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MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

Division of Medicaid Adjusting to Affordable Care Act Requirements

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Over the last several years there has been a great deal of interest in the Affordable Care Act. The majority of the provisions of this law were set to be implemented by January 1, 2014. Now that the date has passed, I thought it might be instructive to review the history and requirements of the Affordable Care Act and how it's affecting the Mississippi Division of Medicaid (DOM) and you as the provider.

History and Background

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law. On March 30, 2010, Congress enacted and passed into law the Health Care and Education Reconciliation Act of 2010 as an amendment to the PPACA. Together, these two laws (commonly referred to as the Affordable Care Act or ACA) comprise the largest comprehensive reform to the United States health care system since the enactment of Medicare and Medicaid in 1965. However, the constitutionality of the ACA was challenged by several states, and their repeal efforts reached the United States Supreme Court.

On June 28, 2012, the Supreme Court upheld the ACA with the caveat of restricting one section impacting Medicaid expansion. The ACA, as written, requires states to enlarge their Medicaid programs to cover lower-income adult populations. If states refused to cover these individuals, the Center for Medicare and Medicaid Services (CMS) could withhold the federal matching funds for the states' existing Medicaid beneficiaries. The Supreme Court ruled that this tenant of the law was unduly coercive to states to expand Medicaid coverage. Therefore, states now had the option to expand or not to expand Medicaid to cover this non-pregnant, non-elderly adult population.

During the 2013 session, the Mississippi Legislature decided not to expand the Medicaid program to cover non-pregnant, non-elderly adults. However, the Mississippi Division of Medicaid is still required to comply with the mandatory requirements of the ACA which are described below.

IN THIS ISSUE

Foster Children Expansion to Age 26

In Mississippi, the health-care needs of most foster children are covered either by Medicaid or the Department of Human Services (DHS). Currently, eligible foster children receive Medicaid coverage until age 21. Beginning January 2014, the ACA mandate requires states to extend coverage to age 26. This regulation builds upon the Foster Care Independence Act of 1999, which gave states the option of extending Medicaid coverage to foster children from age 18 to age 21.

The expansion of coverage for foster children coincides with ACA requirements for private insurers to allow children to be covered by their parents' health insurance to age 26. As of December 31, 2013, 6,919 children are in foster care and on adoption assistance certified by DHS for services that are covered by Medicaid. DOM estimates that the extension of Medicaid coverage for foster children from age 21 to age 26 will have a financial impact on the state budget of approximately $12 million over the next seven years.

Health Insurer Fee

Another ACA mandate requires private health insurers nationwide to pay an annual fee of $8 billion. On the surface the health insurance fee seems to have little impact to the state or DOM. However, our managed care organizations that participate in the Mississippi Coordinated Access Network (MississippiCAN) will be impacted by this fee. As a result, this fee will be passed down to DOM in the form of an increase in cost per beneficiary participating in the MississippiCAN program. DOM estimates that managed care fees will increase by 1.4 percent in 2014 and by 2.5 percent for 2015 through 2020. The estimated financial impact to the state from 2014 through 2020 for the health insurer fee is $92 million.

New Methodology to Determine Eligibility for Medicaid

Included in the ACA mandates and part of eligibility modernization is an updated method for determining income qualifications called Modified Adjusted Gross Income (MAGI), which utilizes Internal Revenue Service (IRS) rules. Theoretically, MAGI will standardize and simplify the eligibility process nationwide by changing how income is calculated and household composition is defined. For example, the current complex system of income disregards will be replaced by a flat 5 percent universal rate and stepparents will be included in the broader family definition.

MAGI will apply to populations who make up 65 percent of our beneficiaries such as children, caretakers, pregnant women and low income families. This system will not apply to a specific list of categories including the Age, Blind and Disabled (ABD) group and foster care children. The net effect of eligibility modernization is expected to increase the number of individuals who qualify for Medicaid services. These updates will help us be a more efficient agency to provide access to quality health-care in the state.

Enhanced Payments to Primary Care Physicians

In order to ensure access for services to meet the anticipated higher demand for care, the ACA requires states to pay primary care physicians (family medicine, internists and pediatricians) fees equal to those paid by Medicare. These enhanced payments will minimize the difference between the state's Medicaid fees effective July 1, 2009, and Medicare fees for 2013 and 2014. There is a wide range between Medicaid to Medicare fees across the country; listed below are a few facts regarding this comparison:

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

The primary care fee increase is fully funded by the federal government for 2013 and 2014 (calendar years). Right now it is uncertain if the enhanced payment to primary care physicians will continue beyond 2014, and ultimately, this decision will be determined by our elected officials. If enhanced payments are extended, the estimated cost to the state would be approximately $76 million for 2015 to 2020.

