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MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

Legislature OKs DOM Including Children in Managed Care Program

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MS Division of Medicaid

The 2014 Legislative session was a productive one for the Division of Medicaid, and I want to take this opportunity to outline some of the new provisions for the agency and how they will impact providers.

Medicaid's technical amendments bill, House Bill (HB) 1275, was signed into law by Gov. Bryant on April 16. It contains a number of changes that will improve efficiency and allow the agency to continue providing quality health coverage to Mississippians.

One of our priorities with HB 1275 was to update some technical terminology to reflect the modern mission and operations of DOM, such as changing the designation "mentally retarded" to "individuals with intellectual disabilities" and deleting the number of allowable outpatient emergency hospital services to comply with the Center for Medicare and Medicaid Services (CMS) regulations.

The Affordable Care Act (ACA) requires Medicaid to reimburse primary care providers at 100 percent of the Medicare rate. DOM already reimburses physicians at 90 percent, the 7th highest percentage in the nation, and federal funds committed to closing that gap expire at the end of this year. After December 31, 2014, individual states must choose whether or not to continue paying primary care providers at this enhanced rate.

This bill allows the agency to continue enhanced payments for primary care physicians beyond the 2014 expiration until 2016. The technical amendments bill will not be taken up again until the 2016 Legislative session, so this change enables us to continue that enhanced payment for pediatricians, family practitioners and internal medicine providers for the next two years.

Our most ambitious goal in the bill was enlarging DOM's managed care program, the Mississippi Coordinated Access Network (MississippiCAN), to include children. MississippiCAN was launched in 2011, and currently there are about 140,000 Mississippians enrolled with our two coordinated care providers – Magnolia Health Plan and United Healthcare. The MississippiCAN enrollees make up 23 percent of the state's Medicaid population and include some of the state's most vulnerable residents, such as our Supplemental Security Income beneficiaries.

I have always been an advocate of including children in the managed care environment because I believe it will improve their overall health. Children under 19 years old make up 60 percent of our beneficiaries; they are by far our greatest category of eligibility. Through managed care there is more accountability to encourage these children to be healthy and stay healthy.

This will primarily impact pediatricians because, naturally, they will be providing the treatment for this increased population. After many discussions and meetings, we came to a consensus regarding managed care and received robust support from pediatricians across the state.

IN THIS ISSUE

Pediatricians throughout Mississippi can expect to have a collaborative working relationship with Magnolia Health Plan and United Healthcare, with whom we have recently reached a new three-year contract. Before finalizing the new contracts, we took the time to listen to concerns and suggestions from all involved parties in an effort to make MississippiCAN a better program. The new contracts include many improvements and ways to keep everyone accountable, while also focusing on providing quality health services.

On a final note, beginning May 5, Medicaid beneficiaries will be issued a new identification (ID) card. Medicaid beneficiaries will be issued a new blue ID card, which will replace their current green card. Family Planning Waiver beneficiaries will receive a new yellow ID card, which will replace their old yellow ID card. All new Medicaid ID cards will display the updated Medicaid logo.

Possession of a Medicaid ID card does not guarantee eligibility. Providers should always verify eligibility regardless of the color of the ID card a beneficiary presents. New Medicaid ID cards do not reflect any change in eligibility, or the benefits and services beneficiaries are currently receiving.

When visiting a provider, beneficiaries are required to present their Medicaid ID card and a picture ID or similar form of identification to confirm their identity. Beneficiaries need to present their new Medicaid ID when receiving any type of medical service.

During this transition, providers should continue to accept the old green and yellow ID cards through September 30, 2014. Old ID cards should no longer be accepted effective October 1, 2014.

If you have any questions regarding ID cards, contact Xerox toll-free at 1-800-884-3222 or the Division of Medicaid at 1-800-421-2408.

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.

