FRONTAGE ROAD MERIDIAN, MS 39301
MONDAY, OCTOBER 1, 2012 9:00 AM	JACKSON, MS – EAGLE RIDGE CONFERENCE CENTER 1500 RAYMOND LAKE ROAD RAYMOND, MS 39154
TUESDAY, OCTOBER 2, 2012 9:00 AM	HATTIESBURG, MS – JACKIE DOLE SHERRILL COMMUNITY CENTER 220 W. FRONT STREET HATTIESBURG, MS 39401

Space is limited! It is imperative that you **RSVP** indicating which workshop you will be attending.

Fax your RSVP To:
Xerox State Healthcare, LLC
ATTN: Provider/Beneficiary Services
601-206-3119

Or Workshop attendees may call or email Amy Burns at 601-206-3028 / amy.burns@xerox.com.

MississippiCAN

Provider Name _____

Date of Workshop _____

Location of Workshop _____

Number of Attendees _____

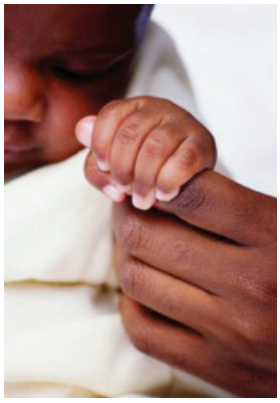
NEWS

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. The hospital must request a permanent ID by completing the "Application for Newborn Health Benefits Identification Number" form.

"The Application for Newborn Health Benefits Identification Number form is located on the Division of Medicaid website"

The "Application for Newborn Health Benefits Identification Number" form is located on the Division of Medicaid Internet website http://www.dom.state.ms.us/Provider/Newborns/newborns.html. To access the form, click on "Request for Newborn Health Benefits ID number form." The form can be saved and printed as a blank form or be completed interactively by tabbing to each text field. The form must be completed and signed by the mother prior to the mother's hospital discharge. All information on the form must be correct including the baby's name, date of birth and the hospital's fax number. The signed form should be faxed immediately to the Medicaid Regional Office in the county where mother and baby will reside. The regional office will fax the form back to the hospital within 7-10 days indicating the baby's permanent Medicaid ID number.



A newborn's eligibility can be verified by using the mother's swipe card (enter mother's ID with "K" and baby's date of birth), by calling the AVRS at 1-866-597-2675, by calling Provider and Beneficiary Services call center at 1-800-884-3222, or by accessing Mississippi Envision Web Portal http://msmedicaid.acs-inc.com.

For information on newborn payments for dates of service beginning October 1, 2012 under APR-DRG, refer to http://www.medicaid.ms.gov.

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

Notification of State Plan Amendments and/or Administrative Code Changes

If a provider or individual would like to be added to the distribution list for notification of approved State Plan Amendments and/or Administrative Code changes, please notify the Division of Medicaid at the appropriate e-mail addresses below.

State Plan Amendments – spa@medicaid.ms.gov
Administrative Code – admincode@medicaid.ms.gov

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
- 60461

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).

PROVIDER COMPLIANCE

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

The Division of Medicaid is continuously working to implement the required enrollment and screening provisions of the Affordable Care Act (ACA) in an effort to prevent fraud, waste and abuse. The Division of Medicaid has procured a vendor to facilitate the enrollment and screening requirements of the ACA Act. The specific screenings to be conducted on enrolling and re-validating providers based on the assigned risk categories are:

Limited Risk:

- Conduct license verifications including verifications across state lines
- Federal Database Checks (To confirm identity, NPI, and exclusion status of the provider, person(s) with an ownership or control interest or who is an agent or managing employee of the provider)

Moderate Risk:

- Conduct license verifications including verifications across state lines
- Federal Database Checks (To confirm identity, NPI, and exclusion status of the provider, person(s) with an ownership or control interest or who is an agent or managing employee of the provider)
- Unscheduled or unannounced site visits

High Risk:

- Conduct license verifications including verifications across state lines
- Federal Database Checks (To confirm identity, NPI, and exclusion status of the provider, person (s) with an ownership or control interest or who is an agent or managing employee of the provider)
- Unscheduled or Unannounced Site Visits
- Criminal Background Checks and Fingerprinting

Additionally, this Rule requires:

- All ordering or referring physicians or other professionals to be enrolled as a participating Medicaid provider. If referrals are made by non-enrolled providers, reimbursement for services rendered may be denied.
- An application fee be imposed on institutional providers and suppliers at initial enrollment, if applicable
- A temporary moratoria be enforced, if imposed by CMS
- A provider may be 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.