The Welcome Mat Population

Currently a segment of the population qualifies for Medicaid but is not enrolled in the program. It is anticipated that the increase in awareness surrounding the ACA will encourage this already eligible group of people to seek health-care coverage through Medicaid. In addition, through pressure from the individual mandate (the ACA requirement that individuals obtain some form of health insurance), referrals

from the Health Insurance Exchange, and potential loss of employer coverage, many people will discover they are actually eligible for Medicaid.

As a result, the welcome mat has the potential of adding 48,000 to 72,000 Mississippians to Medicaid as beneficiaries. The welcome mat population represents a significant financial challenge to DOM and the state, being the largest expenditure of the mandatory ACA provisions. In respect to medical services costs, this population will be considered regular beneficiaries, matched at our current federal medical assistance percentage (FMAP) of 73.05 percent. The total estimated cost to cover the welcome mat population and maintaining these enrollees through 2020 is $413 million in expenditures to the state budget.

CHIP to Medicaid Transition

The ACA requires that states extend Medicaid coverage up to 138 percent of the federal poverty level for children ages 6 to 18 years of age. In Mississippi this transition will affect approximately 30,000 children and was set to happen on January 1, 2014. Due to concerns over the continuity of care for these children during this transition, Mississippi asked for and was granted an extension of this deadline until December 31, 2014. The federal government will provide an enhanced FMAP for this transitioning population through 2020. Because of the enhanced FMAP, this transition is projected to be a cost-saver for DOM of approximately $239 million over the next seven years.

DOM has been working diligently to prepare for the mandatory changes required by the ACA. The ACA significantly impacts how we operate Medicaid in Mississippi. Our goal is for a seamless transition as DOM works to minimize any disruptions to you as the provider community.

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 www.ms-medicaid.com.

iPASS Summit

www.msmaonline.com

The Mississippi State Medical Association (MSMA) is hosting the 2014 iPASS Summit to provide an opportunity for physicians and their staff to:

- ✓ Gain direct access to major healthcare payers, including the Division of Medicaid, eQhealth Solutions, MedSolutions, Xerox, MississippiCAN/CHIP, UnitedHealthcare, Magnolia Health Plan, Ambetter, etc.
- ✓ Learn tips to get paid more efficiently;
- ✓ Meet payor representatives to resolve individual claims issues; and
- ✓ Preview new programs, policy changes, and claims submittal tips.

The 2014 iPASS events will be held on the following dates at the locations noted below:

May 2, 2014	Oxford, MS	Oxford Conference Center
May 7, 2014	Hattiesburg, MS	Lake Terrace Convention Center
May 9, 2014	Pearl, MS	Hinds Community College, Muse Center

For more information and/or questions, please visit www.msmaonline.com.





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 2014 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
Tuesday, March 25, 2014	**1:00 - 4:00 P.M.**
Tuesday, May 13, 2014	**1:00 - 4:00 P.M.**
Tuesday, July 22, 2014	**1:00 - 4:00 P.M.**
Tuesday, September 23, 2014	**1:00 - 4:00 P.M.**
Wednesday, November 19, 2014	**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.

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**,

  Select (*) for MississippiCAN enrollment and eligibility,
  Select (1) for Non-MSCAN Beneficiary Calls,
  Select (2) for Provider related Calls, or
- ✓ Calling the Automated Voice Response System (AVRS), or
- ✓ Accessing the Point of Service eligibility verification system, or
- ✓ Accessing the Envision Web Portal at new address www.ms-medicaid.com

Providers must state or enter the date of service to verify the correct payer, as eligibility changes from regular Medicaid coverage to MississippiCAN coverage. MSCAN has two Coordinated Care Organizations (CCOs): Magnolia Health Plan and UnitedHealthcare. Eligibility also changes from one CCO to the other. These two CCOs are to be billed for medical services for all beneficiaries that are enrolled in MSCAN. These CCOs also have Durable Medical Equipment (DME) and 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
Mississippi Medicaid	Blue (new cards) Green (old cards)	Multiple	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 Health Plan	Purple	Medical	1-866-912-6285	
Cenpatico	(same card)	Behav Hlth	1-866-912-6285	
Univita	(same card)	DME	1-866-912-6285	
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)	Behav Hlth		
OptumRx	(same card)	Pharmacy	1-877-305-8952	
CHIP			1-800-884-3222	1-800-421-2408
UnitedHealthcare	White	Multiple	1-877-743-8731	

