Volume 19, Issue 3 June 2013

MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

Mandatory ACA Provisions Requires Enhanced Payments to Primary Care Physicians

DR. DAVID DZIELAK
Executive Director
MS Division of Medicaid

Although most discussion surrounding the Patient Protection and Affordable Care Act (PPACA) seems to focus on the optional expansion of Medicaid eligibility, states are also tirelessly working on accommodating the mandatory provisions of the PPACA.

"Regardless of whether or not lawmakers accept the optional expansion, the mandatory requirements will greatly impact the agency and the state," said Dr. David J. Dzielak, Executive Director of the Mississippi Division of Medicaid. Mandatory provisions of the PPACA include modifications to the program such as extending coverage for foster care children to age 26, a private health insurer fee, eligibility modernization, and enhancing primary care physician fees.

To ensure access for services will be able to meet the anticipated higher demand for care, the PPACA is mandating states to pay primary care physicians fees equal to those paid by Medicare. Primary care physicians are categorized as providers practicing family medicine, internal medicine and pediatrics.

Medicaid is a combined state and federal matching program and has no correlation to Medicare, which is fully funded by the federal government. These enhanced payments will minimize the difference between the states Medicaid fees effective July 1, 2009 and Medicare fees for 2013 and 2014. Across the country, there is a wide range between Medicaid to Medicare fees; a few facts regarding this comparison are listed below:

- The latest data from 2012 indicates Medicaid physician fees were 66% of Medicare fees nationwide.
- Medicaid rates in the southeastern United States averages 76% of Medicare.
- In Mississippi, Medicaid physician fees are 90% of Medicare.
- Mississippi has the 7th highest ratio of Medicaid to Medicare physician fees in the country.

IN THIS ISSUE

In regards to Mississippi, Dr. Dzielak says, ″As it stands, the Division of Medicaid (DOM) has already submitted necessary documentation to the Center for Medicare and Medicaid Services (CMS) regarding our plan to implement the increase in payments to primary care physicians. We are currently waiting on final approval for this plan and anticipate receiving final approval in the near future.″

To qualify for the enhanced payments, physicians will need to complete the attestation form which is available on the DOM's Envision website portal at https://msmedicaid.acs-inc.com/PE_PDFs/PCPAttestationForm.pdf. Providers who have attested will begin receiving enhanced payments as part of the normal reimbursement cycle in July. Payments for services rendered prior to July, will be made between October and December 2013 by mass adjustment.

The increase for primary care physician fees is fully funded by the federal government for 2013 and 2014 (calendar years). Currently there is no federal funding for these enhanced payments beyond 2014 and it is uncertain if these payments will be continued beyond the projected time frame. If the augmented fees are extended, additional state revenue will be essential to support the enhanced payments.

The decision to continue paying the larger fees rests with our elected policymakers, and it will need to be taken into consideration during the next Legislative session,″ said Dr. Dzielak. ″From 2015 to 2020, we estimate the cost to the state would be approximately $76 million total if payments are extended.″

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

Attention All Providers!

MississippiCAN Workshops are coming your way!

www.medicaid.ms.gov/mscan/

The Division of Medicaid, Bureau of Coordinated Care, in conjunction with Magnolia Health Plan and UnitedHealthcare, will conduct MississippiCAN Provider Workshops June 4, 2013 through June 26, 2013 at locations throughout the state. Providers are encouraged to attend these workshops as the following topics will be covered:

- Access to care
- Billing
- Claims Processing
- Pay for Performance (P4P)
- Prior Authorizations
- Provider Enrollment/ Credentialing
- Behavioral Health
- Case Management
- EPSDT
- Pregnant Women & Children
- 2012 MississippiCAN Expansion
- Other changes