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.

Updated Provider Enrollment Application

The Mississippi Division of Medicaid (DOM) is in the process of revising our provider enrollment application. The updated applications should be available for use in the Fall of 2012.

Please watch for upcoming communications on the DOM website and the Envision Web Portal for the ***"go live"*** date and the discontinuation of the current Mississippi Medicaid Enrollment Application.

Attention EHR Providers

Providers please update your MS Medicaid Provider file when you **LEAVE**, **CHANGE** or **JOIN** a new group practice or clinic. By updating your provider file with the most current information, this will ensure that your EHR Incentive Payments will be deposited into the correct bank account.

The change of address form and direct deposit form may be found on our MS Medicaid website http://www.medicaid.ms.gov. Click on the Provider tab and click on forms.

For more information on how to update your MS Medicaid Provider file, please contact Xerox Provider Enrollment at 1-800-884-3222.

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.

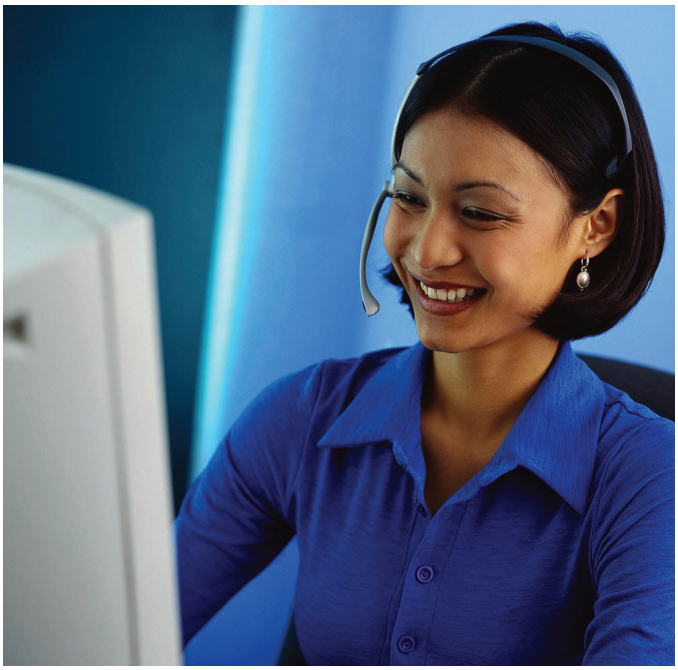
"Paper clips and staples are prohibited when submitting paper claims."

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 and Medicaid Part C 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.

******Note: This is a revised version to the previous article published in the June 2012 bulletin.***

EHR Incentive Payments and 1099 Forms

EHR Incentive Payments are made to the individual provider. Assignment of EHR payments is strictly voluntary. Ownership of the certified EHR software does not obligate a clinic or group to receive EHR Incentive Payments.

Question: If I am a physician practicing in a group and I assign my incentive payment to the group, who will receive the 1099?

Answer: The 1099 will be sent to the entity that received the payment based on the TIN reported at registration as the payee designee.

If Medicaid makes EHR Payment to the individual provider, the 1099 will reflect the social security number.

PHARMACY

DOM's PDL to Undergo Annual Review

Starting in 2012, DOM's Preferred Drug List (PDL) will undergo an annual review each autumn. The revisions brought about by this annual review will become effective the following January 1, with the first such update occurring on January 1, 2013. Throughout the year, there will be quarterly additions or deletions. Changes outside of the January 1st implementation annual review updates will generally be minimal. Providers are encouraged to monitor the DOM website frequently for advanced notice of these PDL updates.