NEWS

Especially for You . . . Our Providers

The Mississippi Division of Medicaid (DOM) is diligent in keeping its Providers informed and updated on all Medicaid related Federal and State regulations. There are various avenues through which the DOM distributes and makes available updates to its providers. The Envision Web Portal, "your One-Stop Resource", is one of those options as it offers providers the ability to search and retrieve pertinent information. Providers may log into the web portal for answers to frequently asked Medicaid questions, contact information, provider bulletins, banner messages, online provider enrollment and to check the enrollment status of pending applications. Access to the web portal is available 24 hours a day, 7 days a week, and 365 days a year at www.ms-medicaid.com.

Additionally, "Late Breaking News" postings are available to providers for a more up-to-date listing of issues and recommended resolutions concerning Medicaid claims concerns. Providers may also contact Xerox Provider and Beneficiary Services at (800) 884-3222, if you have questions or need additional information.

Medicaid Identification Card Changes Color

In the coming months, all newly approved and current Mississippi Medicaid beneficiaries will receive a blue identification card displaying the new Mississippi Division of Medicaid logo. For current beneficiaries, the new blue identification card will replace their green identification card.

During the transition of issuing new Medicaid Identification cards, all providers are asked to continue to provide services for all eligible beneficiaries with green or blue Medicaid cards. It is important to note, that the color change for Medicaid's identification cards does not reflect any changes in benefits or services.

- If there are questions regarding identification cards or if a beneficiary needs a replacement identification card, providers should contact Xerox at (800) 884-3222.

- To verbally verify a beneficiary's eligibility status or service limits, providers should contact Xerox at (800) 884-3222 or the MS Division of Medicaid, Bureau of Provider Beneficiary Relations at (800) 421-2408.

More details will be forthcoming as the new blue MS Medicaid Identification card is rolled out.

Phase II Cardiac Rehabilitation Services

Effective February 1, 2014, Mississippi Division of Medicaid (DOM) will cover Phase II Cardiac Rehabilitation services for Medicaid beneficiaries eighteen (18) and older when ordered by a physician and if medically necessary. DOM defines Phase II Cardiac Rehabilitation services as a physician supervised program designed to recondition the cardiovascular system and restore beneficiaries with cardiovascular heart disease to their optimal functional status including their physiological, psychological, social, vocational and emotional status. Phase II Cardiac Rehabilitation Services must be furnished in the outpatient hospital setting with physician supervision as required in compliance with AACVPR guidelines, and prior authorized by the current Utilization Management and Quality Improvement Organization (UM/QIO).

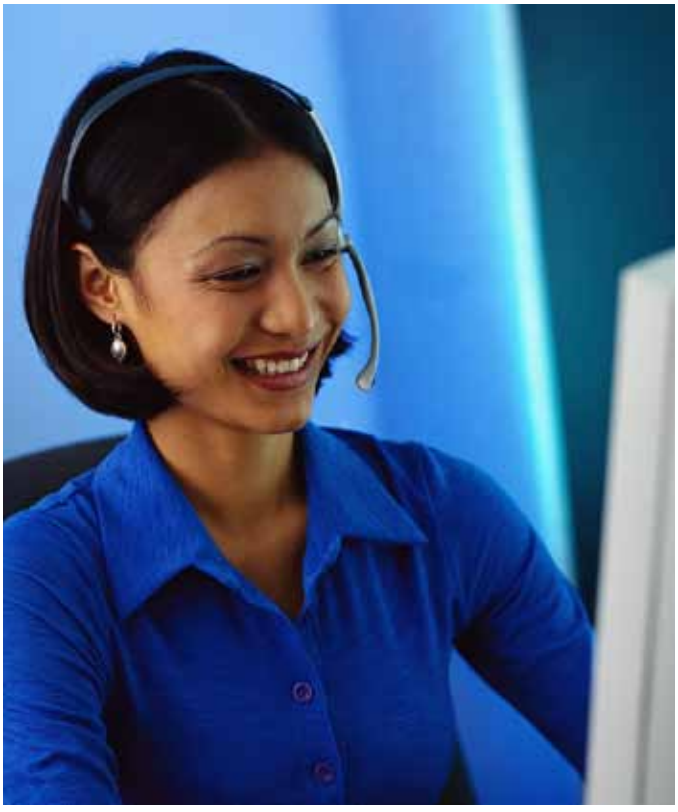
DOM covers up to thirty-six (36) Phase II Cardiac Rehabilitation sessions per twelve (12) months regardless of the number of qualifying episodes. The thirty-six (36) Phase II Cardiac Rehabilitation sessions must occur within twelve (12) weeks from initiation of services unless a medical condition prevents the beneficiary from completing the thirty-six (36) sessions. Prior authorization for the extension must be obtained from the Utilization Management and Quality Improvement Organization (UM/QIO) for up to an additional twelve (12) weeks.