Date/Time	Location
Tuesday, June 4, 2013 9:00 a.m.	Starkville Sportsplex Activities Room 405 Lynn Lane **Starkville**, MS 39759
Tuesday, June 4, 2013 2:00 p.m.	BancorpSouth Arena 375 East Main Street **Tupelo**, MS 38804
Wednesday, June 5, 2013 10:00 a.m.	Union Station 1901 Front Street **Meridian**, MS 39301
Monday, June 10, 2013 10:00 a.m.	Alcorn County MSU – Exhibit Hall 2200 Levee Road **Corinth**, MS 38834
Tuesday, June 11,2013 10:00 a.m.	Southaven Performing Arts Center 2101 Colonial Hills Drive **Southaven,** MS 38671
Wednesday June 12, 2013 9:30 a.m. / 2:00 p.m.	Eagle Ridge Conference Center 1500 Raymond Lake Road **Raymond**, MS 39154

Continued on next page

Monday, June 17, 2013 9:00 a.m.	Taylor Hall 600 Butler Hall **Grenada**, MS 38901
Monday, June 17, 2013 2:00 p.m.	William Alexander Perry Memorial Library 341 Main Street **Greenville**, MS 38701
Tuesday, June 18, 2013 1:30 p.m.	Alcorn State University – Natchez Campus 15 Campus Drive **Natchez**, MS 39120
Tuesday, June 25, 2013 10:00 a.m.	Forrest County Multipurpose Center 962 Sullivan Road **Hattiesburg**, MS 39401
Wednesday, June 26, 2013 8:30 a.m.	Handsboro Community Center 1890 Switzer Road **Gulfport**, MS 39507

SPACE IS LIMITED! Please forward your RSVP indicating which workshop you plan to attend to:

Attn: Amy Burns, Provider Services
Xerox State Healthcare
Fax: 601-206-3119
Phone: 601-206-3028
Email: Amy.Burns@xerox.com

Date of Workshop: _____

Location of Workshop: _____

Number of Attendees: _____

Pre-Admission Screening Training Course for New Screeners

Attention: Long Term Care Providers and Hospital Discharge Planners

The Division of Medicaid, Bureau of Institutional Long Term Care / Case Mix is pleased to announce its 2013 training course on the Pre-Admission Screening Application (PAS) process.

- The course objective is to educate attendees on current PAS policy, completing the PAS application and the electronic PAS submission process.
- Target audience: providers/employees requiring basic PAS training or individuals who may be new to the PAS process.
- There is no charge for the training.

Course Dates/Time	Location/Site: Mississippi Division of Medicaid Walter Sillers Building 550 High Street Jackson, Mississippi 39201 Fourth Floor Conference Room
Thursday, July 18, 2013	**1:00 - 4:00 P.M.**
Thursday, September 19, 2013	**1:00 - 4:00 P.M.**
Thursday, November 5, 2013	**1:00 - 4:00 P.M.**

For additional information you may contact Gay Gipson at 601-359-9529 or Cherlyn Carter at 601-359-5251. To enroll, complete and submit the following information to the attention of Gay Gipson.

Fax: 601-359-9521 **or** email: gay.gipson@medicaid.ms.gov

Attendee Name and Title:	
Facility Name and Provider ID:	
Date of Course/Training:	
Phone Number:	**Fax Number:**

Directions: From I-55, take the High Street exit (Exit 96 B, toward the State Capitol). The Walter Sillers Building is located at the corner of President Street and High Street (the 6th red light after exiting onto High St.). You may park in the lot on the right, or visitor parking on the ground floor of the parking garage (located directly behind the Sillers Building). Once inside the Sillers Building, a guard will have you sign in and issue a visitors pass.

NEWS

MS Cool Kids (EPSDT) Screenings – Quick Billing Tips

- Always bill age appropriate screening codes (99381-99395) on submitted claims.
- Adhere to the EPSDT/MS Cool Kids periodicity examination schedule.
- Annual age specific screenings should not be completed prior to the child's birthday. *For example: Provide 12 month screening on or after the child's first birthday.*
- Do not schedule annual screenings prior to the child's birthday. *For example: Do not schedule at 11.5 months for the 12 month screening.*
- Schedule future annual screenings one year from the anniversary date. *Remember that only one screening is allowed per fiscal year for ages 2-21.*
- Always use the EP Modifier.
- Append the 25 Modifier along with the EP modifier when immunizations are administered with EPSDT well check age appropriately to prevent denial of screening service.
- Bill for all medically appropriate services rendered.

