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MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

New Year Brings New Vision to DOM - Improved Communications

DR. DAVID DZIELAK
Executive Director
MS Division of Medicaid

"The beginning of a New Year creates opportunities for improvement, which will be a catalyst for change at DOM," said Dr. David Dzielak, Executive Director of the Mississippi Division of Medicaid. With one full year as Executive Director under his belt, Dr. Dzielak is refining and re-evaluating his goals for the future of the agency. After tackling issues such as budgetary concerns, Affordable Care Act (ACA) expansion impacts, payment reforms and program implementations, he has quickly become immersed into the complicated world of Medicaid.

Drawing from those experiences, he has made it a priority to establish new goals which affect both internal and external relationships. He says, "Although it's always been of highest importance to provide excellent customer service to our beneficiary and provider populations, we are going to be more proactive about communicating information and changes." By finding more effective ways to collaborate he intends to transcend a siloed infrastructure and open up new avenues of communication.

Internally, the business process and procedures of DOM will be examined to identify information gaps, pinpoint efficiencies and find areas of improvement. Dr. Dzielak is also implementing a pilot plan to improve leadership skills and provide more employee cross training.

Externally he intends to implement measures to expand provider networks, strengthen relationships with the provider community and present a kinder, gentler face of DOM. Dr. Dzielak says, "Often times we have to walk a fine line between state and federal regulations while following mandatory policies and procedures, which leaves us scrambling to discern how those factors translate into the work we do at Medicaid. This doesn't allow for much leeway, but we will strive to disperse changes with more forewarning."

Reflecting his intentions, one change he is pleased to announce is the unveiling of a new DOM logo (above). The refreshed logo symbolizes a transformation in leadership, as well as a modern visualization of the DOM mission. It also promotes a renewed internal unity by focusing on providing unsurpassed service to our beneficiaries and providers.

After extensive research of similar entities, consideration of many factors and numerous revisions, three finalized concepts were narrowed down to one. To reach this end, an internal employee survey was conducted which resulted in a response ratio of 1 out of 4 employees and over 100 comments. In addition, logo ideas were tested with healthcare professionals and other external target audiences.

Dr. Dzielak says the selected concept was designed with our diverse audiences in mind, more clearly portraying our central mission to provide quality healthcare coverage to vulnerable Mississippians.

Two distinct blue elements form the shape of Mississippi, creating two transparent hands from the negative space

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reaching across the state. The bottom hand is slightly smaller (signifying children, DOM's largest beneficiary population) which is being assisted up. Emulating compassion for Mississippians, the image is reinforced by the subtle emphasis on aid in the agency name.

These efforts are a part of his overall vision and ongoing process to be a progressive agency. "The purpose is to examine how we can work better together in a more efficient manner," he says. "We want to support your efforts to provide quality healthcare to all Medicaid beneficiaries."

Mississippi Division of Medicaid Unveils New Logo

As part of a rebranding process, the Mississippi Division of Medicaid (DOM) has updated their 20-year-old logo and is pleased to introduce a new logo design.

Utilizing soft rounded lines, a bright blue color and simple imagery, the updated logo more accurately reflects DOM's mission in a friendly and appealing way. Blue was chosen as the spot color for its fresh, calming properties and association to healthcare. The typeface selected strikes a fine balance between elegance and readability, further solidifying the professionalism of the agency. Taking in special consideration to cost, the new logo was designed in-house, will be easy to replicate, and utilizes a pure blue hue (Pantone Process Blue) for consistent high quality printing.

MISSISSIPPI DIVISION OF MEDICAID

The new logo will be rolled out on signage, collateral material and online throughout the beginning of the year. We appreciate your patience during this transition.

If you have questions regarding the new DOM logo, contact Erin Barham, Web and Design Director at erin.barham@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.

Mississippi Division of Medicaid

~ Quality Healthcare Services Improving Lives ~

WHAT is MississippiCAN?

The MississippiCAN program is a statewide program that has been put in place to give Medicaid beneficiaries a chance to receive better health care.