MISSISSIPPI DIVISION OF MEDICAID

ATTENTION ALL PROVIDERS!
MississippiCAN Workshops are coming your way!

www.medicaid.ms.gov/mscan/

The Division of Medicaid Coordinated Care, in conjunction with Magnolia Health Plan and UnitedHealthcare Community Plan, will conduct MississippiCAN Provider Workshops July 8, 2014 through July 24, 2014 at locations throughout the state. Office directors, office managers, coders and billing staff are encouraged to attend. The following topics will be covered:

- **MississippiCAN Changes**
- **Provider Enrollment**
- **Provider Portal**
- **Eligibility Verification**
- **PCP Panel**
- **Claims Processing**

DATE AND TIME	LOCATION
Tuesday, July 8, 2014 10:00 a.m.	Forrest County Multipurpose Center 962 Sullivan Road **Hattiesburg,** MS 39104
Wednesday, July 9, 2014 10:00 a.m.	Handsboro Community Center 1890 Switzer Road **Gulfport**, MS 39507
Thursday, July 10, 2014 1:00 p.m.	Greenville Higher 1134 Archer Range Road **Greenville,** MS 38701
Friday, July 11, 2014 10:00 a.m.	Southaven Performing Arts 2101 Colonial Hills Drive **Southaven,** MS 38671
Tuesday, July 15, 2014 10:00 a.m.	Bancorp South 375 East Main Street **Tupelo,** MS 38804
Wednesday, July 16, 2014 10:00 a.m.	Hilton Garden Inn 975 Hwy 12 East **Starkville,** MS 39759

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MississippiCAN Workshops continued from page 3

Thursday, July 17, 2014 10:00 a.m.	Holiday Inn Meridian 100 North Frontage Road **Meridian,** MS 39301
Friday, July 18, 2014 10:00 a.m.	Alcorn State University Graduates Business Building 15 Campus Drive **Natchez,** MS 39120
Monday, July 21, 2014 10:00 a.m.	Corinth Public Library 1023 Filmore Street **Corinth,** MS 38834
Tuesday, July 22, 2014 10:00 a.m.	Comfort Inn & Suites 255 SW Frontage Road **Grenada**, MS 38901
Thursday, July 24, 2014 10:00 a.m. & 2:00 p.m.	Eagle Ridge Conference Center 1500 Raymond Lake Road **Raymond,** MS 39154

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

Attention: Amy Burns, Provider Services

Xerox State Healthcare

Fax: 601-206-3119

Phone: 601-206-3028

Email: Amy.Burns@xerox.com

Date of Workshop:_____

Location of Workshop: _____

Number of Attendees: _____

NEWS

Mississippi Medicaid Issues New Beneficiary Identification Card

Starting May 5, 2014, Mississippi Medicaid beneficiaries will be issued a new Medicaid identification (ID) card. New Medicaid ID cards do not reflect any change in eligibility or the benefits and services beneficiaries are currently receiving.

- Medicaid beneficiaries will be issued new blue ID cards, which will replace their current green ID cards
- Family Planning Waiver beneficiaries will receive new yellow ID cards which will replace their old yellow ID cards
- All new Medicaid ID cards will display the new Medicaid logo

When visiting a provider, beneficiaries are required to present their Medicaid ID card and a picture ID or a similar form of identification to confirm their identity. Beneficiaries need to present their new Medicaid ID when receiving any type of medical service.

During this NEW ID card issuance transition, providers should continue to accept the old green Medicaid ID cards through September 30, 2014. Old green Medicaid ID cards should no longer be accepted effective October 1, 2014.

Attention MS Cool Kids (EPSDT) Screening Providers

Effective immediately, the Mississippi Cool Kids (EPSDT) Program has adopted the evidenced-based principles of preventive health care services periodicity schedule as set forth by the American Academy of Pediatrics (AAP) Bright Futures.

The AAP Bright Futures Recommendations for Preventive Pediatric Health Care Periodicity Schedule is located at: http://brightfutures.app.org/pdfs/Guidelines.

The MS Cool Kids (EPSDT) Program recommends regular well-check screening visits as indicated in the table shown on page 6 of this bulletin.

Completion of all components of the age appropriate EPSDT comprehensive visit is required for EPSDT provider reimbursement.

EPSDT PERIODIC EXAMINATION SCHEDULE

Screening Code		Age of Child	Unit
New Patient	Established Patient		
99381-EP	99391-EP	0-1 Months	1
99381-EP	99391-EP	2 Months	1
99381-EP	99391-EP	4 Months	1
99381-EP	99391-EP	6 Months	1
99381-EP	99391-EP	9 Months	1
99382-EP	99392-EP	12 Months	1
99382-EP	99392-EP	15 Months	1
99382-EP	99392-EP	18 Months	1
99382-EP	99392-EP	2 – 4 years *	1
99383-EP	99393-EP	5 – 11 years *	1
99384-EP	99394-EP	12 – 17 years*	1
99385-EP	99395-EP	18 – 21 years*	1

*Beginning at 2 years of age MS Cool Kids (EPSDT) Screenings can be done annually.