Mississippi Cool Kids (EPSDT) Screening and Participation Ratios by Age Group: 2010, 2011, and 2012

Mississippi Cool Kids, formerly known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), is Medicaid's comprehensive and preventive child health program for beneficiaries under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA89) legislation and includes periodic screening, vision, hearing and dental services. In addition, section 1905 (r) (5) of the Social Security Act requires that any "medically necessary"

health care service discovered through the exam be provided to the Medicaid-eligible beneficiary even if the service is not routinely covered under the regular Medicaid program.

The state of Mississippi is required to report EPSDT performance information annually on the CMS-416 form. The annual EPSDT report includes basic information on participation in the Medicaid child health program. This information is used to assess the effectiveness of the State's EPSDT program. The chart below shows the State's EPSDT participation and screening ratios by age groups for federal fiscal years 2010 – 2012. The Centers for Medicare & Medicaid Services (CMS) standard screening and participation ratio is 80% or greater. As reflected in the results below, Mississippi has an overall average of 64% screening ratio, and a 42% participation ratio for the three federal fiscal years respectively. In spite of the State's effort to achieve CMS' 80% overall screening and participation standard requirements, Mississippi has only been consistently successful for ages 2 and under in the screening ratio standard.

The Division of Medicaid is requesting that all Medicaid providers assist in stressing the importance of this screening to eligible beneficiaries aged 5 to 21. Please encourage patients to take advantage of this vital preventive health screening service to help Mississippi achieve or surpass CMS' 80% universal screening and participation standard requirements.

The results are as follows:

State FY	2010		2011		2012	
	Screening Ratio	Participation Ratio	Screening Ratio	Participation Ratio	Screening Ratio	Participation Ratio
All Children	64%	42%	63%	42%	65%	42%
< 1	100%	89%	100%	90%	100%	95%
1 – 2	100%	69%	100%	71%	100%	71%
3 – 5	62%	53%	62%	53%	64%	53%
6 – 9	30%	27%	28%	25%	29%	25%
10 – 14	30%	27%	29%	26%	33%	28%
15 – 18	24%	22%	23%	21%	25%	21%
19 – 20	12%	11%	11%	10%	11%	10%

PROVIDER COMPLIANCE

2013 Provider Workshops... Don't miss out!

The Division of Medicaid along with Xerox State Healthcare, LLC, will host a series of workshops throughout the year. For details including dates, times and locations more information will be posted on the Mississippi Medicaid web portal under "What's New" and "Late Breaking News" at http://msmedicaid.acs-inc.com. Stay tuned. We look forward to seeing you soon!

Vaccines for Children (VFC) Billing Tips

To ensure timely and accurate payment:

- Enroll as a VFC provider through the MSDH.
- Always use approved vaccines codes 90476–90748 series with $ 0.00 submit charge and 1 unit.
- For the administration codes 90471–90474 series, always use administration code 90471 or 90473 for 1st dose and 90472 and/or 90474 for the 2nd dose of the vaccine (single or combination) with a payment of $10.00 per administration code.
- For the administration codes 90460–90461 series, always use 90460 for the 1st component with a payment of $10.00, and 90461 with a payment of $0.00 for additional components of the vaccine (single or combination).
- Always use the EP Modifier.

Policy Bulletin

DOM filed eight (8) revisions to the Administrative Code with the Secretary of State from January 1, 2013 – April 1, 2013. The changes have been added in the DOM Administrative Code. The revisions can be viewed by accessing the DOM website http://www.medicaid.ms.gov. Click on the "Publications" tab at the top and then the Administrative Code. All Proposed and Final Filings with the Secretary of State can be accessed via this link http://www.sos.ms.gov/adminbulletinsearch/default.aspx. Select Title 23 – Division of Medicaid from the Agency Search pick list.