If you have any questions, please contact Fallon Brewster, Program Administrator, or Christy Lyle, Program Nurse, at 601-359-6150.

Mississippi Medicaid Provider Billing Manual

The Mississippi Medicaid Provider Billing Manual is designed to provide guidance and assistance to providers in submitting beneficiary claims to the Mississippi Division of Medicaid (DOM). The manual provides step-by-step instructions on completing claim forms to ensure providers are reimbursed in a timely manner for services rendered.

Providers may obtain a hard copy of the manual at a minimal cost, by contacting the fiscal agent's Provider and Beneficiary Services Unit toll-free at 1-800-884-3222, or an electronic version of the Manual may be downloaded at www.medicaid.ms.gov. This manual must be used in conjunction with the Mississippi Administrative Code, Title 23. Key Medicaid reimbursement issues are addressed in the Administrative Code, and fee schedules are also found on the www.medicaid.ms.gov website.



Medicaid and CHIP Eligibility Changes Related to the Affordable Care Act (ACA)

The Mississippi Division of Medicaid has been working since the fall 2011 to develop and implement changes to our Medicaid eligibility systems required by the ACA. Although all of the changes required by ACA have not been completed, below are the new categories of eligibility that have been implemented.

- New Categories of Eligibility (COE) – DOM has five new COEs to match the ACA eligibility requirements. There will be some new eligible beneficiaries in these COEs, and many that simply moved from a different COE. Beneficiaries who are in these COEs are eligible for full Medicaid benefits. The new COEs are:

New Category of Eligibility		
071	Newborns	Newborn age 0-1 with income at or below 194% FPL
072	Children 1-5	Children age 1-5 with income at or below 143% FPL
073	Children 6-19	Children age 6–19 with income at or below 107% FPL
074	Quasi-CHIP	Children age 6-19 with income between 107% and 133% FPL who would have qualified for CHIP under pre-ACA rules
075	Parents/ Caretakers	Parents/Caretakers of children under age 18

- Changing COE – DOM is making updates to the description for some COEs. The eligible beneficiary that no longer fits into an old COE is being moved to a different COE. Due to the change in COEs, beneficiaries will still be eligible for Medicaid or CHIP.

088	Pregnant Women	Pregnant Women under 194%
099	CHIP	Children age 1-19 with income between 133% and 209% FPL Children age 0-1 with income above 194% to 209% FPL

- Discontinued COEs – DOM is discontinuing three COEs, which are being replaced with the new ones explained above. The eligible beneficiaries in these COEs are generally just being moved into a new COE and are not losing eligibility for Medicaid.

085	Medical Assistance	Medical Assistance for Intact Family
087	Expanded Medicaid	Children age 1-5 under 133%
091	Poverty Level	Children under age 19 under 100%

Applicants may now apply for Medicaid or CHIP benefits in any one of the following ways:

- Local Medicaid Regional Office
- Apply by phone
- Mail-in paper application
- Apply on-line at the Division of Medicaid website www.medicaid.ms.gov
- Apply on-line at the Federal web portal website www.healthcare.gov

PROVIDER COMPLIANCE

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

Effective July 1, 2013, Evaluation and Management CPT codes (99201-99205, 99211-99215) 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
Clinic	C	HI
Psychiatrist Physician	P	
Nurse Practitioner	K	
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 do 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.

Billing With Anatomical Modifiers

Providers must bill multiple units on a single line for CPT/HCPCS codes performed on the same date of service, unless anatomical modifiers are appropriate to indicate the differences in each line. If the same CPT/HCPCS code is billed on two or more separate lines for the same date of service, the additional lines will deny as duplicates unless the appropriate modifier is appended to the code indicating the reason for multiple lines.