Questions may be directed to the Bureau of Medical Services at 601-359-6150 or 1-800-421-2408.

Payment Error Rate Measurement (PERM)

The Centers for Medicare and Medicaid Services (CMS) implemented the Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (CHIP). PERM is designed to comply with the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300) and to evaluate the accuracy of Medicaid payments to providers, including medical records documentations. Mississippi has been selected as 1 of 17 states required to participate in the PERM reviews of Medicaid and CHIP payments in federal fiscal 2014 (October 1, 2013, through September 30, 2014).

CMS is using two national contractors to measure improper payments. The statistical contractor, The Lewin Group, will coordinate efforts with the State regarding the eligibility sample, maintaining the PERM eligibility website, and delivering samples and details to the review contractor. The review contractor, A+ Government Solutions, will be communicating directly with providers and requesting medical record documentation associated with the sampled claims. Providers are required to furnish the records requested by the review contractor within the specified timeframe as stated in the Medical Records Request letter.

It is anticipated that A+ Government Solutions will begin requesting medical records for Mississippi sampled claims by the summer of 2014. Providers are urged to respond to these requests promptly with timely submission of the requested documentation. Please note that there may be requests for additional documentation following your initial submission. Please respond to these specific requests promptly to avoid errors of insufficient or lack of documentation.

Understandably, providers are concerned with maintaining the privacy of patient information. However, providers are required by Section 1902(a) (27) and 2107 (b) (1) of the Social Security Act to retain records necessary to disclose the extent of services provided to individuals receiving assistance and furnish CMS with information regarding any payments claimed by the provider for rendering services. The collection and review of the protected health information contained in individual-level medical records for payment review purposes is permissible by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implementing regulations at 45 Code of Federal Regulations, parts 160 and 164.

For information about the federal PERM regulations, contractor oversights, and overall project information, please refer to the CMS website at www.cms.hhs.gov.

Payment Error Rate Measurement (PERM) updates will be published in the upcoming Medicaid Provider Bulletins.

PROVIDER COMPLIANCE

Family Planning Demonstration Waiver Program

The Division of Medicaid Family Planning Demonstration Waiver provides services to eligible beneficiaries who voluntarily choose to prevent pregnancy, plan the number of pregnancies, or plan the spacing between pregnancies. Counseling and education must be included as part of the family planning visit. Office visits are limited to four (4) annually, occurring during the Federal fiscal year, October 1 through September 30. Beneficiaries are eligible to receive the following limited Medicaid pharmacy services: Oral contraceptive agents, topical patches, self-inserted contraceptive products and injectable contraceptives.

Providers may access an updated list of covered diagnosis and procedure codes for the Family Planning Waiver at www.medicaid.ms.gov. If you have any questions, please contact De'Sonya Andrews, Program Administrator, or Christy Lyle, Program Nurse, at 601-359-6150.

Hospital Inpatient and Outpatient Alerts

HOSPITAL INPATIENT UPDATE

The Mississippi Division of Medicaid will adopt V.31 of the 3M Health Information System APR-DRG Grouper and V.31 of the Health Care Acquired Conditions (HCAC) utility for payment of hospital inpatient claims for discharges on or after July 1, 2014. APR-DRG parameters may also change effective for hospital inpatient discharges on or after July 1, 2014.

Hospitals are not required to purchase 3M software for payment of claims; however, all hospitals that have purchased the 3M software should ensure their internal systems are updated to reflect all changes that occur for hospital discharges beginning on or after July 1, 2014.

HOSPITAL OUTPATIENT UPDATE

The Mississippi Division of Medicaid OPPS fee schedule will be updated July 1, 2014 for Medicare Outpatient Addendum B or C changes effective April 1, 2014, as required by the State Plan. Hospitals will be notified at a future date about other July 1, 2014 Medicaid OPPS fee schedule changes resulting from the CMS Hospital OPPS final rule.

The Mississippi Division of Medicaid is expecting to move forward with OPPS Phase 2 in the near future.

Hospitals will be notified of all information related to these changes and training session dates via e-mail, the DOM website www.medicaid.ms.gov, Late Breaking News, and RA Banner Messages.

