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MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

ACA Changes to Move Segment of Children From CHIP to Medicaid

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Executive Director
MS Division of Medicaid

Under federal law, the Patient Protection and Affordable Care Act (PPACA) implements mandatory changes regarding eligibility guidelines for the Children's Health Insurance Program (CHIP) and Medicaid.

Effective Jan. 1, 2014, a new methodology based on Modified Adjusted Gross Income (MAGI) will be used for determining CHIP eligibility. As a result of a conversion to MAGI, children in households with income limits up to 133 percent of the federal poverty level will be transitioning from CHIP to traditional Medicaid.

In Mississippi, the Division of Medicaid estimates this transition will affect nearly 29,000-30,000 children on CHIP and more than 1,400 providers who solely see CHIP beneficiaries.

CHIP children in households with income limits up to 133 percent of the federal poverty level will need to ensure their CHIP provider is also enrolled in Medicaid. If the provider does not accept Medicaid they will need to locate a new provider or they will be responsible for full payment of services and prescribed medications.

Providers solely seeing CHIP beneficiaries and not enrolled in Medicaid need to inform their patients of this upcoming change. If CHIP-only providers continue to provide services to the transition group after Jan. 1, 2014, the provider will be responsible for recovering payment of services from the former CHIP beneficiary.

To maintain patient caseloads, ensure uninterrupted compensation for services and assure continuity of care for this segment of children, the Division of Medicaid encourages affected providers to enroll in Medicaid.

Specially designated staff in the Bureau of Provider Beneficiary Relations are standing by to expedite the enrollment application process for these providers. We appreciate your patience during this change and would be happy to offer assistance to facilitate a smooth transition. For more information contact the Division of Medicaid by calling toll-free at (800) 421-2408 or (601) 359-6050.

IN THIS ISSUE

NEWS

MississippiCAN Evolves and Initiates Program Improvements

The Mississippi Coordinated Access Network or, MississippiCAN, was implemented in 2012 with the purpose of improving the lives of the most vulnerable Mississippians by meeting their medical needs. It began as an optional health care program, versus traditional Medicaid, with a limited number of beneficiaries eligible for enrollment. The three main goals were, and continue to be, to expand access for essential medical services, improve quality of care, and increase efficiencies resulting in cost effectiveness.

On Dec. 1, 2012, the Bureau of Coordinated Care (within the Mississippi Division of Medicaid) initiated an expansion of MississippiCAN after the Legislature granted authorization to raise the enrollment cap, making the program mandatory for many populations and behavioral health services. As a result of these changes, almost 100,000 new beneficiaries have been added to MississippiCAN over the last ten months.

MississippiCAN comes with many expanded benefits such as, no co-pays, unlimited office visits and access to case management through the health plans.

"For Medicaid, the program affords better coordination of care for our beneficiaries and a more stable fiscal environment for budget predictability," said Dr. David J. Dzielak, Executive Director of the Mississippi Division of Medicaid.

Currently, Medicaid has a contract with two coordinated care organizations, UnitedHealth Care and Magnolia Health Plan, charged with providing services to those enrolled. Participation in the program empowers beneficiaries to utilize the health plans for assistance with issues ranging from locating providers in their area, to coordinating with providers to ensure needed health care and equipment is approved.

Examples of success stories come from both coordinated care organizations making significant impacts on the lives of beneficiaries. One beneficiary, who was at risk of having both lower extremities amputated due to poor circulation, received medical equipment preventing unnecessary surgery. Their case manager contacted the beneficiary's primary care physician, who stated a specific compression system was needed to prevent any further damage to the beneficiary's extremities. Although the compression system was not a covered piece of durable medical equipment, the case manager coordinated with the provider and health plan to gain approval. Going a step further, the case manager also contacted a home health agency to have the beneficiary trained on how to properly use the equipment.

Another story illustrates how a case manager was able to assist a beneficiary who requested to change their medical home. Through conversation, the case manager discovered the beneficiary was traveling more than 100 miles for physical therapy appointments. To reduce this burden, the case manager was able to secure arrangements with a local hospital for the beneficiary to receive physical therapy, and change their medical home to a clinic less than 20 miles from the beneficiary's residence.

In both instances, these seemingly ordinary conversations and small steps resulted in big changes.

With hopes of turning all cases into success stories, the Division of Medicaid is dedicated to maintaining open lines of communication, expanding educational opportunities and assisting providers.

The first two years of implementation was a period of transition, not only for beneficiaries, but also for providers acclimating to the guidelines of each coordinated care organization. Acknowledging this adjustment, Dzielak said, "although the introduction of any new program has growing pains, Medicaid staff has made a concerted effort to listen to questions and concerns."

In addition to workshops offered by both health plans, the Division of Medicaid also holds annual provider workshops throughout the state. After attending these workshops

and reviewing provider requests, the division collaborates with the Magnolia Health Plan and UnitedHealth Care to ensure providers are well informed on the guidelines for the MississippiCAN program.

Another outcome of this combined effort has been devoting coordinated care staff to monitor the health plans to ensure claim payments are made accurately and no less than the Medicaid rate.

"The Bureau of Coordinated Care is dedicated to the success of the MississippiCAN and achieving the set goals of the program," said Roxanne Coulter, nurse administrator. "We encourage providers to contact us for assistance or inquires when needed, and allow us to work together to ensure Mississippi Medicaid beneficiaries receive quality, accessible health care."