WHO is eligible?

If you are listed in one of the Medicaid categories below, you may be required to enroll.

Required Populations:	Ages:
001—SSI	19 - 65
025—Working Disabled	19 - 65
027—Breast and Cervical Cancer	19 - 65
088—Pregnant Women	8 - 65
088—Infants	0 - 1
087—Children	0 - 1
091—Children	0 - 1
085—Family/Children (TANF)	0 - 1 &

Optional Populations: *	Ages:
001 -SSI	0 - 19
019—Disabled Child Living at Home	0 - 19
026—Foster Care Children	0 - 19
003—Foster Care Children	0 - 19

**** Opt Out (Optional) is available within the 90 day window.****

WHAT will I receive?

Unlimited Office Visits - No Co-payments - Case Management and Disease Management
Additional Vision Services - Incentive Rewards Cards - And much more.....

HOW does MississippiCAN work?

The Division of Medicaid, along with Magnolia Health Plan and UnitedHealthcare, have joined together to make sure that your health care needs are met.

For more information, you may call The Division of Medicaid
Toll Free @ 1-800-884-3222 or 1-800-421-2408; or 601-359-3789; or visit us online at www.medicaid.ms.gov/mscan

Mississippi Division of Medicaid

~ Quality Healthcare Services Improving Lives ~

WHO should you contact for MississippiCANi ?

MississippiCAN Contact Information

- **Xerox Health Solutions**

  Toll-free: 800-884-3222, then (*)
  FAX 601-206-3015
  MSCAN Enrollment (Beneficiary Calls and Enrollment Forms)

- **Magnolia Health Plan**

  Beneficiaries 866-912-6285
  Provider Relations 601-863-0717
  www.magnoliahealthplan.com/plan/state/MS

- **UnitedHealthcare**

  Beneficiaries : 877-743-8731
  Provider Relations 601-718-6614
  www.uhcommunityplan.com

- **Mississippi Division of Medicaid**

  Telephone: 601-359-3789

  Toll-free: 1-800-421-2408
  FAX 601-359-5252
  www.medicaid.ms.gov/mscan/

NEWS

Behavioral Health Medicaid Providers

The Mississippi Division of Medicaid has opened the behavioral health and psychiatry CPT codes for covered services based on changes by the American Medical Association (AMA) effective January 1, 2013. Claims using the new codes for dates of service beginning January 1, 2013 may now be submitted.

The switch to the new codes is based on the date of service, not the date the claim was submitted. For dates of service prior to January 1, providers should bill with the old codes. Any claims already submitted for service dates after January 1, 2013 using the old codes should be voided and resubmitted using the new CPT codes.

Please contact Kim Sartin-Holloway, Charlene Toten, or Bonlitha Windham at 601-359-9545 if you have questions. For additional information on the CPT code changes, please refer to the fee schedules located at http://www.medicaid.ms.gov/FeeScheduleLists.aspx, your 2013 CPT Code book, or to http://www.thenationalcouncil.org/cs/cpt_codes.

Increased Payments for Services Furnished by Certain Primary Care Physicians

On November 6, 2012, the Centers for Medicare & Medicaid Services (CMS) published the final rules (42 CRF Part 438, 441 and 447) for implementation of a Medicaid payment rate increase for primary care Evaluation & Management (E&M) services and vaccine administration codes furnished by certain physicians in calendar years **2013 and 2014**, at rates not less than the Medicare rates.

The minimum payment level applies to specified primary care services furnished by a physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine. The regulation stipulates that specialist and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS) the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) also qualify for the enhanced payment as do advanced practice clinicians (i.e., nurse practitioners, nurse midwives, and physician assistants) providing services within the state of Mississippi's scope of practice and under the supervision of an eligible physician. To be eligible for the higher payment providers must self-attest to a covered specialty or subspecialty designation indicating:

1) Board certification and currently practicing in an eligible specialty or subspecialty, or

2) Submission of 60 percent of his or her prior year Medicaid claims for the E&M codes and vaccine administration codes specified in this regulation (c. Eligible Primary Care Services §447.400(b)).