Vaccines for Children (VFC) Program Update

The following meningococcal conjugate vaccines, MCV4 or MCV4-D (CPT code 90734) and HibMenCY-II (CPT code 90644) are now covered for Medicaid beneficiaries ages 2 months – 18 years through the Vaccines for Children Program. The Division of Medicaid reimburses for the administration of the vaccines ONLY when the vaccines are obtained through the Mississippi State Department of Health's Vaccines for Children Program.

Detailed billing instructions are located on the Mississippi Envision Web Portal (https://www.ms-medicaid.com). Click on the Provider heading, Provider Bulletin, then select September 2012 and the article is on page 8.

Electronic PA Submission for DME and Medical Supplies

The Division of Medicaid understands the urgency of timeliness surrounding prior authorization requests for our beneficiaries. For this reason, we urge providers to submit requests through the eQHealth Solutions web portal, eQSuite™. Prior authorizations submitted via eQSuite are subject to faster processing and turn-around.

eQSuite's™ Key Features Include:

- Secure HIPAA-compliant technology allows you to electronically record and transmit most information necessary for a review to be completed
- Secure transmission protocols including the encryption of all data transferred
- System access control for changing or adding authorized users
- 24x7 access with easy to follow data entry screens
- Rules-driven functionality and system edits
- A reporting module that provides the real time status of all review requests
- A HELPLINE module through which providers may submit questions about a specific PA request

Providers requesting authorization for nebulizers, diapers, bluepads, and oxygen supplies can receive instant treatment authorization numbers (TANs) from eQSuite™ when the necessary information is submitted in accordance to clinical and policy guidelines. To electronically submit for prior authorization log on to eQSuite™ at https://mswebapps.eqhs.org/webportal/Login.aspx

Providers may contact eQHealth Solutions by calling toll free at 1-866-740-2221 (local: 601-360-4961) or via email at education@eqhs.org, with questions and concerns regarding eQSuite.

EPSDT Providers Billing Two Visits (Sick and EPSDT) on the Same Day

The Division of Medicaid encourages primary care providers to perform an EPSDT screenings in accordance with published periodicity schedules. If a beneficiary is due for an EPSDT screening on the same date of service as a sick visit, both the sick visit and the EPSDT screening may be completed on the same day. One claim may be submitted for a sick visit and EPSDT screening with the appropriated procedure and diagnosis codes for the services provided. The sick visit must be billed with a 25 modifier, indicating a separate service was provided and must be supported by documentation in the beneficiary's medical record.

The current CPT® manual instructs, "If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported."

Documentation must support billing both services. A provider may elect to create either two separate documents or a single document for both services. Regardless of documentation format, the problem-oriented history, exam, and decision making must be separately identifiable from documentation of the preventive service.

Updates/Changes to Your Medicaid Provider File

Medicaid providers are responsible for reporting any changes to their provider files within 30 days of the effective date of the change. To prevent the non-receipt of important letters, notices, and payments to the incorrect banking information, providers should check and update their file with the most accurate information. Changes to be reported include but are not limited to:

- Address
- Phone number
- Fax number
- Contact name
- Email address
- Banking information
- Provider affiliations
- Change of ownership – Must complete a new provider enrollment application
- Managing/Directing employee information
- Change of tax identification
- Individual and group name changes

The change of address and direct deposit authorization agreement forms may be found on our website https://www.ms-medicaid.com/msenvision. Click on the provider header/provider enrollment.

Please fax or mail information to Xerox Provider Enrollment.

Fax number: 888-495-8169

Address: Xerox Provider Enrollment
P.O. Box 23078
Jackson, MS. 39225

If you have any questions, please contact Xerox Provider Enrollment at 800-884-3222.

Covered Entities Under Section 340B of the Public Health Services Act

Per the Mississippi Administrative Code, Title 23, Part 200, Rule 4.10, all covered entities, as defined in Section 340B of the Public Health Service Act, are required to notify the Division of Medicaid as of July 1st of each year of their election to opt-in or opt-out of the 340B program by completing the 340B Covered Entity Attestation and Election Form. The instructions and the form are located at https://www.msmedicaid.com/msenvision.