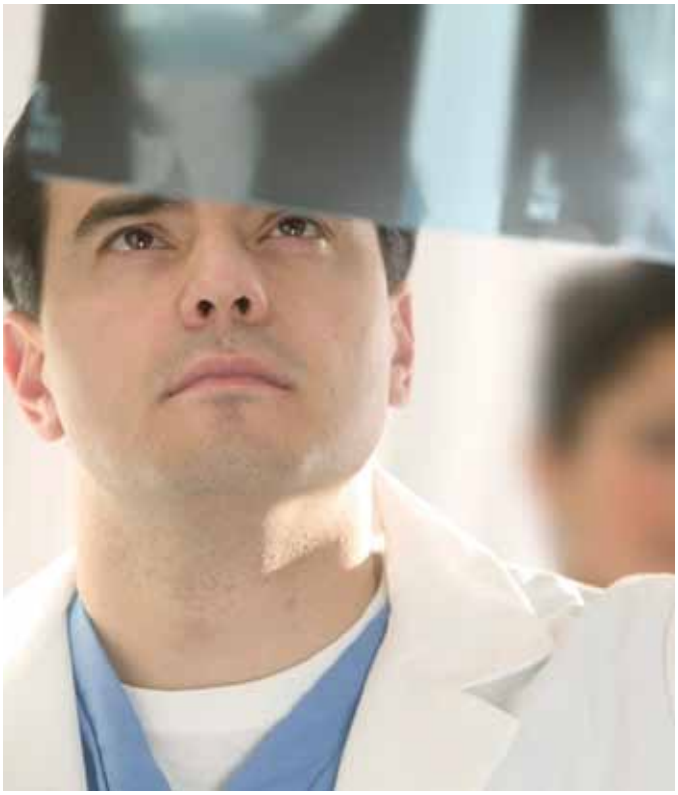
On Oct. 4, 2013, a Request for Proposals (RFP) for the second, three-year period of the program was released to the public. The RFP contains numerous improvements that will aid the Division of Medicaid in growing MississippiCAN into a more robust program to achieve our goals. These changes were the result of countless meetings with providers, beneficiaries and other bureaus within the Division of Medicaid to collect criticism, suggestions and requests regarding the future of the program.

Some of the biggest changes will include:

- required utilization of the Division of Medicaid Preferred Drug List;
- quality requirements and reporting improvements; and
- customer service improvements, including quicker turnaround times for provider payments, prior authorization requests and beneficiary inquiries.

Providers looking for assistance can contact the Bureau of Coordinated Care directly by phone at (601) 359-3789, or by visiting the website www.medicaid.ms.gov/mscan/Welcome.aspx and clicking on the Inquiry/Complaint link. All submissions receive a response within five working days.

"The initial overall success of MississippiCAN is encouraging to the parties involved," said Dzielak. "We look forward to the continuing evolvement of the program and positive impact it has on the health and well-being of our beneficiaries."



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.

PROVIDER COMPLIANCE

All Medicaid Providers – Prior Authorization Changes

Mississippi Division of Medicaid is changing several aspects of the prior authorization processes effective Dec. 1, 2013. Please see the information below for details.

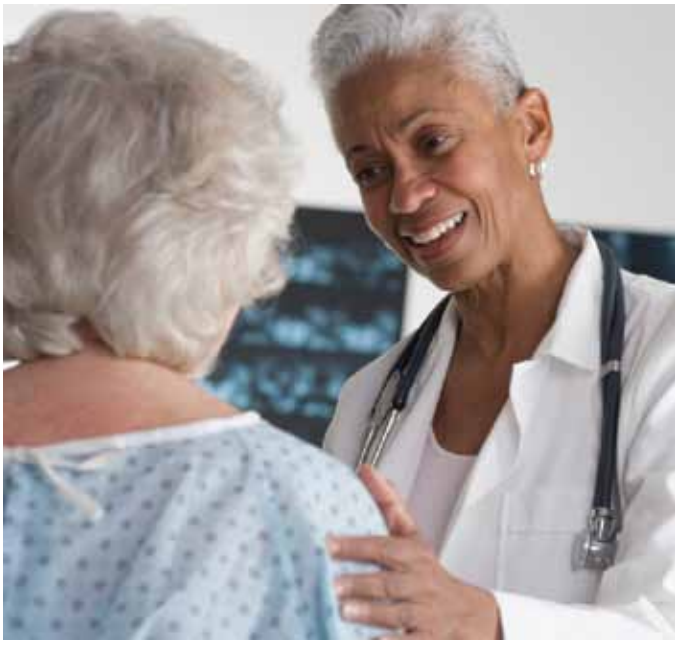
HEALTHSYSTEMS OF MISSISSIPPI HAS A NEW NAME

HealthSystems of Mississippi (HSM), one of the Utilization Management/ Quality Improvement Organization (UM/QIO) vendors for Mississippi Division of Medicaid, is changing their name to eQ Health Solutions (eQHS) effective Dec. 1, 2013. Prior authorization web submissions can be processed at http://ms.eqhs.org. Contact eQHS with any questions at (601) 360-4846.