Services provided by Federally Qualified Health Centers, Rural Health Centers and Clinics and Health Departments and reimbursed on an encounter or visit rate, are not eligible for the higher payment, nor are services provided in nursing facilities that are reimbursed as part of the per diem rate.

The Division of Medicaid has been actively working to implement the required CMS changes. Attestation procedures and higher fee schedule rates, effective January 1, 2013, are being developed. Once attestation procedures are in place, providers will be notified. Although physicians will continue to be reimbursed at the 2012 rates for a limited period of time, providers identified as being eligible for higher payments will receive one or more supplemental payments for the difference between the 2012 amount paid and the applicable new Medicare rates.

Recovery Audit Contractors (RACs)

On March 23, 2010, Section 6411 of the Affordable Care Act, Expansion of the Recovery Audit Contractor (RAC) Program, mandated states to contract with RACs in an effort to establish programs that would audit payments made to Medicaid providers. The Medicaid RACs mission is to identify and reduce improper payments through the efficient detection and collection of overpayments and identification of underpayments.

"Medicaid RAC's mission is to identify and reduce improper payments"

The Division of Medicaid (DOM) has awarded PRGX Global, Inc. (PRGX) the RAC contract for the state of Mississippi. Under this contract, PRGX will provide audit services to the DOM. As a provider, you may receive medical record requests or other correspondence from PRGX indicating that you are the subject of an audit. DOM encourages providers to communicate the existence of this overpayment recovery program with their staff to ensure an appropriate and timely response is received from all providers.

Upon completion of the audit, providers will have the opportunity to rebut PRGX's findings. Once the rebuttal process is complete and a final determination is attained, PRGX will mail demand letters to notify providers of overpayments made by the DOM. These letters will request payment for an overpayment identified during the audit. Providers who disagree with the RAC determination may request an Administrative hearing. If providers do not request an Administrative hearing, the DOM will begin the process of recoupment. Please follow the appeals requirements of Title 23, Part 300 of the Mississippi Administrative Code located at http://www.medicaid.ms.gov/AdminCode.aspx.

Providers are responsible for submitting Adjustment/Void Request Forms in instances when a partial overpayment has been identified. Partial overpayments occur when a Transaction Control Number has multiple line items and not all line items were billed in error. Adjustment/Void Request Forms must be submitted within 30 days of the date of the demand letter to the DOM. The Adjustment/Void Request Form is available at: http://www.medicaid.ms.gov/Forms/ProviderForms/Adj-Void_rev_0306_rev.pdf.

In instances when entire claim(s) are voided, and no Administrative Hearing has been requested, the DOM will perform actions necessary to recoup overpayment. There is no action necessary from the provider.

We encourage the provider community to monitor the DOM website for updates and announcements regarding the Mississippi Overpayment Audit Recovery program. Additional opportunities for provider education and training will be forthcoming and we encourage your full participation in the program.

ICD-10 Transition

On September 5, 2012, the U.S. Department of Health and Human Services (HHS) released the final rule delaying the ICD-10 compliance date mandating that everyone covered by the Health Insurance Portability and Accountability Act (HIPAA) must implement ICD-10 for medical coding by October 1, 2014.

October 1, 2014, 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.

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

PROVIDER COMPLIANCE

Providers Must Verify Medicaid Eligibility and Beneficiary Identification

It is the responsibility of the Medicaid Provider to verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service. The provider is also responsible for confirming that the person presenting the card is the person to whom the card is issued. This can be done by requesting a picture ID, such as driver's license, school ID card or verifying the social security number and/or birth date. It is preferred that the providers verify the identity of the person presenting for service with a picture ID when possible.

"It is the responsibility of the Provider to verify a beneficiary's eligibility."

If it is found that the person presenting for service is not the Medicaid beneficiary to whom the card was issued, the provider is responsible for refunding any monies paid by Medicaid to the provider for all services billed.