The Centers for Medicare and Medicaid (CMS) approved seven (7) State Plan Amendments submitted by the DOM from January 1, 2013 – April 1, 2013. The State Plans can be viewed via this link http://www.medicaid.ms.gov/MsStatePlanAmendments.aspx.

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 following e-mail addresses:

State Plan Amendments – spa@medicaid.ms.gov

Administrative Code – admincode@medicaid.ms.gov

A Provider Reference Guide (PRG) for each Part of the Administrative Code Title 23 is available via this link http://www.medicaid.ms.gov. The PRG provides additional information and guidance to providers of medical services participating in the Mississippi Medicaid program. Some Parts of the Administrative Code do not have a PRG as all the information contained in the old Provider Policy Manual Sections was transcribed into the current Administrative Code. The PRG will be updated as needed. The Administrative Code supersedes the PRG and must be adhered to by all providers. The Provider Policy Manual is no longer available on the DOM website as of April 1, 2013.

Increased Primary Care Service Payments

On November 6, 2012, the Centers for Medicare & Medicaid Services (CMS) issued the final rules to implement increased Medicaid payments for certain primary care services and vaccine administration billing codes provided by qualified practitioners enrolled as a Mississippi Medicaid provider.

For dates of services on and after January 1, 2013, through December 31, 2014, the Division of Medicaid (DOM) will reimburse certain primary care services provided by qualified physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect for calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, DOM uses the rate specified in a fee schedule established and announced by CMS. The specific E&M and vaccine procedure codes included in this program are listed in the Increased Primary Care Service Fee Schedule located on the DOM website at: http://www.medicaid.ms.gov/Fees/NewIncPrimaryCareServFee.pdf.

Services rendered in an FQHC, RHC, or Mississippi Health Department clinic settings are excluded from the increased payment because reimbursement is included in the encounter rate.

CMS defines a qualified provider as one who delivers certain primary care services and self-attests to meeting one of the following criteria:

1. **Physician**

   Physician's must have a specialty designation of family medicine, general internal medicine, pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS) or the American Osteopathic Association (AOA), **and** one (1) of the following:

   - Board certification
   - At least 60% of total MS Medicaid claims for the previous calendar year (CY) were for the specific E&M and vaccine procedure codes covered as of July 1, 2009, as listed in the Increased Primary Care Service Fee Schedule located on the DOM website at: http://www.medicaid.ms.gov/Fees/NewIncPrimaryCareServFee.pdf.

2. Newly Enrolled Physician

- A newly enrolled MS Medicaid physician provider that is a specialist or subspecialist in Family Medicine, General Internal Medicine or Pediatric Medicine, but not board certified by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA) or the American Board of Physician Specialties (ABPS) must attest that at least 60% of total MS Medicaid claims **WILL BE** for the specific E&M and vaccine procedure codes covered as of July 1, 2009, as listed in the Increased Primary Care Provider Fee Schedule located on the DOM website at: http://www.medicaid.ms.gov/Fees/NewIncPrimaryCareServFee.pdf.

3. Non-Physician Practitioner

- A non-physician practitioner providing primary care services must be in a Practice Agreement with a qualified physician. The qualified physician must be a current MS Medicaid provider and enrolled for the increased primary care service payment.

Information for Vaccine for Children (VFC) Providers

VFC providers who self-attest as meeting the requirements of a qualified provider and administer vaccines to a child through the VFC Program will receive an increased payment for the administration of the VFC vaccines only. The provider will receive $0.00 reimbursement for the vaccine itself, pursuant to DOM policy.

How to Attest

Providers can complete just one (1) Self-Attestation Form for CYs 2013 and 2014 if the information has not changed. For CY 2013, there is no cut-off date for submission of the Self-Attestation Form to receive the Primary Care Service Payment Increase. For CY 2014, the cut-off date for submission of the Self-Attestation Form will be March 31, 2014.

Providers can verify the processing of electronically submitted Self-Attestation Form by accessing the Envision Web Portal. Processing of forms prior to June 30, 2012, may take ten (10) or more business days depending on the volume of forms received. Beginning July 1, 2013, forms will be processed within five (5) business days from receipt.