DENTAL, EXPANDED EPSDT, HEARING, THERAPEUTIC AND EVALUATIVE, AND VISION PA'S HAVE A NEW HOME

Effective Dec. 1, 2013, eQ Health Solutions (formerly known as HealthSystems of Mississippi) will begin performing prior authorization reviews for the following services:

- Dental, oral surgery and orthodontia services
- Expanded EPSDT office visits (Physician visits over the twelve (12) visit per state fiscal year limit)
- Hearing services
- Therapeutic and evaluative mental health services for children
- Vision services



These services have traditionally been prior authorized through the Envision Portal or paper form by the Division of Medicaid. eQHS and the Division of Medicaid will offer provider training opportunities prior to and following this change. If you have questions or need more information, contact eQHS:

Toll-free (866) 740-2221
Local (601) 360-4961
Email education@hsom.org
Website http://ms.eqhs.org

This change does not impact Medicaid beneficiaries enrolled in the MS Coordinated Access Networks (MSCAN).

PHYSICAL, OCCUPATIONAL AND SPEECH LANGUAGE THERAPY HAVE NEW CRITERIA

Effective Dec. 1, 2013 eQ Health Solutions (formerly HealthSystems of Mississippi) will begin using National Guidelines as a tool to aid in making medical necessity determinations for prior authorization requests for physical, occupational and speech language therapy for eligible Beneficiaries.

The guidelines are professional resources endorsed by the American Physical Therapy Association, American Occupational Therapy Association, and the American Speech-Language Hearing Association. These guidelines will replace the Milliman/MCG Guidelines currently utilized. The new guidelines are readily available to all Providers and will enhance the alignment between Providers, professional organizations, and DOM's prior authorization requirements. For more information, visit http://ms.eqhs.org.

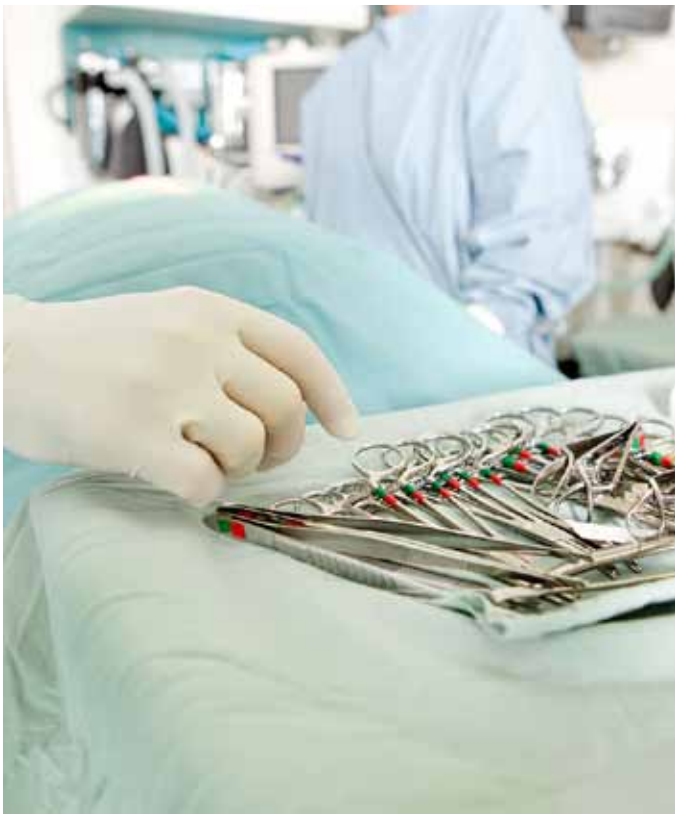
PRIOR AUTHORIZATION NEWS BY AREA

- Community Mental Health Services – Name and website change from HSM to eQHS (http://ms/eqhs.org)
- Dental, Dental Surgery and Orthodontia – eQHS new vendor (see article on page 4)
- Disabled Child Living at Home – Name and website change from HSM to eQHS
- Durable Medical Equipment – Bluepads, diapers and oxygen now included in the eQHS webportal autogeneration system along with nebulizers; Name and website change from HSM to eQHS
- Expanded EPSDT Office Visits – eQHS new vendor (see article on page 4)
- Hearing Services – eQHS new vendor (see article on page 4); MSDOM covers digital hearing aids, effective 12/01/13, please refer to the hearing fee schedule at www.medicaid.ms.gov/feeschedulelist.aspx, for fee, code and coverage details
- Home Health – Name and website change from HSM to eQHS
- Hospice – Name and website change from HSM to eQHS
- Inpatient Hospital – Name and website change from HSM to eQHS
- Inpatient Psychiatric Services – Name and website change from HSM to eQHS
- MYPAC – Name and website change from HSM to eQHS
- Organ Transplant – Name and website change from HSM to eQHS
- Outpatient Hospital Mental Health Services – Name and website change from HSM to eQHS

- Pharmacy – Prior Authorization form change (see article on page 10 of this bulletin for details)
- Physical, Occupational and Speech Language Therapy – New clinical guidelines (see article on page 4); Name and website change from HSM to eQHS
- Private Duty Nursing – Name and website change from HSM to eQHS
- Psychiatric Residential Treatment Facility – Name and website change from HSM to eQHS
- Radiology – No change (MedSolutions www.medsolutionsonline.com)
- School Health Related Physical, Occupational and Speech Language Therapy – New clinical guidelines (see article on page 4); Name and website change from HSM to eQHS
- Therapeutic and Evaluative Mental Health Services for Children – eQHS new vendor (see article on page 4)
- Vision Services – eQHS new vendor (see article on page 4)

Upcoming NCCI Edits for Evaluation-and-Management Services Billed with Surgical Procedures

On October 1, 2013, the Medicaid National Correct Coding Initiative (NCCI) added over 300,000 Procedure-to-Procedure (PTP) edits that pair certain evaluation-and-management (E&M) CPT codes in the ranges 99201 – 99499 and 92002 – 92014 as column two codes with all surgical procedure codes (over 5,000 codes). These edits were implemented in the Medicare NCCI program on July 1, 2013.