Pharmacy Billing for Influenza and Pneumonia

In the MS Medicaid Pharmacy program, influenza and pneumonia immunizations are covered services for Medicaid beneficiaries ages 19 and older who are not residents of long-term care facilities. These are the only vaccines/ immunizations available via the Pharmacy Program. As with other pharmacy services, a hard copy prescription must be on file. Immunizations provided from a credentialed pharmacist will count against the service limits and co-payments are applicable. MS Medicaid reimburses for the drug's ingredient cost and pays a dispensing fee for immunizations administered in the pharmacy venue. No administration fee is paid for immunizations administered in the pharmacy venue.

All immunizations for children age 18 and younger must be handled through the Vaccines for Children Program

(VFC). For additional information regarding immunizations and Medicaid policies, refer to Title 23: Medicaid, Part 224 Immunizations of the Administrative Code, which may be found at http://www.medicaid.ms.gov/AdminCode.aspx.

Pharmacy Claims from Non-Enrolled Medicaid Providers to Deny

Effective October 1, 2012, pharmacy claims not affiliated with an active and accurate national prescriber identification (NPI) number linked to a MS Medicaid provider number will deny. The Affordable Care (AAC) requires that services provided to a Medicaid beneficiary must be provided and/or referred by a Medicaid provider. For additional information, on the AAC and this initiative, please refer to http://www.cms.gov/CMCSBulletins/downloads/6501-Term.pdf.

Using an incorrect/random NPI may be a fraudulent entry. It is considered a fraudulent act to knowingly submit a prescriber identification number, such as a NPI, another prescriber's identification number, or a pharmacy provider number, that does not belong to the provider who has written the prescription.

When a pharmacy is filling a prescription and the prescriber's identification number is not known or the number that pharmacy has does not work on the claim and the pharmacy inserts a random provider/NPI number into the required field, this is a fraudulent act. Entering the wrong prescriber's identification number is fraud. The pharmacy employee entering the wrong number has just committed a fraudulent act against MS Medicaid which could lead to sanctions against them and the company.

Synagis Season, 2011-2012

The Mississippi Division of Medicaid (DOM) supports the administration of Synagis® for children meeting the American Academy of Pediatrics (AAP) Redbook 2012 criteria for RSV immunoprophylaxis. Beginning October 22, 2012, prior authorization requests may be submitted to DOM's Pharmacy PA unit for administration starting on October 31, 2012.

Up to a total of five doses will be allowed per beneficiary. Be advised that in accordance with AAP's 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, go to Prior Authorization, and select Synagis® 2012-2013 PA form and criteria.

Keep in mind that PA requests for beneficiaries enrolled in MSCAN are to be submitted to the respective Pharmacy Benefit Manager (PBM) and not to Medicaid. Submission of PAs for MSCAN beneficiaries prolong the process and cause delays for both Medicaid fee for service and coordinated care beneficiaries.

Medicare Part D Changes and Medicaid Drug Coverage

The Centers for Medicare and Medicaid Services (CMS) recently announced that effective January 1, 2013, Part D plans will be required to make changes to Part D drug coverage and to include the benzodiazepine drug class in their formularies. Additionally, the barbiturate drug class will also be required to be included in formularies for the indications of epilepsy, cancer, or chronic mental health disorder.

Benzodiazepines:

- Since the benzodiazepine drug class becomes a mandatory Medicare Part D drug category on January 1, 2013, Medicaid will no longer cover benzodiazepine drugs for the dually eligible beneficiary.
- Any prior authorizations for the dually eligible beneficiary for benzodiazepines will be closed as of December 31, 2012.
- Medicaid coverage of benzodiazepines fee for service beneficiaries will not change.
- The benzodiazepine drug class is comprised of the following drugs: Ativan or lorazepam, Diastat/Valium or diazepam, Dalmane or flurazepam, Doral or quazepam, Halcion or triazolam, Klonopin or clonazepam, Librium or chlordiazepoxide, Restoril or temazepam, Serax or oxazepam, Tranxene or chlorazepate, and Xanax or alprazolam.

Barbituates:

- Since the barbiturate drug class becomes a mandatory Medicare Part D drug category on January 1, 2013 when used for epilepsy, cancer, or chronic mental health disorder, Medicaid will no longer cover barbiturates for these indications.
- For the full dually eligible, Medicaid will cover the barbiturates drug class excluding for epilepsy, cancer, or chronic mental health disorder indications.
- Any prior authorizations for the dually eligible beneficiary for barbiturates used for epilepsy, cancer, or chronic mental health disorder will be closed as of December 31, 2012.
- Medicaid coverage of barbiturates for the Medicaid fee for service beneficiaries will not change.
- Medicaid coverage of barbiturates is limited to phenobarbital and Mebaral.