Examples:

Incorrect Billing of Multiple Lines – Second line would deny as duplicate

Line 1	73070-TC	1 unit
Line 2	73070-TC	1 unit
Line 1	73140-TC	1 unit
Line 2	73070-TC	1 unit
Line 1	V2100	1 unit
Line 2	V2100	1 unit

Correct Billing of Multiple Lines

Line 1	73070-TC-RT	1 unit
Line 2	73070-TC-LT	1 unit
Line 1	73140-TC-F3	1 unit
Line 2	73070-TC-F5	1 unit
Line 1	V2100-RT	1 unit
Line 2	V2100-LT	1 unit

State Level Registry for Provider Incentive Payments

The Medicaid Electronic Health Records (EHR) Provider Incentive Program is a part of the stimulus program known as the American Recovery and Reinvestment Act of 2009. Participation in this program is voluntary. However, in order to receive incentive payments Providers are asked to submit yearly attestation through the Mississippi State Level Registry (https://ms.arraincentive.com). Normally, an eligible professional may participate in the EHR Provider Incentive program for six years. The last year to start in this program is 2016. If an eligible professional participates for the entire six years he/she can receive incentive payments totaling $63,750.00.

Providers that are eligible to participate include:

1) Physicians
2) Nurse Practitioners
3) Dentists
4) Certified Mid Wives
5) Physicians Assistants under the leadership of a Qualified Physician working in a Federally Qualified Health Clinic
6) Doctors of Optometry

To get started and enroll in the MS Medicaid EHR Provider Incentive Program, providers must:

1) Adopt, Implement or Upgrade technology that is Office of National Coordinator (ONC) certified
2) 2) Have a Medicaid patient volume of at least 30% from a selected 90-day period

It has been brought to the attention of the MS Division of Medicaid (DOM) that several third-party consulting groups are working with providers as they submit EHR attestations to the DOM. DOM cautions providers before they enter into a contract with a third-party consulting group, that a detail review of the consulting group be completed, to validate their authenticity. DOM has identified several groups that are misrepresenting the EHR Provider Incentive Program. There are, however some consultants, endorsed by the MS Division of Medicaid, that are doing an outstanding job. Please contact the DOM before any commitments are made with a third-party consultant. DOM has staff available that will share our experiences with the known consultants working in the State.

For additional information about participation in the Mississippi Medicaid EHR Provider Incentive Program, please contact our staff.

Shakarma Green, Provider Incentive Program Specialist
601-359-6142 shakarma.green@medicaid.ms.gov

Tommie Milton, Provider Incentive Program Specialist
601-359-6143 tommie.milton@medicaid.ms.gov

Nick Maisel, Provider Incentive Program Manager
601-576-4165 nick.maisel@medicaid.ms.gov

Online resources for the Medicaid EHR Incentive Program:

CMS – *This site offers guidance and additional information on the EHR Incentive Program Index.*
http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html

HealthIT.Gov – *This is a very helpful site when planning and implementing an Electronic Health Record system. This site includes frequently asked questions by providers who have enrolled in EHR.*
http://www.healthit.gov/providers-professionals/ehr-implementation-steps

NEW Medicaid Requirements: Ordering, Referring or Prescribing (ORP) Providers

Traditionally, most providers have enrolled in the Mississippi Medicaid program to furnish covered services to Medicaid beneficiaries and to submit claims for such services. However, 42 CFR 455.410(b) of the Affordable Care Act (ACA) requires state Medicaid agencies enroll all ordering, referring or prescribing physicians and other eligible professionals providing services under the State Plan or under a waiver of the State Plan. The Division of Medicaid will begin implementation of this requirement effective January 1, 2014.

Beginning April 1, 2014, claims submitted by providers who actually render services to Medicaid beneficiaries based on your order, referral, or prescription (ORP) **will be denied** for such items or services unless you, the ORP Provider is enrolled in Medicaid and your National Provider Identifier (NPI) number is included on the claim submitted to Medicaid by the rendering provider.

Physicians or other professionals who are already enrolled with Mississippi Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as ORP providers.

There are two options for enrolling as a Medicaid provider:

1. The provider may complete a short form application for providers that wish **ONLY** to enroll as an "Ordering, Referring and Prescribing (ORP)" provider. Effective January 1, 2014, this application will be located at www.ms-medicaid.com, select provider, provider enrollment and follow the prompts to the ORP application and instructions. If there are questions, please contact Xerox at 1-800-884-3222.

   Participation as an ORP provider allows Medicaid reimbursement for the covered services and supplies you ordered, referred or prescribed for our Medicaid beneficiaries. A provider enrolled as an ORP **cannot** submit claims to Medicaid for payment for services rendered.