Self-Attestation Forms can be accessed on the DOM website, Envision Web Portal or by calling the Xerox Call Center at 1-800-884-3222. Completed forms must be submitted to Xerox Provider Enrollment in one of the following ways:

- E-mailed to: msinquiries@xerox.com
- Mailed to: Xerox Provider Enrollment
P. O. Box 23078
Jackson, MS. 39225
- Faxed to: Xerox Provider Enrollment
(601) 206-3015

Program Integrity

Omission, misrepresentation or falsification of any information contained in the Self-Attestation or contained in any communication supplying information to Division of Medicaid to complete or clarify the application for the Increased Primary Care Services Payment may be punished by criminal, civil or other administrative actions.

Reminders for Providers Submitting Paper Claims

Providers who submit paper claims are 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.***

Providers Must Verify Medicaid Eligibility, MississippiCAN Eligibility, and Third-Party Coverage

It is the responsibility of the Medicaid provider to verify a Medicaid beneficiary's eligibility each time the beneficiary appears for a service. Evidence of eligibility is demonstrated by the Medicaid identification card issued to each Medicaid eligible member in a family. A beneficiary is expected to present his/her Medicaid identification card when services are rendered. This includes presentation of other cards for medical services, such as MississippiCAN, Medicare, other Third-party coverage (i.e. Blue Cross/Blue Shield). Medicaid is the payer of last resort after other payers or third-parties.

Medicaid providers may verify beneficiary eligibility status by several methods:

- Calling the fiscal agent at 1-800-884-3222, or
- Calling the Automated Voice Response System (AVRS), or
- Accessing the Point of Service eligibility verification system, or
- Accessing the Envision Web Portal.

The date of service must also be stated or entered to verify correct payer, as eligibility changes from regular Medicaid coverage to MississippiCAN coverage, in addition to Coordinated Care Organization (CCO) subcontractors.
There are two CCOs for MississippiCAN: **Magnolia Health Plan** and **UnitedHealthcare**. These two CCOs are to be billed for medical services. They also have Behavioral Health subcontractors to which providers must submit claims directly. Delays in submitting claims to the proper payer may result in timely filing denials.

Payer	Card Color	Type Service	Telephone	DOM
Medicaid	Green		1-800-884-3222	1-800-421-2408
Medicare	Red/White/Blue		1-800-633-4227	
MississippiCAN			1-800-884-3222	1-800-421-2408
Magnolia	Purple	Medical	1-866-912-6285	
Cenpatico	(same card)	Behavioral Hlth		
Univita	(same card)	DME		
US Script	(same card)	Pharmacy	1-800-460-8988	
MississippiCAN			1-800-884-3222	1-800-421-2408
UnitedHealthcare	White	Medical	1-877-743-8731	
UBH-OptumHealth	(same card)	Behavioral Hlth	1-877-743-8731	
OptumRx	(same card)	Pharmacy	1-877-305-8952	

Attention Hospitals and Radiology Providers

Effective for dates of service on or after July 1, 2013, Mississippi Division of Medicaid (DOM) will require prior authorization for certain outpatient non-emergency advanced imaging services to include:

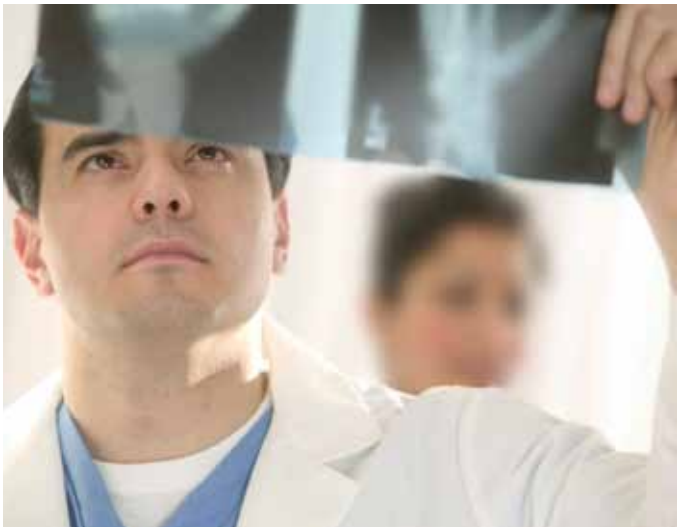
- CT
- MRA
- MRI
- PET
- Nuclear Cardiac studies

This change is effective for enrolled Mississippi Medicaid ordering and rendering providers. Advanced imaging services performed during an inpatient stay, emergency room visit, or twenty three (23) hour observation period will not require prior authorization.