Covered entities electing to change their 340B enrollment status or billing of 340B or non-340B drugs must immediately notify the Division of Medicaid by completing the appropriate sections on the 340B Covered Entity Attestation and Election Form. The change is effective thirty (30) days from the date the Division of Medicaid receives the Provider's completed attestation form. Covered entities include, but are not limited to the following provider types:

Covered entities include, but are not limited to, the following:

- Health Centers, such as Federally Qualified Health Centers, Federally Qualified Health Center Look-Alikes, and Tribal/Urban Indian Health Centers.
- Hospitals, such as Children's Hospitals, Critical Access Hospitals, Disproportionate Share Hospitals, Free Standing Cancer Hospitals, Rural Referral Centers, and Sole Community Hospitals
- Specialized Clinics, such as Black Lung Clinics, Comprehensive Hemophilia Diagnostic Treatment Centers, Title X Family Planning Clinics, Sexually Transmitted Disease Clinics, and Tuberculosis Clinics.

Covered entities who fail to notify the Division of Medicaid of their 340B election according to the Mississippi Administrative Code Part 200, Rule 4.10.E, annually by July 1st, will be considered as opting-out of the 340B program. The Division of Medicaid will collect rebates on drugs billed by covered entities that opt-out of the 340B program.

Billing of 340B Purchased Drugs

Effective 7/1/2014, these providers must bill 340B drug claim lines as follows:

- The 340B drugs must only be provided to eligible beneficiaries and they must receive health care services other than the drug from the 340B provider.
- The charges billed should be at the estimated acquisition cost (EAC) or the 340B actual acquisition cost paid to the wholesaler or manufacturer for the drug.
- The provider must specify the drugs purchased under the 340B program by appending the UD modifier with the applicable HCPCS code and NDC on the CMS-1500/837 Professional and the UB04/837 Institutional claims forms to properly identify the 340B outpatient drugs.

340B Pharmacy Provider

Effective July 1, 2014, DOM enrolled pharmacy providers who are 340B providers must charge DOM no more than their actual acquisition cost for a drug product plus the division's established dispensing. Additional information and directives for Pharmacy 340B providers may be viewed on page 13 of this Bulletin.

Radiology Reminders

As of July 1, 2013, prior authorization (PA) is required for certain non-emergency advanced imaging services including: CT/CTA, MRI/MRA, PET, and Nuclear Cardiac Studies. Advanced imaging services performed during an inpatient stay, emergency room visit, or twenty-three (23) hour observation will **NOT** require prior authorization.

Prior authorizations for advanced imaging services are processed by the Utilization Management/Quality Improvement Organization (UM/QIO), MedSolutions. Additional information on this process can be accessed at www.medsolutions.com/implementation/msmedicaid, or by calling their Customer Service Department at 888-693-3211.

Exclusions to the Advanced Imaging Prior Authorization Requirement

Prior authorization is required for all Medicaid beneficiaries, including pediatrics, with the following exceptions:

- MSCAN (Coordinated Access Network) – prior authorization performed by United Health Care or Magnolia Health Plan
- COE 29 (Family Planning Waiver)
- COE 31 (Crossover QMB)
- COE 35 (Qualified Working Disabled)
- COE 51 (Special Low-Income Medicare)
- COE 54 (Qualified Individual)

Prior authorization is NOT required when Medicare or other Third Party Liability coverage is primary and MS Medicaid is secondary.

Special Circumstances

Please contact MedSolutions Customer Service by phone for any of the following situations:

- Outpatient Urgent Studies
- Outpatient Expedited Studies
- Changes in Study
- Changes in Performing Provider Location

Allowable case updates that will require additional clinical review PRIOR to the procedure being performed:

- Upcode in contrast level
- Change in body part
- Change in modality (i.e. CT to MRI)
- Change in rendering facility
- Anything that would require a change in the associated CPT code

Who Can Obtain/Start Prior Authorization Requests?

MedSolutions will accept authorization requests from the ordering or rendering provider. Complete clinical information is required in order to initiate a request. MedSolutions will contact the ordering physician listed on the case to obtain the clinical information needed to complete the case. Please verify that the appropriate authorization has been secured prior to performing any services.

Who is Responsible?

It is the responsibility of every Medicaid provider to verify a Medicaid beneficiary's eligibility each time a beneficiary appears for a service. Medicaid providers may verify beneficiary eligibility status by the following methods:

- Calling Provider/Beneficiary Services Call Center at 800-884-3222,
- Calling the Automated Voice Response System (AVRS) at 866-597-2675,
- Envision web portal at https://www.ms-medicaid.com/msenvision/index.do, or
- MEVS transaction using personal computer (PC) software or point of service (POS) swipe card verification

Eligibility should be verified each time a service is provided whether or not a beneficiary is able to present an ID card.