Providers are reminded that they should review this policy periodically with their office staff.

Attention Family Planning Demonstration Waiver Providers

Family Planning Demonstration Waiver participants are eligible to receive the following birth control methods:

- Contraceptive Devices
- Contraceptive Prescriptions for:
  - Contraceptive Patches
  - Self-inserted Contraceptive products (ie. NuvaRing)
  - Oral Contraceptive Agents (ie. pills)
  - Injectable Contraceptives (ie. Depo-Provera)

Please note the following regarding contraceptive devices.

- Insertion and removal of contraceptive intrauterine devices are covered services.

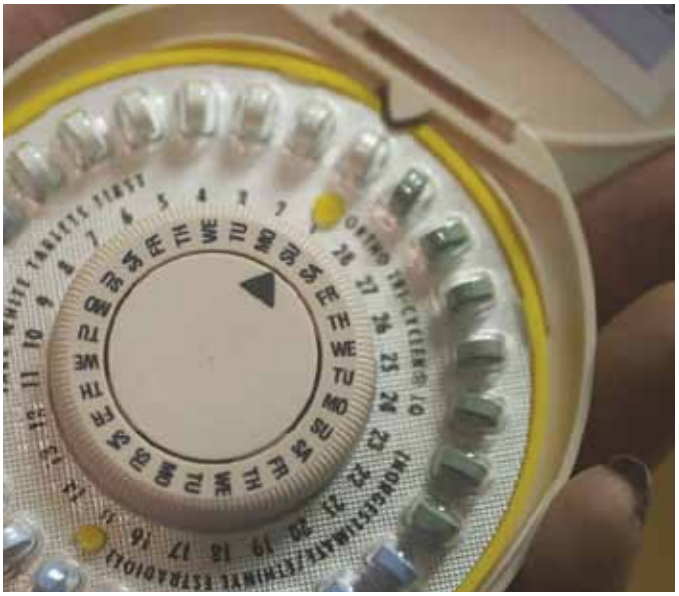
- Removal of an intrauterine device (IUD) because the beneficiary has a uterine or pelvic infection is a non-covered service.

❖ Insertion and removal of contraceptive implants are covered services.

❖ Diaphragm or cervical cap fitting with instruction is a covered service.

❖ Vaginal rings are covered.

For more information regarding covered and non-covered services for the Family Planning Demonstration Waiver, please refer to Title 23 of the Administrative Code, Part 221 Family Planning Services, Chapter 2.



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 revision to the previous article published in the June 2012 bulletin.***

Suspended Claims – What Do They Mean?

When claims process they either pay, deny, or suspend and are reflected on the Remittance Advice (RA) as such. Claims that deny should be researched, corrected, and resubmitted immediately. Claims that suspend should **NOT** be resubmitted.

Claims suspend for various reasons and will eventually pay or deny. If a second claim is submitted while the initial claim

is in a suspended status, both claims will suspend. Providers should allow the suspended claim to be fully processed and reported on the RA as paid or denied before additional action is taken.

Claims commonly suspend when:

- beneficiary eligibility updates are required
- manual pricing from an invoice is required
- a prior authorization is required and the authorization is not in the Medicaid system
- a consent form is required
- generic codes are billed

PHARMACY

Medicare Part D Changes and Medicaid Drug Coverage

CMS recently announced that effective January 1, 2013, Part D plans will be required to make changes to Part D drug coverage; 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.
- 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.

For the Medicaid only beneficiaries: Onfi (clobazam) is added as a non-preferred covered service. Please refer to DOM's PDL for drug criteria.

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 is limited to phenobarbital.

Preferred Drug List (PDL) Update, Effective January 1, 2013

Starting in 2012, DOM's Preferred Drug List, or PDL, will undergo an annual review each autumn. The revisions brought about by this annual review will become effective the following January 1st ***with the first such update occurring on January 1, 2013***. Throughout the year, there will be quarterly additions, or deletions. Changes outside of 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.