Advanced imaging prior authorizations will be processed by the Utilization Management/Quality Improvement Organization (UM/QIO), MedSolutions. To request a prior authorization, the ordering or rendering provider must contact MedSolutions by:

- Calling toll-free at 877-791-4106
- Utilizing their Web Portal at www.medsolutionsonline.com
- Faxing a MedSolutions request form (available on the Web Portal) to 888-693-3210
- Mail

The ordering provider will be notified of prior authorization decisions via fax.



Please be advised that advanced imaging services rendered without securing prior authorization may be denied for payment. Providers may not seek reimbursement from the beneficiary.

During the month of June and the first week of July, DOM and MedSolutions will be conducting orientation sessions designed to assist providers with the new radiology prior authorization process. During these orientation sessions, there will be detailed discussions about the prior authorization requirements for proper submissions and how to navigate through the MedSolutions Web site, www.medsolutionsonline.com. Topics to be discussed include:

- The new prior authorization process
- Accessing information from the Web Portal
- A review of the Quick Reference Guide
- A Question-and-Answer session

WEB ORIENTATION SESSIONS

All providers are encouraged to attend one of these informative sessions to ensure understanding of the new prior authorization process for imaging services.

Any provider that plans to attend one of the online web orientation sessions must register in advance. Each online web orientation session is free of charge and will last approximately one hour.

Listed below are the dates and times for each web orientation session. All sessions times are held during Central Standard time unless otherwise stated.

June 19, 2013	**Wednesday**	**11:00 AM Central**
June 20, 2013	**Thursday**	**12:00 PM Central**
June 28, 2013	**Friday**	**3:00 PM Central**
July 2, 2013	**Tuesday**	**10:00 AM Central**

How to Register

Please read the following instructions carefully to register for and participate in a session:

1. Once you have chosen a date and time, please go to http://medsolutions.webex.com/.
2. Click on the "Training Center" tab at the top of the Web page.
3. Find the date and time of the conference you wish to attend by clicking the "Upcoming" tab. All of the Provider Orientation Sessions will be named "Mississippi Division of Medicaid Provider Orientation Session."
4. Click "Register."
5. Enter the registration information.

After you have registered for the conference, you will receive an e-mail containing:

1. The toll-free phone number and pass code needed for the audio portion of the conference.
2. A link to the Web portion of the conference.
3. The conference password.

Please retain the web registration e-mail for quick reference to the Web conference link and call-in number for the session in which you will be participating.

Training Materials

If you are unable to participate in any of the scheduled web orientation sessions listed, you may obtain a copy of the presentation by visiting www.medsolutions.com/implementation/msmedicaid. The presentation is in PDF format. If you need Adobe Reader, you can download it from www.adobe.com/products/reader/.

If you have any questions regarding this new program or questions about MedSolutions in advance of the program launch, please contact their Customer Service Department at 888-693-3211 or DOM Bureau of Medical Services at 601-359-6150. A provider reference guide is also available on the MedSolutions Web Portal at www.medsolutionsonline.com.

PHARMACY

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

Effective July 1, 2013, there will be a minor PDL update. Please note that starting in 2012, DOM's Preferred Drug List (PDL) undergoes 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 implemented on January 1, 2013. Throughout the year there are quarterly additions, or deletions. Changes outside of January 1st implementation annual review updates will generally be minimal.