When is a Retrospective Request Allowed?

MedSolutions will accept retrospective requests only when clinical urgency prevented prior authorization. To be considered for approval, the case must be:

- Clinically urgent,
- Requested within 3 business days following the date of service, and
- Meet clinical criteria for appropriateness.

Cases not submitted on time, where clinical urgency is not established or where clinical and administrative criteria are not satisfied will not be approved.

Retrospective Eligibility Requests

MedSolutions will accept retrospective requests due to retroactive enrollment for a period of **1 calendar month** from the date of enrollment. Requests will be authorized for dates of service no greater than **1 calendar year** of the date of enrollment. Retrospective requests initiated beyond these time limits will be abandoned and referred to the Mississippi Division of Medicaid pursue a claim appeal.

Failure to Obtain Prior Authorization

A valid Prior Authorization number or appropriate modifier must be included on all claims for advanced imaging services that meet the PA requirement. Failure to obtain the appropriate authorization will result in claim denials.

Reconsiderations and Appeals

MedSolutions will accept requests for a peer-to-peer consultation or reconsideration up to and including **30 calendar days** after the initial adverse determination. Request for reconsiderations beyond this time period will not be accepted. Beneficiaries have the right to request an appeal (fair hearing) through DOM within 30 days of the date of the initial denial letter.

Billing Recommendations

- The technical component (TC) of a procedure includes the equipment, supplies, and technical personnel required to perform a procedure. This part of the procedure should be billed with the **TC modifier**.
- The professional component (PC) of a procedure includes the physician's interpretation and reporting of the procedure. This part of the procedure should be billed with the **26 modifier**.
- The full or global procedure should be billed on one claim line with no modifier.
- In order for ER services to be excluded from PA requirements, Revenue Code 045X must be billed or G0378/G0379 (23 hour observation) must be on the claim.

If a claim line has been denied in error, please contact Xerox Call Center at 800-884-3222. Call Center Representatives are available to review, explain, provide instructions on how to reverse the denial and have the payment processed accordingly if appropriate.

If you have any questions regarding this program or questions about MedSolutions, please contact their Customer Service Department at 888-693-3211 or to the Division of Medicaid Bureau of Medical Services at 601-359-9542. For additional information, you may also log on to www.medsolutions.com/implementation/msmedicaid or reference the Mississippi Division of Medicaid Administrative Code, Title 23, Part 220 for Radiology Services at www.medicaid.ms.gov/AdminCode.aspx.

Tobacco Cessation Counseling for Pregnant Women

Effective March 1, 2014 Mississippi Division of Medicaid began coverage for tobacco cessation counseling for pregnant women according to the following criteria. Tobacco cessation counseling services must be provided face-to-face and be performed in one of the following settings:

(i) By or under supervision of a physician;

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid covered services *other* than tobacco cessation services; or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations.

Services are ONLY available for Medicaid-eligible pregnant females who smoke.

Face-to-Face tobacco cessation counseling services for pregnant women are limited to one (1) counseling session per quit attempt with mandatory referral to the MS Tobacco Quitline.

The following CPT codes are open for coverage effective March 1, 2014:

Code	General Fee	Site Differential Fee
99406	$11.57	$9.97
99407	$22.65	$21.32

Claims must include a diagnosis code from the following list based on the date of service:

Dates of Services Thru 09/30/2014

- ICD-9-CM – 649.03 (Tobacco use complication Pregnancy)

Dates of Services Beginning 10/01/2014

- ICD-10-CM – 099.331 (Smoking (Tobacco) complicating Pregnancy, 1st trimester)
- ICD-10-CM – 099.332 (Smoking (Tobacco) complicating Pregnancy, 2nd trimester)
- ICD-10-CM – 099.333 (Smoking (Tobacco) complicating Pregnancy, 3rd trimester)

Information on providing Tobacco Cessation Medications is located in the Administrative Code, Part 200, Chapter 5: General, Rule 5.4: Tobacco Cessation at http://www.medicaid.ms.gov/AdminCode.aspx.

Please contact your provider representative or the Division of Medicaid if you have further questions.

All Medicaid Ophthalmologist, Optometrist, Optician, and Vision Providers

Polycarbonate lenses (V2784) require prior authorization before being dispensed. A complete list of vision-related CPT codes requiring prior authorization is located at http://www.medicaid.ms.gov/FeeScheduleLists.aspx.