The introduction to the "Surgery" section of the *CPT Manual* provides a general description of the services that are components of a "surgical package", including related E&M codes. The Medicaid NCCI program has a more detailed definition of a global surgery policy as it relates to E&M codes billed by the surgeon. It is important to note that the upcoming PTP edits only address E&M codes billed on the same day as the surgery by the same physician. The edits do not address E&M services rendered prior to the day of surgery or during the global period after the day of surgery.

A description of the policy can be found in the *National Correct Coding Initiative Policy Manual for Medicaid Services* in the "Evaluation & Management Services" section of the surgery chapters. That manual is posted on the Medicaid NCCI webpage on the Medicaid.gov website:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html.

The global surgery policy divides surgical procedures into two groups – major and minor surgeries. The Medicaid NCCI program utilizes the same definition of major and minor surgery as the Medicare program.

- Major surgery – those codes with 090 Global Days in the "Medicare Physician Fee Schedule Database / Relative Value File"
- Minor surgery – those codes with 000 or 010 Global Days

The Medicare designation of global days can be found in the 2013 "Medicare National Physician Fee Schedule Database / Relative Value File" on the CMS website at:

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU13B.html.

In the zip file, select document " PPRRVU13_V0215_02132013.xlsx" and refer to "Column O, Global Days".

In brief, the NCCI program policy for E&M services rendered by the surgeon on the day of surgery states:

- For major surgical procedures, an E&M service addressing the decision to perform the surgery is payable on the date of surgery. That service may be reported with modifier 57, if appropriate. Other preoperative E&M services on the date of surgery are not separately reportable.
- For minor surgical procedures, an E&M service addressing the decision to perform the surgery is not separately payable on the date of surgery and should not be reported. This is true even if the patient is "new" to the provider. If an unrelated significant and separately identifiable E&M service is performed on the day of surgery and before the surgery, it may be reported with modifier 25, if appropriate.
- For all surgical procedures, other E&M services related to the surgical procedure or to post-operative complications are not separately payable on the day of surgery and should not be reported.
- For all surgical procedures, significant and separately identifiable postoperative E&M services rendered on the day of surgery that are unrelated to the diagnosis for which the surgical procedure was performed are separately payable. They may be reported with modifier 24 or 25 if appropriate.

All of the upcoming surgery/E&M code edits will have a Correct Coding Modifier Indicator (CCMI) of "1", which should allow the edit to be bypassed, if a PTP-associated modifier is appended to the E&M code. The PTP-associated modifiers that are applicable to these edits are:

- Modifier 24 – Unrelated E&M service during the postoperative period
- Modifier 25 – Significant, separately reportable E&M on the same day as the surgery
- Modifier 57 – E&M service that resulted in the decision to perform a major surgical procedure

If a surgery code and an E&M code are reported by the same physician for the same date of service and if a PTP-associated modifier is not correctly appended to one of the codes, payment for the column two E&M code will be denied and the column one surgery code will be eligible for payment.

In order to prevent unintended denials of payment for valid claims, it is important to understand this policy and bill accordingly, utilizing modifiers 24, 25 and 57, when appropriate.

If payment for a claim with an E&M code is denied because the provider did not append one of these modifiers, when it would have been appropriate to do so, the claim may be resubmitted with the modifier appended to the code.

For additional general information regarding PTP edit characteristics, claim adjudication rules and PTP-associated modifiers, refer to the *Medicaid NCCI Edit Design Manual*, which is posted on the Medicaid NCCI webpage at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html.

Attention Private Duty Nursing Providers

PDN providers must submit a plan of care to the UM/QIO at least ten (10) days prior to initiation of services and ten (10) days prior to the last day certified on continued stay reviews. If the required information is not received by the UM/QIO the hours from the last certification period until the date of receipt of required documentation are subject to denial. The provider cannot bill the beneficiary for those hours if the provider failed to seek certification in a timely manner. Information pertaining to request for preadmission certification and continued stay/recertification for PDN services can be found at: http://www.hsom.org/Provider%20Manuals%20and%20Forms%20with%20new%20Address/HH/PDN/PDN%20Manual.pdf

Billing Evaluation & Management (E & M) Codes for Mental Health Services

Effective July 1, 2013, Evaluation and Management (E & M) CPT codes billed for mental health services required one of the modifiers below. These modifiers are needed in order for the service to be applied to the appropriate service limit.

Provider Type	Claim Type	Modifier
Psychiatrist Physician Physician Assistant Nurse Practitioner	P	HI
Community Mental Health Center Private Mental Health Center	M	HW

Any claims previously submitted with a date of service on or after July 1, 2013 that did not include the required modifier for psychiatry E & M services should be voided and resubmitted. Please contact Kim Sartin-Holloway, Charlene Toten, or Bonlitha Windham at 601-359-9545 if you have questions.