   Remember, enrolling with Medicaid as an ORP provider:

   - Does not obligate you to see Medicaid patients
   - Does not mean that you will be listed as a Medicaid provider for patient assignment or referral
   - Helps ensure that your orders, referrals and prescriptions for Medicaid patients are accepted and processed appropriately

OR

2. The provider may enroll as a Mississippi Medicaid "Billing/Servicing Provider" by completing the Mississippi Medicaid Provider Enrollment Application located at www.ms-medicaid.com. The "Billing/Servicing" provider can order, refer, prescribe AND receive payment for services rendered.

ORP IMPLEMENTATION PROCESS

I. Fee for service claims

a. Claims submitted January 1, 2014 and thereafter will suspend if the ordering or referring provider's NPI is not valid and that provider is not actively enrolled as a participating Medicaid provider.

b. If the NPI number of the ordering/referring is not enrolled with Medicaid as an active provider, the claim will suspend for a 90 day grace period giving the ordering/referring Provider time to enroll.

c. When the claim suspends, the Medicaid system will systematically look for the most current address information for the ordering/referring provider and a system generated letter will be sent to the provider with information regarding the ORP requirement and enrollment instructions for Mississippi Medicaid. If the ordering/referring Provider does not enroll during the 90 day grace period, the claims will deny on the 91st day and thereafter until the ordering/referring provider enrolls.

II. ORP for Pharmacy Point of Sale Claims

a. Prescription claims with a *date written* on or after January 1, 2014, must be written by a prescriber who has a valid and active MS Medicaid enrollment which is verified by the prescriber's NPI number.

b. Beginning January 1, 2014, first time claims received for non-Medicaid providers "with a date written" on or after January 1, 2014, will post NCPDP Reject `56-Non Matched Prescriber ID' with the accompanying message *'FEDERAL LAW REQUIRES THAT ALL MEDICAID PRESCRIBERS ARE ENROLLED AS A MEDICAID PROVIDER. NPI SUBMITTED ON CLAIM MUST BE THE ACTUAL PRESCRIBER ON THE PRESCRIPTION (RX); ANY OTHER IS CONSIDERED FRAUD'.*

c. The Medicaid system will systematically look for the most current address information for the ordering/referring provider NPI noted on these first time claims received with a date written on or after January 1, 2014, and a system generated letter will be sent to the provider

with information regarding the ORP requirement and enrollment instructions for Mississippi Medicaid.

d. If the Prescriber's NPI number is not enrolled with Medicaid as a valid and/or active provider, that prescriber will have a *grace period of 90 days* to enroll.

e. If these prescribers do not enroll during their 90 day grace period, then on the 91st day and thereafter their Medicaid prescriptions will deny.

f. Pharmacy claims will not actually start denying until April 1, 2014 and after.

WHAT IS THE PHARMACIST'S ROLE:

1. Enter the correct NPI for the prescriber. It is imperative that the NPI on the claim be the prescriber of the prescription. Any other NPI used is considered fraud.
2. Remind prescribers to enroll if you continue to see NCPDP Reject `56-Non Matched Prescriber ID' on that prescriber's claims.

All other instructions related to claims billing for this requirement will be located at http://www.medicaid.ms.gov/BillingManuals.aspx or you may contact your Provider Field Representative. (Please reference the Provider Field Representative list contained in this Bulletin).

HIPAA Operating Rules Phase II & Provider Enrollment Form Changes, Effective 12/30/2013

CURRENT PROVIDERS

Electronic Data Interchange (EDI) Provider Enrollment Form *(Existing Form)*

The current EDI Provider Enrollment form available for download on the Web Portal at www.ms-medicaid.com (Provider Tab, Provider Enrollment, Download Enrollment Package, EDI Provider Enrollment Form) will no longer include the option for 835 Transactions. This form will still need to be submitted to request all other EDI Transactions.

Electronic Remittance Advices (ERA) Enrollment Form *(New Form)*

Current providers who will enroll, change, or cancel their ERA (835Transactions) will need to download, mail or fax in the new ERA Enrollment form. The form is available on the Web Portal at www.ms-medicaid.com (Provider Tab, Provider Enrollment, ERA Enrollment) or (Provider Tab, Provider Enrollment, Download Enrollment Package, ERA Enrollment Application).