Prior authorization requests for polycarbonate lenses require the prescriber to provide a medical diagnosis or medical condition that substantiates the medical necessity for prescribing the lens. The prescriber may include this information on the prescription.

Below are examples of medical, behavioral health diagnosis, and conditions to support polycarbonate lens:

- Severe seizure disorder with grandmal seizures or
- Disease of the eye requires a width and curvature of non-polycarbonate lenses that would not fit the facial structure of the patient.

Examples of reasons and conditions that do not support medical necessity for polycarbonate lenses:

- Beneficiary plays sports in the summer
- Beneficiary enjoys riding bicycle and hiking outdoors

Please direct questions or concerns to eQHealth Solutions at 866.740.2221 or via email at education@eqhs.org.

PHARMACY

340B Pharmacy Providers and Pharmacy Point of Sale (POS) Billing

Effective July 1, 2014, DOM enrolled pharmacy providers who are 340B providers must charge DOM no more than their actual acquisition cost for a drug product plus the divisions established dispensing. The following section addresses only pharmacy providers who are 340B Covered Entities who have elected to 'opt in', that is dispense ALL of their 340B drugs to Medicaid beneficiaries at their 340B actual acquisition cost (340B AAC). It is understood that some 340B Covered Entities purchase both 340B drugs and non-340B drugs for their patients who are ineligible to receive 340B drugs.

These billing directions only address billing of 340B drugs. The non-340B drugs should continue to be billed using the 'Usual and Customary' charge. 340B pharmacies will be paid the agency's established dispensing fee.

NCPDP directions for POS billing of 340B drugs:

- **In field '420-DK' (Submission Clarification Code) enter a value of '20'** (Description – 34ØB – **Indicates that, prior to providing service, the pharmacy has determined the product being billed is purchased pursuant to rights available under Section 340B** of the Public Health Act of 1992 including sub-ceiling purchases authorized by Section 340B (a)(10) and those made through the Prime Vendor Program (Section 340B(a)(8)).
- **In field 423-DN (Basis Of Cost Determination) enter a value of '08'** (340B/Disproportionate Share Pricing/ Public Health Service – Price available under Section 340B of the Public Health Service Act of 1992 including sub-ceiling purchases authorized by Section 340B (a)(10) and those made through the Prime Vendor Program (Section 340B(a)(8)). Applicable only to submissions to fee for service Medicaid programs when required by law or regulation.)
- **In field 409-D9 (Ingredient Cost Submitted) the 340B actual acquisition cost must be entered.**
- **In field 426-DQ (Usual and Customary Charge or Total Charge) the lowest net charge that a non-Medicaid, 340B eligible patient would pay for the same prescription must be entered.**

A contract pharmacy, defined by the Division of Medicaid as an agent of a 340B covered entity and ineligible to be a freestanding 340B covered entity, cannot dispense and bill the Division of Medicaid for 340B outpatient drugs for Medicaid beneficiaries.

Billing directions for pharmacy point of sale (POS) 340B claims are posted on the Pharmacy services' web page at http://www.medicaid.ms.gov/Pharmacy.aspx.

Termination from the Rebate Program

Effective July 1, 2014, CutisPharma, Inc., labeler 65628, has voluntarily terminated its participation in the federal drug rebate program. CutisPharma products will no longer be reimbursable by MS Medicaid in the pharmacy point of sale program as of July 1, 2014.

Pharmacy Fee for Service Reimbursement Changes

Background: State Medicaid agencies reimburse participating pharmacy providers for covered outpatient drugs that are prescribed and dispensed to Medicaid beneficiaries. The payment consists of two parts: 1) reimbursement for drug ingredient costs, and 2) reimbursement for the cost of dispensing. In general, federal regulations require that Medicaid programs reimburse for drug ingredient costs at no more than the agency's best estimate of the acquisition cost for a drug. As defined in federal regulations at §42 CFR 447.502, estimated acquisition cost (EAC) is the state's best estimate of the prices generally and currently paid by providers for a drug marketed or sold by manufacturers or labelers in the package size of the drug most frequently purchased by providers.