Time Limit for Filing Claims

Claims for covered services will be paid only when received by the fiscal agent within 12 months of the through/ending date of service. Providers are encouraged to submit claims on a timely basis. The following are the only reasons allowing consideration for overriding the timely filing edit:

1. Claims filed within 12 months from the date of service, and were denied can be resubmitted with the transaction control number (TCN) from the original denied claim recorded in the appropriate field on the resubmitted claim.
2. Claims over 12 months can be processed if the beneficiary's Medicaid eligibility has been approved retroactively by the Division of Medicaid or the Social Security Administration through their application processes. When Medicaid is the primary insurance the claims can be filed hardcopy or electronically as they no longer require proof of the retroactive determination. The claims must be submitted within 12 months of the retroactive determination date.
3. Newly enrolled providers have 1 year from the date of their welcome letter to submit initial claims for payment
4. The 180-day filing limitation for Medicare/Medicaid crossover claims will be determined using the Medicare payment register date as the date of receipt by Medicaid. Claims filed after the 180-day timely filing limitation will be denied. Claims submitted two years from the date of service are not reimbursable unless the beneficiary's Medicaid eligibility is retroactive. If the beneficiary is a dual eligible, the claims must be filed and processed within 6 months of the retroactive determination date.

If you have any questions or require additional information, please contact Xerox Provider and Beneficiary Services at 1-800-884-3222.

Update Your Provider File!

Providers are encouraged to utilize the Change of Address form and the Direct Deposit Authorization agreement located on the Envision Web Portal at https://msmedicaid.acs-inc.com/msenvision/. Once completed, these forms should be faxed to the attention of Provider Enrollment at 1-888-495-8169. This helps to ensure that the Mississippi Division of Medicaid has the most current and accurate information on your provider file.

If you have any questions or require additional information, please contact Xerox Provider and Beneficiary Services at 1-800-884-3222.

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.***

PHARMACY

Pharmacy Permit Renewal, Expiration December 31, 2013

MS Medicaid requires that providers be in good standing with their regulatory authorities. Pharmacists are required to update their provider information with license renewal information with Division of Medicaid's (DOM) fiscal agent or Xerox. Most MS pharmacy permits expire on December 31, 2013.

Fax the following to Xerox's Provider Enrollment at 1- 888-495-8169 and not to DOM's Pharmacy Bureau:

- Cover sheet with name of pharmacy and/or pharmacy DME, MS Medicaid provider number(s), NPI(s), and a copy of the renewal(s).
- If you are going to use the pharmacy license to update both, MS Medicaid Pharmacy and DME provider numbers, please indicate that on the cover sheet, otherwise only your pharmacy license will be updated.
- To assure that the information DOM has on hand is accurate, be sure to include the servicing pharmacy's email address, telephone number and facsimile number on the cover sheet.

Please take time now to verify if your permit expires on December 31, 2013. Be advised that Pharmacy claims may **deny** after December 31, 2013 ***IF*** license renewal information has not been submitted to Xerox. ***If you fax these documents to DOM, they will be returned to you.***

Preferred Drug List Update, Effective January 1, 2014

DOM's Preferred Drug List or PDL undergoes an annual review each autumn. The revisions brought about by this annual review will become effective the following January 1st. To reference the current PDL, go to http://www.medicaid.ms.gov/Pharmacy.aspx and select the MS Preferred Drug document from the menu on the left hand side of the page. To view the document in its entirety, go to 'MS PDL Effective January 1, 2014.' To reference the preferred/non-preferred additions and deletions, see 'MS PDL Changes-Provider Notice, effective January 1, 2014.'

We recommend adding this link to your favorites as you will find it very helpful.

Limited Number of CHIP Beneficiaries Moving to Medicaid Fee For Service (FFS), Effective January 1, 2014

In accordance to new federal guidelines, some CHIP beneficiaries will become Medicaid FFS eligible on January 1, 2014. *Beneficiary identification numbers for CHIP and Medicaid are the same.* When processing a pharmacy claim for a CHIP beneficiary who becomes eligible for Medicaid FFS on January 1, 2014, the following message will be returned to pharmacy providers:

Bill Medicaid BIN 610084, PCN DRMSPROD, GROUP SIPPI. Providers should call 800-884-3222 for all issues and questions.

New Pharmacy Prior Authorization (PA) Manual Form, Effective January 1, 2014

In accordance to state law passed in the 2013 legislative session, health benefit plans, including Medicaid, are directed to establish a standardized pharmacy prior authorization form.

DOM encourages Medicaid providers to use preferred agents whenever possible; most preferred drugs do not require PA. Drugs designated as preferred have been selected for their efficaciousness, clinical significance, cost effectiveness, and safety for Medicaid beneficiaries. Note that there are multiple preferred alternatives for non-preferred drugs. Before submitting a PA request, remember to check for options not requiring a PA on the current PDL which may be referenced on http://www.medicaid.ms.gov/Pharmacy.aspx.

To reference the new Medicaid fee for service (FFS) Pharmacy form, go to http://www.medicaid.ms.gov/Pharmacy.aspx, and click on Prior Authorization. Pharmacy PA FAX line is 1-877-537-0720.

Online PA submission is strongly recommended and is the quickest, most efficient way to enter and process a PA:

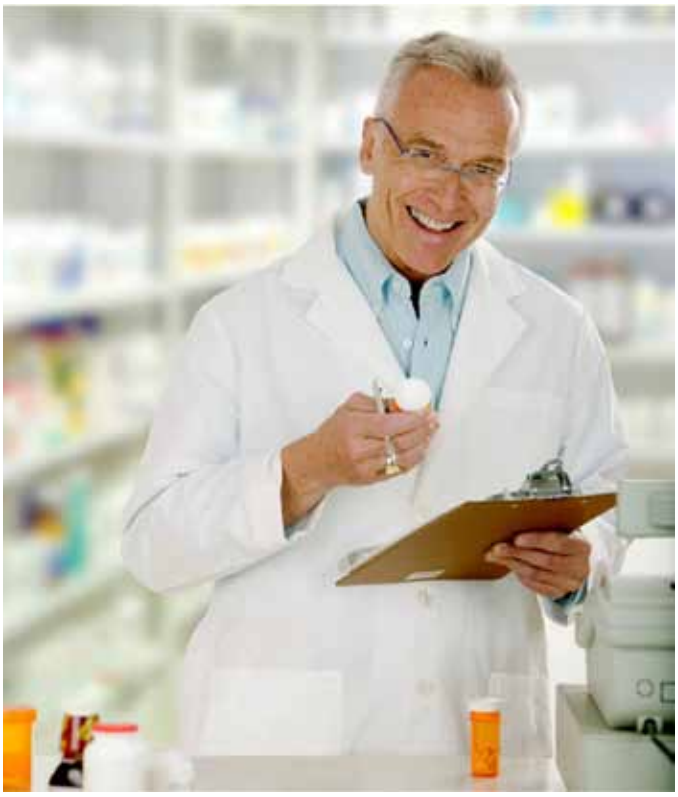
- If you are a MS MEDICAID PRESCRIBER, please submit your PA requests via the Envision Web Portal for the most efficient processing. https://msmedicaid.acs-inc.com/msenvision/pharmacyPriorAuthAction.do
- If you are a MS MEDICAID PRESCRIBER, but are not a registered MS ENVISION WEB PORTAL USER, click here to register https://msmedicaid.acs-inc.com/msenvision/regUserSelection.do

Be mindful that in order for DOM to be in compliance with state law, submissions on forms used previously can no longer be accepted for Medicaid beneficiaries and will be returned to the prescriber.

Billing Changes: Over-the-Counter (OTC) Drugs for Beneficiaries Residing in Long-Term Care Facilities

Effective January 1, 2014, over the counter drugs (OTCs) can no longer be billed to MS Medicaid as a point of service (POS) claim for beneficiaries residing in LTC facilities, i.e. Nursing Home (NH), Intermediate Care Facilities for the Mentally Retarded (ICFMR) and Psychiatric Residential Treatment Facilities (PRTF). For these beneficiary populations, DOM's OTC formulary items are now considered 'stock items' and are to be included in the facility's cost report.

DOM's OTC formulary can be located at http://www.medicaid.ms.gov/Pharmacy.aspx. The only exclusions to this policy are as follows:



- ***OTC insulin:*** bill dually eligible beneficiary's Medicare Part D plan; for the Medicaid only, bill Medicaid as a POS claim.
- ***Pseudoephedrine and Pseudoephedrine combination products limited to agents listed on the OTC formulary:*** since these agents are classified as controlled substances in MS, for the dually eligible and Medicaid only, bill Medicaid as a POS claim.
- ***Guaifenesin/codeine limited to agent(s) listed on the OTC formulary:*** since this agent is classified as controlled substance in MS, for the dually eligible and Medicaid only, bill Medicaid as a POS claim.

Effective January 14, 2014: FDA Dose Reduction of Acetaminophen in Prescription Drugs

For several years, the FDA has been actively involved regarding drug safety for both legend and over the counter drugs. Now, the FDA is taking steps to reduce the maximum dosage unit strength of acetaminophen in prescription drug products. This change will provide an increased margin of safety to help prevent liver damage due to acetaminophen overdosing, a serious public health problem. This notice explains the reasons for the reduction in dosage unit strength and describes how FDA is implementing it for approved prescription drug products that exceed the new maximum tablet or capsule strength. FDA is also requiring safety labeling changes, including a new boxed warning, for acetaminophen-containing prescription drug products to address new safety information about the risk of liver damage. Sponsors of approved prescription drug products containing more than 325 milligrams (mg) of acetaminophen have until January 14, 2014 to request that FDA withdraw approval of the product's application, after which they may be subject to action by FDA.

Be advised that the FDA originally posted notice on January 10, 2011, giving industry 3 years to implement these changes. To view the notice, go to http://www.regulations.gov/#!documentDetail;D=FDA-2011-N-0021-0001. To view the list of the affected products , see this Excel file.

Additionally, this notice is posted on the Pharmacy Services page of the Agency's website at http://www.medicaid.ms.gov/Pharmacy.aspx.

Effective December 1, 2013: Addition of Zoster Vaccine Administered in the Pharmacy Venue to Medicaid Fee for Service (FFS) Beneficiaries

Effective December 1, 2013, in the MS Medicaid Pharmacy program zoster immunizations are covered services for Medicaid beneficiaries ages 60 and older. 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 a dispensing fee for immunizations administered in the pharmacy venue. *No administration fee is paid for immunizations administered in the pharmacy venue.*

For the dually eligible, bill the beneficiary's Medicare Part D plan.

LONG-TERM CARE

Attention Assisted Living Waiver Providers

The Assisted Living Waiver was renewed for an additional five (5) years by The Centers of Medicare and Medicaid Services (CMS) effective October 1, 2013. In the near future, the Division of Medicaid will be sponsoring training opportunities for Medicaid Assisted Living Waiver providers to become familiar with the new waiver requirements. The Division of Medicaid will be reaching out to providers regarding scheduled dates, times and venues for the upcoming training.

James Horton has accepted the position of Division Director I within the Bureau of Long Term Care and will be responsible for the oversight of the Assisted Living Waiver and Hospice services. He has been with DOM for over ten years and we look forward to his continued contributions to Home and Community Based Services. Should questions arise concerning the Assisted Living Waiver or Hospice services that are not covered by Mississippi CAN, please contact Mr. Horton at 601-359-9544.