Direct Deposit Authorization Agreement *(Existing Form)*

Current providers who will enroll, change or cancel their Direct Deposit Authorization will need to download, mail or fax the Direct Deposit Authorization Agreement form. The form is available on the Web Portal at www.ms-medicaid.com (Provider Tab, Provider Enrollment, EFT Enrollment) or (Provider Tab, Provider Enrollment, Download Enrollment Package, Direct Deposit Authorization Agreement). A copy of the voided preprinted check, preprinted deposit slip, or bank letter must be submitted with the Direct Deposit Authorization Agreement form.

NEW PROVIDERS

Applying Online

The online Provider Enrollment Application on the Web Portal at www.ms-medicaid.com (Provider Enrollment, Enroll Online) contains many forms including the new ERA Enrollment form and the revised Direct Deposit Authorization Agreement form. These two forms may be submitted online or separately via mail. All other documents that require a signature must be mailed. The Provider Enrollment Application will not be

approved until a Direct Deposit Authorization Agreement form and a copy of the voided preprinted check or bank letter is received. New providers enrolling online will need to download and mail/fax in the EDI Enrollment Application if additional EDI Transactions other than the 835 are desired.

Downloading a Paper Application

The downloadable Provider Enrollment Application on the Web Portal at www.ms-medicaid.com (Provider Enrollment, Download Enrollment Package) contains many forms including the revised EDI Enrollment form, new ERA Enrollment form, and the revised Direct Deposit Authorization Agreement form. The Provider Enrollment Application will not be approved until a Direct Deposit Authorization Agreement form and a copy of the voided preprinted check, preprinted deposit slip or a bank letter is received.

Updated 835 Companion Guide

The 835 Companion Guide has been updated in the new template as per CAQH CORE rules. It will be published on the GCRO website located at http://www.acs-gcro.com.

EFT Payments and Corresponding Remittance Advices (RA)

EFT (direct deposit) files sent to financial institutions will now contain additional data (record type '7'), which contains the re-association number needed to associate the EFT payment with the corresponding Check/EFT Payment number already shown on the Remittance Advices. It is the provider's responsibility to reach out to their financial institutions and request this additional payment data to be sent to them.

Free Dual Delivery of Paper and Electronic Remittance Advices

Providers newly enrolling in Electronic Remittance Advices may request free dual delivery of both paper and electronic RAs for at least 31 days or 3 payment cycles. After that time period, paper RAs will stop being printed and the provider will receive only ERAs. However, paper RAs are always available for download on the Web Portal even for providers enrolled in ERAs. Instructions for requesting dual delivery of RAs are on the ERA Enrollment form.

Changes to Claims Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) on 835s

Providers may expect to see new CARCs and RARCs on their 835s as MS Medicaid has remapped their CARCs and RARCs as mandated per CAQH CORE.

Improving Claims Processing

At Xerox State Healthcare, LLC we are working to improve claims processing. We would like to make sure that every provider's claim is processed correctly and expeditiously. In order to improve this process, DOM request that the Provider community:

1. Please do not staple your claims together. Providers can simply place their attachments behind the associated claim and place them in an envelope.
2. Please sign the claim in ink. The vast majority of the claims are Returned to the Provider (RTP) because they are not properly signed.
3. Providers are sending claims with Medicare Explanation of Benefits (EOB) showing that payment has been received by Medicare. Please submit requests for Medicaid payment on Crossovers.
4. Please list the Third Party Liability (TPL) payment in the appropriate field. For all claims submitted with TPL payments, the payment must be shown in the prior payments (UB-04) field and the amount paid in the (CMS-1500) field on the claim.
5. Please do not send a stack of claims and one copy of the attachment that goes with each claim. If there is an attachment that is critical to the processing of the claim, copy the attachment for each claim and place it with its associated claim before submitting those claims for processing.
6. Please submit standard 8x11 attachments. Strips, cutouts and the like are not acceptable.
7. Please put the bill date on each claim.
8. Please place bill types on UB-04's and Crossover A's.
9. Please mail or electronically submit your claims. WE DO NOT ACCEPT FAXED CLAIMS.

All of the above will result in effective processing of your claims. We appreciate your time and cooperation with these matters. If you have any questions please call Provider and Beneficiary Services at 1-800-884-3222 or 1-888-495-8169.

Increased Primary Care Services 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 Mississippi Medicaid providers

For dates of services on or after January 1, 2013, through December 31, 2014, the Division of Medicaid (DOM) will reimburse certain primary care services provided by qualified providers meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate in effect for Calendar Years (CYs) 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the CY 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 payments because reimbursement is included in the encounter rate.

CMS defines a qualified provider as one who delivers certain primary care services and self-attests. Self-Attestation criteria is explained in detail on the Attestation Form.