To reference the current PDL, go to http://www.medicaid.ms.gov/Pharmacy.aspx and select the PDL Effective 1-1-2013 document from the menu on the left hand side of the page. Additionally, to view the additions and deletions to preferred or non-preferred status, select PDL Changes, January 1, 2013 document from the menu on the left hand side of the page.

Medicaid and MSCAN Pharmacy PA Contact Information

Payer	Provider Phone Number	Beneficiary Contact Info
MS Medicaid Pharmacy PA *only*	**1-877-537-0722 601-359-6685 Fx 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 601-863-0700**
MSCAN: UnitedHealthcare Pharmacy Help Desk	PBM is OptumRX **1-877-305-8952**	**1-877-743-8731**

Keep in mind that MSCAN 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 Medicaid, providers, and beneficiaries.

Pharmacy Prior Authorization (PA) Manual Forms

Since January 1, 2011, Pharmacy prior authorizations have been processed internally by the Division of Medicaid's Pharmacy Bureau. The only acceptable prior authorization forms can be found on our website at http://www.medicaid.ms.gov/Pharmacy.aspx, click on Prior Authorization from the horizontal menu, then select requested PA form(s). The Pharmacy PA FAX line is 1-877-537-0720.

The former vendor's PA forms are obsolete. Often these obsolete forms have been copied and/or faxed multiple times and are difficult to read, which delays the prior authorization process. Furthermore, the fax number printed on the old forms is not functional. Therefore, the Division of Medicaid will no longer accept these obsolete forms for prior authorization purposes.

If you require assistance using the Xerox's Envision Web Portal, please contact Xerox at 1-800-884-3222, select option 2 for Provider, then option 2 for Pharmacy.

Smoking Cessation Products Coverage

Tobacco use can lead to nicotine dependence and serious health problems. According to the Centers for Disease Control and Prevention (CDC), nicotine dependence is the most common form of chemical dependence in the United States. To assist MS Medicaid beneficiaries in breaking free from nicotine dependence, the following smoking cessation drugs are covered through the MS Medicaid Pharmacy Program:

(1) Over the counter nicotine products;
(2) Legend or prescription nicotine replacement products;
(3) Bupropion hydrochloride; and
(4) Varenicline tartrate

Correctional Facilities

The MS Medicaid Program is prohibited by federal regulations, 42 C.F. §435.1009 and 42 C.F. §435.1010, from paying for services for Medicaid beneficiaries who, on the date of service are incarcerated in a correctional or holding facility for individuals who are prisoners, including juvenile correctional facilities, are detained pending disposition of charges, or are held under court order as material witnesses.

If medications are requested for incarcerated Medicaid beneficiary, the medications cannot be billed to the Medicaid pharmacy program and are subject to recoupment. Pharmacists should contact the correctional facility regarding the facility's reimbursement procedures for the requested medications.

Medicaid Verification

The MS Medicaid Pharmacy Program reimburses for covered outpatient drugs for Medicaid beneficiaries with prescription drug benefits. *Only medications prescribed to that beneficiary can be billed using the beneficiary's Medicaid ID.* Sanctions and requests for repayment may be imposed against a provider for engaging in conduct that defrauds or abuses the Medicaid program. This could include billing a parent's medication to a child's Medicaid ID number and vice-versa.

Be mindful that it is the provider's responsibility to

- verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service; and
- confirm that the person presenting the card is the person to whom the card is issued.

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.

XEROX STATE HEALTHCARE, LLC
P.O. BOX 23078
JACKSON, MS 39225

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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., wish you and yours a Happy New Year!

JANUARY 2013

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1	2	3	4	5
6	7 CHECKWRITE	8	9	10 EDI Cut Off 5:00 p.m.	11	12
13	14 CHECKWRITE	15	16	17 EDI Cut Off 5:00 p.m.	18	19
20	21 CHECKWRITE	22	23	24 EDI Cut Off 5:00 p.m.	25	26
27	28 CHECKWRITE	29	30	31 EDI Cut Off 5:00 p.m.		

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.