2013 Owner Salary Limits for Long-Term Care Facilities

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities as owner's salaries for 2013 are based on 150% of the average salaries paid to non-owner/ administrators that receive payment for services related to patient care. The limits apply to all salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2013 are as follows:

Small Nursing Facilities (1-60 Beds)	$127,202
Large Nursing Facilities (61 + Beds)	$149,048
Intermediate Care Facilities for individuals with intellectual disabilities (ICF-IID)	$138,354
Psychiatric Residential Treatment Facilities (PRTF)	$201,516

PROVIDER FIELD REPRESENTATIVES

PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY		
AREA 1 **Cynthia Morris (601.572.3237)** **cynthia.morris2@xerox.com**	**Area 2** **Prentiss Butler (601.206.3042)** **prentiss.butler@xerox.com**	**AREA 3** **Clint Gee (662.459.9753)** **clinton.gee@medicaid.ms.gov**
County	**County**	**County**
Desoto	Alcorn	Bolivar
Lafayette	Benton	Coahoma
Marshall	Itawamba	Leflore
Panola	Lee	Quitman
Tate	Pontotoc	Sunflower
Tunica	Prentiss	Tallahatchie
	Tippah	Yalobusha
	Tishomingo	
***Memphis**	Union	
AREA 4 **Charleston Green (601.359.5500)** **charleston.green@medicaid.ms.gov**	**AREA 5** **Ekida Wheeler (601.572.3265)** **ekida.wheeler@xerox.com**	**AREA 6** **Cherry Woods (601.206.3013)** **cherry.woods@xerox.com**
County	**County**	**County**
Attala	Holmes	Kemper
Calhoun	Humphreys	Lauderdale
Carroll	Issaquena	Lowndes
Chickasaw	Madison	Neshoba
Choctaw	Sharkey	Newton
Clay	Washington	Noxubee
Grenada	Yazoo	Winston
Monroe		
Montgomery		
Oktibbeha		
Webster		
AREA 7 **Candice Granderson (601.206.3019)** **candice.granderson@xerox.com**	**AREA 8** **Justin Griffin (601.206.2922)** **Zip Codes (39041-39215)** **justin.griffin@xerox.com** **Randy Ponder (601.206.3026)** **Zip Codes (39216-39296)** **randy.ponder@xerox.com**	**AREA 9** **Joyce Wilson (601.359.4293)** **joyce.wilson@medicaid.ms.gov**
County	**County**	**County**
Adams	Hinds	Copiah
Amite		Leake
Claiborne		Rankin
Franklin		Scott
Jefferson		Simpson
Warren		
Wilkinson		
AREA 10 **Nadia Shelby (601.206.2961)** **nadia.shelby@xerox.com**	**AREA 11** **Pamela Williams (601.359.9575)** **pamela.williams@medicaid.ms.gov**	**AREA 12** **Connie Mooney (601.572.3253)** **connie.mooney@xerox.com**
County	**County**	**County**
Clarke	Covington	George
Forrest	Jefferson-Davis	Hancock
Greene	Lawrence	Harrison
Jasper	Lincoln	Jackson
Jones	Marion	Pearl River
Lamar	Pike	Stone
Perry	Walthall	
Smith		
Wayne		**Mobile, AL**
OUT OF STATE PROVIDERS	**Lashundra Othello (601.206.2996) lashundra.othello@xerox.com** **Jonathan Dixon (601.206.2922) jonathan.dixon@xerox.com**	