HOW TO ATTEST

Providers can complete one (1) Self-Attestation Form for CYs 2013 and 2014 if the information is the same for each year. ***For CY 2013 and CY 2014, the cut-off date for receipt of Self-Attestation Forms is June 30, 2014.*** One final mass adjustment is scheduled for July 2014, for claims of providers having Attestation Forms received January 1, 2014, through June 30, 2014.

Only newly approved Medicaid providers will be allowed to attest for CY 2014 after June 30, 2014, and no claims reprocessing by Medicaid will be conducted for these claims.

Providers can verify the processing of electronically submitted Self-Attestation Form by accessing the Envision Web Portal. Forms are 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
1-888-495-8169

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 Payments may be punished by criminal, civil or other administrative actions.

Billing Modifiers for T & E Service Providers

It is a requirement that ALL Therapeutic and Evaluative Service providers MUST use "HA" as the Modifier 1 on all claims to ensure that the service is applied to the appropriate service limit.

HA= Child/Adolescent Program

Please contact Christal Ford, Kimberly Smith, or Charlene Toten-Hobson at 601-359-9545, should you have questions.

Billing Tips to Avoid Duplicate Claims

The Division of Medicaid along with Xerox State Healthcare, LLC have noticed a pattern in duplicate claims submitted by providers. To ensure that each claim is paid in a timely manner, providers should implement the following tips to avoid unnecessary denials.

- Bill all procedures provided on the same date of service on the same claim.
- Providers are required to bill multiple units for the same procedure code (and modifier, if applicable) when more than one of the same procedure or service is provided on the same date of service.
- Providers should not bill the same procedure codes for the same date of service on separate claim lines.
- Separate claims for the same date of service are only necessary if you run out of claim lines.
- Do not re-bill the same claim repeatedly.
- If all claim lines on the claim were paid, billing the same claim again will result in denials for duplicate services and may be considered fraudulent.
- If claim lines are denied, read the edit messages listed at the bottom the remittance advice. These messages tell why the claims denied. Always refer to Medicaid's Administrative Code, the Provider Billing Manual and the Medicaid Fee Schedules for detailed information about what services and procedure codes are covered as well as applicable service limits.
- Incorrect billing may result in claim denials for duplicate procedures.
- If you think a claim line was denied in error, contact the Xerox Call Center at 1-800-884-3222. Call Center Representatives are available to review, explain and if appropriate, provide instruction on how to reverse the denial to have the payment processed accordingly.

PHARMACY

Preferred Drug List (PDL) Update, Effective April 1, 2014

Effective April 1, 2014, there will be a minor PDL update. Since 2012, 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. Throughout the year, there will be quarterly additions, or deletions. Changes outside of January 1st implementation annual review updates will generally be small.

To reference the current PDL, go to http://www.medicaid.ms.gov/Pharmacy.aspx, and select MS Preferred Drug List (PDL), where you will find the current PDL as well as Provider Notice PDL changes, effective April 1, 2014. We recommend adding this link to your favorites as you will find it very helpful.

New Pharmacy Prior Authorization (PA) Manual Form

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. To reference the new Medicaid 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.

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 PA at the current PDL which may be referenced at http://www.medicaid.ms.gov/Pharmacy.aspx.

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 at 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, register at 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.

Limited Number of CHIP Beneficiaries Moving to Medicaid Fee for Service (FFS)

In accordance to new federal guidelines, some CHIP beneficiaries are becoming Medicaid FFS eligible. Be advised that this is an ongoing process, which started 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. Issues call 800-884-3222.

LONG-TERM CARE

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

Allowable Board of Directors Fees for Nursing Facilities, ICF-IID's and PRTF's, 2013 Cost Reports

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2013 cost reports filed by nursing facilities (NF's), intermediate care facilities for individuals with intellectual disabilities (ICF-IID's), and psychiatric residential treatment facilities (PRTF's) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for all Urban Consumers - All Items. The amounts listed below are the per meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2013 are as follows

Category	Maximum Allowable Cost for 2013
0 – 99 Beds	$ 3,928
100 – 199 Beds	$ 5,893
200 – 299 Beds	$ 7,857
300 – 499 Beds	$ 9,821
500 Beds or More	$11,785

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.

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 (601.206.3022) jonathan.dixon@xerox.com**	

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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
www.ms-medicaid.com

DOM & Xerox State Healthcare, LLC., welcome the spring season

MARCH 2014

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 31 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 www.ms-medicaid.com while funds are not transferred until the following Thursday.