To reference the current PDL, go to http://www.medicaid.ms.gov/Pharmacy.aspx and select the 'PDL Effective 7-1-2013' 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, July 1, 2013' document from the menu on the left hand side of the page. We recommend adding this link to your favorites as you will find it very helpful.

New ICD-9 Codes at Pharmacy Point of Sale (POS), Effective July 1, 2013

Effective July 1, 2013, the Division of Medicaid will require specific ICD-9 codes in the pharmacy point of sale (POS) system for the following drugs used to treat cystic fibrosis:

- ***Cayston (azetreonam)****
- ***Coly-Mycin M (colistimehtate sodium)****
- ***Pulmozyme (dornase alfa)****
- ***Tobi (tobramycin)****

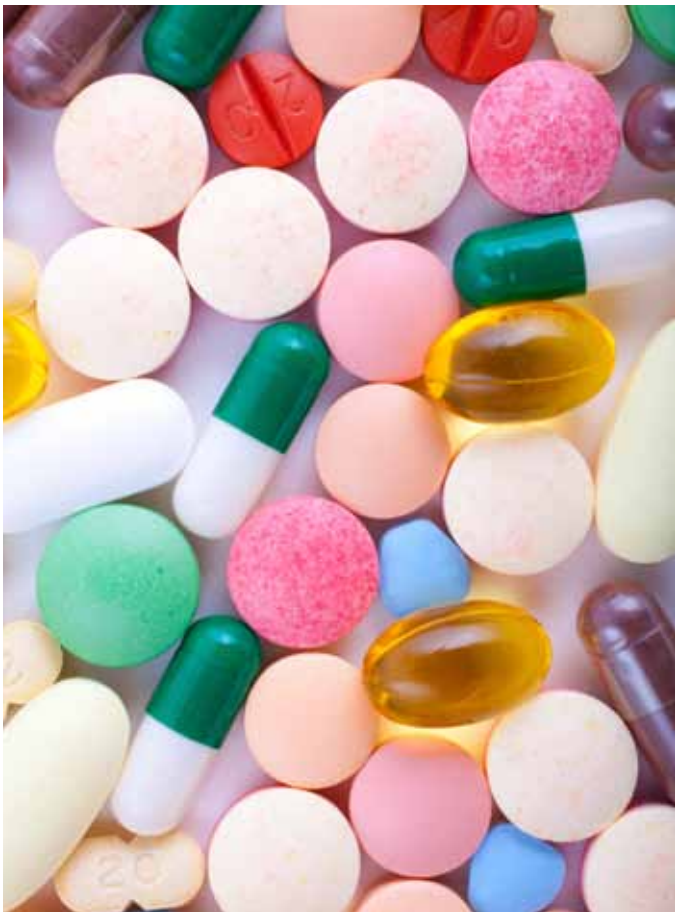
**Existing users as of June 30, 2013 will be grandfathered*

277.0	Cystic Fibrosis
277.00	Cystic Fibrosis without mention meconium
277.01	Cystic Fibrosis with meconium ileus
277.02	Cystic Fibrosis with pulmonary manifestations
277.03	CF with gastrointestinal manifestations
277.09	Cystic Fibrosis with other manifestation

Prescriber must write the validating ICD code on the prescription and no manual prior authorization is required. For the comprehensive list of valid 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 on the aforementioned drugs, please submit a prior authorization request. 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.



Valid Provider or Prescriber NPI must be used on DOM Pharmacy claims, Effective July 1, 2013

Effective July 1, 2013, all pharmacy claim must use a valid provider type's national provider identifier (NPI) number. A valid provider type or prescriber must be a person, and not a building, such as a clinic or hospital. Previously, DOM allowed a clinic or hospital NPI to be used on pharmacy claims. Effective July 1, 2013 pharmacy claims using a non-person's NPI will deny. Valid prescribing provider types are physicians, doctors of osteopathy, podiatrists, dentists, optometrists, nurse midwives, nurse practitioners and physician assistants.