BLOW THE WHISTLE ON FRAUD

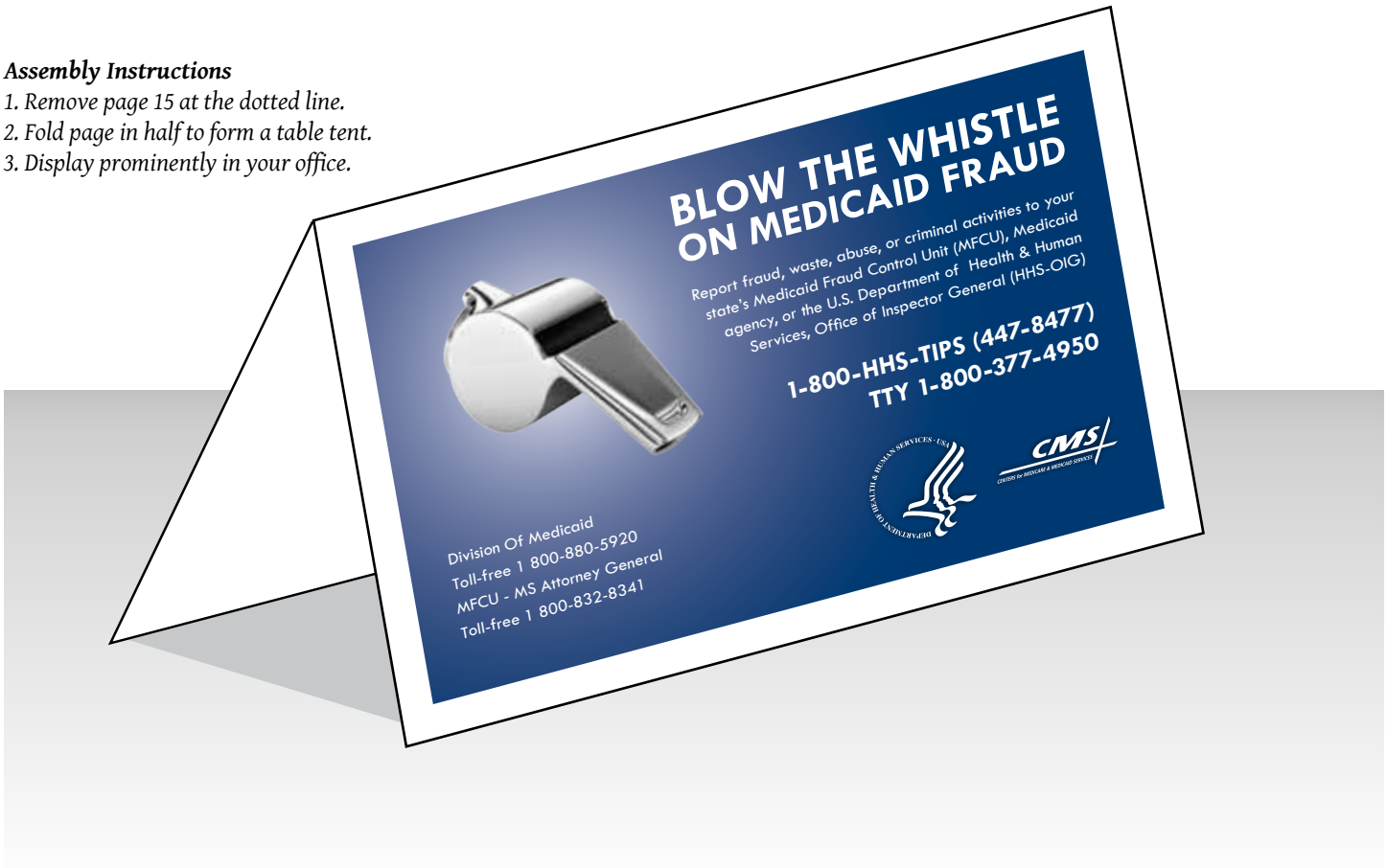
In an effort to increase the awareness of Medicaid Fraud, the Center for Medicare and Medicaid Services (CMS) has developed educational material for Medicaid providers and beneficiaries on how to report Medicaid fraud. The educational material is entitled "Blow the Whistle on Medicaid Fraud." This material contains valuable information that details different ways of Medicaid fraud, waste, and abuse (FWA) can occur. Also, the material lists the various agencies where Medicaid providers and beneficiaries can report Medicaid fraud.

The main source for reporting Medicaid fraud is to the Division of Medicaid Program Integrity (PI) Bureau at 1-800-880-5920. If there are problems reporting Medicaid fraud to DOM, please contact the Medicaid Fraud Control Unit (MCFU) of the Mississippi Attorney General's office at 1 800-832-8341. Also, Medicaid fraud can be reported to the U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG) at 1 800-447-8477.

Included in this bulletin is a tear-away page that forms a tent (page 15). Please remove the tent and display it in your office(s). On one side of the tent are telephone numbers for appropriate entities to report fraud, waste and abuse. On the opposite side are common types of inappropriate payments and/or abuses and definitions of each that are seen by CMS, the Division of Medicaid (DOM) and the Mississippi Attorney General's Medicaid Fraud Control Unit (MFCU). Please help us in the fight against Medicaid fraud.

Assembly Instructions

1. Remove page 15 at the dotted line.
2. Fold page in half to form a table tent.
3. Display prominently in your office.



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.

Upcoding/Billing Fraud and Abuse	Billing for services at a level of complexity that is higher than the service actually provided or documented, billing for services not provided, duplicate billing, or billing in ways inconsistent with sound financial management, professional standards, or payment/billing
Services or Supplies Not Rendered	Billing for services or supplies not provided to a beneficiary and/or not including appropriate documentation
Kickbacks	Soliciting or receiving remuneration (in kind or in cash) in return for referring individuals, goods, or services for which payment may be made under Federal healthcare programs
Excluded individuals	Employing or contracting with any excluded individual or entity for the provision of items or services that are reimbursable, directly or indirectly, by any Federal healthcare program
Drug Diversion	Illegally distributing, abusing, or unintentionally using prescription drugs
Provider Identity Theft	Billing for items or services using another Medicaid provider's number
Patient Abuse/Neglect	Abusing, neglecting, or exploiting Medicaid patients, including committing physical and mental abuse, withholding medically necessary services, or neglecting to provide appropriate or adequate quality of care
Waste	Over-utilizing Medicaid benefits, such as prescribing inappropriate or unnecessary drugs, medical equipment and supplies, or medical services

Medicaid fraud, waste, and abuse (FWA) occurs in many different forms. Below are examples of some common types of FWA. It is not intended to be a complete list. If you have any questions regarding FWA, contact the MFCU or Medicaid agency in your state or call HHS-OIG.

BLOW THE WHISTLE ON MEDICAID FRAUD

Report fraud, waste, abuse, or criminal activities to your state's Medicaid Fraud Control Unit (MFCU), Medicaid agency, or the U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG)

1-800-HHS-TIPS (447-8477)
TTY 1-800-377-4950

Division Of Medicaid
Toll-free 1 800-880-5920
MFCU - MS Attorney General
Toll-free 1 800-832-8341

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

XEROX STATE HEALTHCARE, LLC
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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.medicaid.ms.gov

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

DOM & Xerox State Healthcare, LLC., wish you a Merry Christmas!

DECEMBER 2013

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

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