It will be very important for the dual eligibles taking these drugs to be attentive when selecting plans during the annual renewal period in October 2012. Be advised that Part D coverage may differ from Medicaid's. Regardless, the benzodiazepine drug class will become a non-covered service for the dually eligible beneficiary and barbiturate coverage is limited to indications other than the Medicare Part D covered indications.

EPSDT Policy Change of Urinalysis (Dipstick) Screening

Currently, the EPSDT Screening Program requires routine urinalysis (dipstick) testing during each periodic well child screening visit beginning at age two (2) years. Federal regulations allow state Medicaid agencies to establish screening services after consultation with recognized medical

organizations. After consultation with medical providers and reviewing American Academy of Pediatrics (AAP) Guidelines, the Division of Medicaid has reconsidered the current EPSDT policy of requiring routine urinalysis screening on all children age two (2) and older as part of the EPSDT health screening visit. As of July 1, 2012, the Division of Medicaid will no longer require routine urinalysis screening for asymptomatic children as part of the EPSDT well child screening visit.

Help Slow Rising Prescription Costs

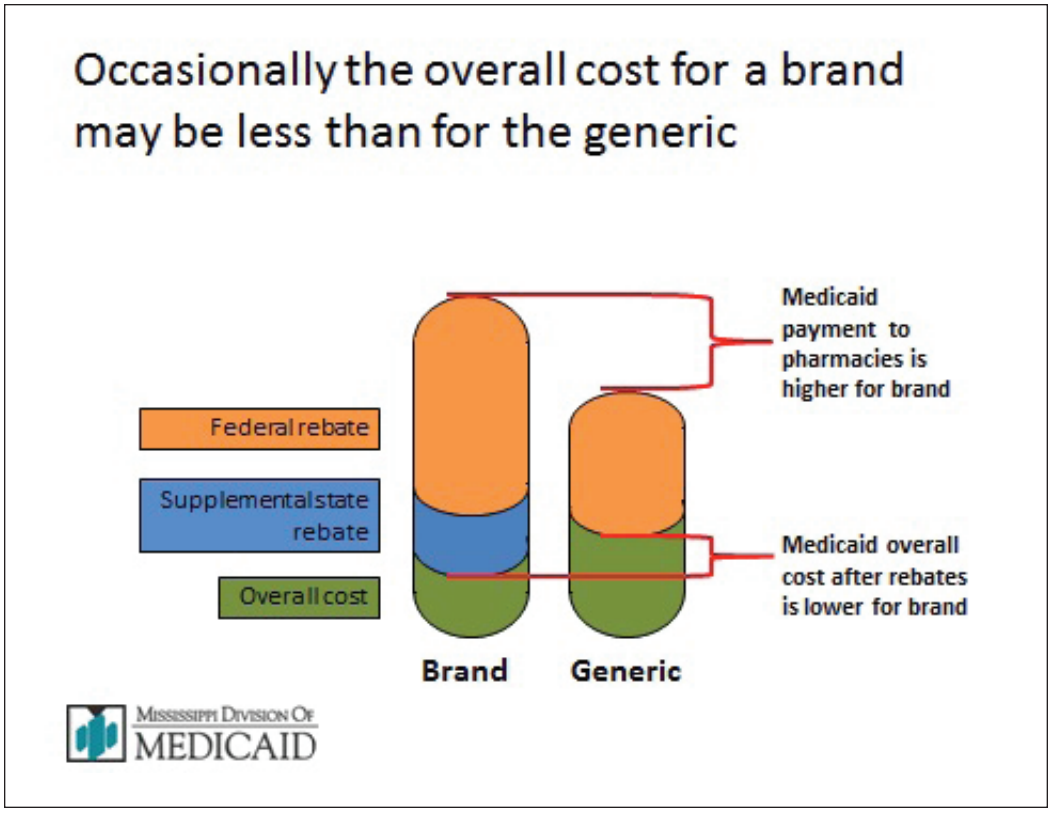
In order to slow rising drug costs, DOM's Pharmacy Program works to help improve quality and manage costs. In State Fiscal Year, 2011, Pharmacy expenditures for Medicaid were over $308.8M. Prescribers can help slow rising prescription costs in DOM's Pharmacy program by:

(1) Prescribing drugs on the Preferred Drug List (PDL): In SFY11, MS Medicaid collected over $10.5M for supplemental rebates for branded drugs on the PDL. Over $124M was collected for federal rebates for all brand and generic drugs dispensed in their pharmacy venue as well as for physician administered drugs.

Every time a prescription is written for a non-preferred PDL drug, MS Medicaid loses money.

(2) Being aware that sometimes generic drugs are more costly to Medicaid than their branded counterparts. In the commercial arena, generic drugs are inexpensive in relationship to the costs of its branded counterparts. Due to federal and supplemental rebates, sometimes branded products are less expensive than the generic. For a comprehensive list of the PDL, refer to Pharmacy Services' web page at http://www.medicaid.ms.gov/Pharmacy.aspx. DOM encourages providers to check the PDL routinely to stay current with preferred and non-preferred drugs.

Every time a non-preferred drug is prescribed and/or dispensed, MS Medicaid loses money.



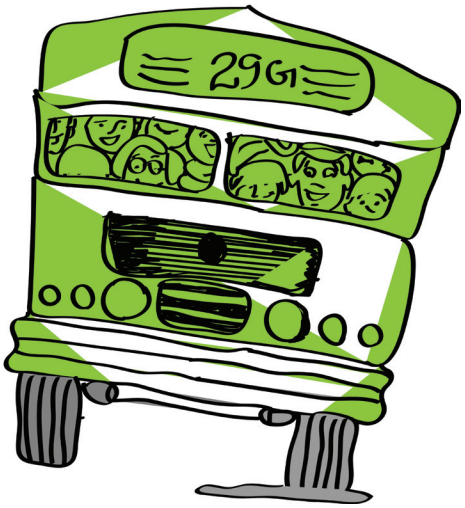
LONG-TERM CARE

Elderly and Disabled Waiver Homemaker Providers

The Division of Medicaid (DOM) has received approval from the Centers for Medicare and Medicaid Services (CMS) to continue the Elderly and Disabled (E&D) Waiver for another five years. DOM has made changes to the E&D Waiver which has been approved by CMS and will be implemented July 1, 2012. All changes will be transitioned slowly as to avoid any undue stress or interruption of services for our waiver participants. The Homemaker Service provider type will no longer be utilized under the E&D Waiver after July 1, 2012, and subsequently, DOM will no longer enroll this provider type for the E&D Waiver program. Those beneficiaries receiving Homemaker Services will be able to continue to receive the services until their next recertification. These beneficiaries will be transitioned from Homemaker Services to Personal Care Services. All transitions will take place by June 30, 2013, after which time all Homemaker Medicaid provider numbers will be closed. All providers of Homemaker Services who are interested in transitioning to provide Personal Care Services are encouraged to contact DOM Long Term Care at 601-359-6141 by November 1, 2012.

Elderly and Disabled Waiver Escorted Transportation Providers

The Division of Medicaid (DOM) has received approval from the Centers for Medicare and Medicaid Services (CMS) to continue the Elderly and Disabled (E&D) Waiver for another five years. This approval includes changes in the waiver which will be implemented July 1, 2012. All changes will be transitioned slowly to avoid any undue stress or interruption of services for our waiver participants. Escorted Transportation Services will no longer be utilized under the E&D Waiver after July 1, 2012, and subsequently, DOM will no longer enroll this provider type for the E&D Waiver program. DOM will allow those beneficiaries receiving Escorted Transportation to continue to receive the services until their next recertification. These beneficiaries will be transitioned from Escorted Transportation Service to Non-Emergency Transportation (NET). All transitions will take place by June 30, 2013, after which all Escorted Transportation provider numbers will be closed. All Escorted Transportation providers will be notified at a later date prior to the closing of their numbers.



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 the fall season…

SEPTEMBER 2012

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

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