Pharmacy Reminder: Tamper Resistant Prescription Pad/ Paper Federal Mandate

Since October 1, 2008 and in accordance with federal regulations, all non-electronic prescriptions are required to be written on tamper-resistant pads/paper. Failure of a State to enforce the tamper-resistant pad requirement of *U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007, Pub. L. No. 110-28, 121 Stat. 112* may result in the loss of Federal financial participation.

Pharmacy audits are ongoing to assure that hard copy prescriptions meet the federal guidelines. Pharmacy providers who accept hard copy prescriptions that are not written on tamper-resistant pads/paper will be required to reimburse to DOM all funds associated with the claims for said prescriptions.

For a comprehensive listing of tamper resistant prescription pad/paper (TRPP) features and exemptions, refer to the agency's website at www.dom.state.ms.us, select Pharmacy Services, and select TRPP information from the menu on the right hand side of the page.

Pharmacy Reminders: Medicaid/Medicare Helpful References

Pharmacy services routinely receive questions regarding the dually eligible, Medicaid/Medicare, beneficiary. The following materials are available on the agency's website at www.dom.state.ms.us, select Pharmacy Services, and select Medicaid/ Medicare from the horizontal menu.

1. **Pharmacy Provider Tip Sheet** is Medicare Part D's Limited income (LI) NET program Quick Reference Guide. This document addresses questions regarding Medicaid beneficiaries who are newly eligible for Medicare and do not have a Part D Plan and pharmacy billing while in this gap period.

2. **Medicare Part A, B and D Basic Tools** are basic tools to assist providers in understanding Medicare drug coverage determinations under Part A, Part B, and Part D of Medicare. Please note that Pharmacy providers must be enrolled as a Pharmacy DME provider in order to bill Medicare Part B drugs. Medicare Part B designed drugs are billed as crossover claims, and cannot be billed through POS.

Other Helpful References on Pharmacy Services' webpage
http://www.medicaid.ms.gov/Pharmacy.aspx

- 90 Day Maintenance List in Disease State Format
- 90 Day Maintenance List
- Products with Quantity Limits
- Suboxone/Subutex information
- ICD9 codes for POS
- And lots more!

LONG-TERM CARE

Elderly and Disabled Waiver Escorted Transportation Providers

The Division of Medicaid (DOM) 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 included some changes in the waiver which was implemented July 1, 2012. Escorted Transportation Services is no longer an approved service under the E&D Waiver effective July 1, 2012. DOM no longer enrolls this provider type for the E&D Waiver program. DOM has allowed beneficiaries receiving escorted transportation service to continue to receive the services until their next recertification. The E&D Waiver case managers are in the process of transitioning beneficiaries from escorted transportation service to Non-Emergency Transportation (NET). All transitions will be completed by June 30, 2013. All Escorted Transportation provider numbers will be closed effective July 1, 2013.

Elderly and Disabled Waiver Homemaker Providers

The Division of Medicaid (DOM) 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 made some changes to the E&D Waiver implementation began July 1, 2012. Homemaker Services is no longer an approved service under the E&D Waiver effective July 1, 2012. DOM no longer enrolls this provider type for the E&D Waiver program. DOM has allowed beneficiaries receiving homemaker service to continue to receive the services until their next recertification. The E&D Waiver case managers are in the process of transitioning beneficiaries from homemaker services to personal care services (PCS). All transitions will be completed by June 30, 2013.

Personal Care Services Training for Homemakers

The Division of Medicaid is giving current homemaker providers an opportunity to transition to become Personal Care Service (PCS) providers. All providers of Homemaker Services who are interested in transitioning to provide Personal Care Services are required to enroll their staff in PCS training. Each provider must ensure that all employees who provide direct care to beneficiaries complete and pass all training requirements. The training is provided through the Arc of Mississippi. Providers may contact the Arc of Mississippi by calling 228-497-1035. If the homemaker agency fails to enroll their staff in the PCS course, they will no longer be able to provide services under the Elderly and Disabled Waiver. PCS training enrollment should have been completed last year, June 1, 2012, after which time homemaker provider numbers will be closed effective July 1, 2013.

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

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

DOM & Xerox State Healthcare, LLC., welcome summertime!

JUNE 2013

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.