Mississippi Division of Medicaid (DOM) is implementing a new drug pricing methodology to reimburse pharmacies that dispense pharmaceutical products to Medicaid beneficiaries. Effective July 1, 2014, DOM will start reimbursing pharmacies using the average acquisition cost (ACC) of a given pharmaceutical product using National Average Drug Acquisition Cost (NADAC) files that gives state Medicaid agencies covered outpatient drug information regarding retail prices for prescription drugs. The NADAC, as published by CMS and updated weekly, is a more accurate reflection of the ingredient cost of the medications covered by the DOM drug benefit program. NADAC weekly files can be located at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Survey-of-Retail-Prices.html. NADAC pricing values are available for over 93% of the drugs billed by Mississippi pharmacies.

DOM will reimburse pharmacy providers based on the NADAC for the ingredient cost and a professional dispensing fee more in line with the true cost of dispensing. There is one professional dispensing fee per 30-day period unless the class of drugs is routinely prescribed for a limited number of days. The professional dispensing fee will be posted on the agency's fee schedule at http://www.medicaid.ms.gov/FeeScheduleLists.aspx.

Reimbursement Methodology:

- The AAC (Actual Acquisition Cost) is defined as the price paid by pharmacies based on an average of actual acquisition costs determined by a survey of retail pharmacy providers. The National Average Drug Acquisition Cost (NADAC) pricing will be used for AAC when available.
- If NADAC is unavailable, then the AAC will be defined as either:
  1. Average Acquisition Cost as determined from surveys of Mississippi Medicaid enrolled pharmacies, or
  2. Wholesale Acquisition Cost (WAC), as published by pricing compendia.
- Payment for brand and generic legend and over the counter drugs will be calculated based on the lower of;
  a. AAC as defined above, plus a professional dispensing fee, or
  b. Provider's usual and customary charges to the general public.
- Blood Factor products, as identified by the Division, will be reimbursed using the Medicare rate of ASP + 6%.

Professional Dispensing Fee

In a proposed rule published in the Federal Register on February 2, 2012 regarding covered outpatient drugs at http://www.gpo.gov/fdsys/pkg/FR-2012-02-02/pdf/2012-2014.pdf, CMS proposes to replace the term "dispensing fee" with "professional dispensing fee". In the proposed rule, CMS retains the current definition of "dispensing fee," but proposes to replace the term with "professional dispensing fee" to reinforce the agency's position that once the reimbursement for a drug is properly determined, the dispensing fee should reflect the pharmacist's professional services and costs.

Proposed reimbursement methodology for pharmacy fee for service point of sale (POS) claims is posted on the Pharmacy services' web page at http://www.medicaid.ms.gov/Pharmacy.aspx.

One Dispensing Fee per Drug per Month for Prescriptions Dispensed to LTC Beneficiaries

Effective July 1, 2014 and in accordance with MS state law § 43-13-117(A) (9)(a), one dispensing fee per drug (i.e. per national drug code or NDC) per month/resident will be paid for long term care (LTC) beneficiaries. LTC beneficiaries are defined as beneficiaries residing in nursing homes, psychiatric residential treatment facilities, or intermediate care facilities for individuals with developmental disabilities.
Limited exclusions may include, but are not limited to, pass medications, and resident moving from one facility to another in the same month.

Friendly Reminders

- ***Preferred Drug List (PDL) Update, effective July 1, 2014:*** Effective July 1, 2014, there will be a minor PDL update. 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 July 1, 2014. We recommend adding this link to your favorites as you will find it very helpful.

❖ ***Hurricane Preparedness, Pharmacy billing procedures in times of officially declared emergencies:*** The Atlantic hurricane season starts June 1, 2014. Be sure that your pharmacy is prepared for the upcoming hurricane season. During states of officially declared emergencies, DOM has a new pharmacy point of sale (POS) procedure. Pharmacists should enter a value of '13-Payor Recognized Emergency' in NCPDP Field 420-DK' when it is necessary to override the following service limit edits:

- 2 Brand/5 Prescription Limit
- Early Refill

Please note that when the declared emergency announcement is made, the fields noted above will be opened for the specified time period. Pharmacy providers are advised to use professional judgment in emergency situations. The Division of Medicaid may conduct audits after such events to ensure appropriate care was taken in dispensing medications for affected beneficiaries. Providers and beneficiaries residing and/or receiving care not in an evacuation area must have documentation on file to justify rationale for early/excess fills. Medicaid monies may be recouped if supporting documentation is not found.

❖ ***Pharmacy manual PA 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. Previous forms are no longer accepted. New form can be located at http://www.medicaid.ms.gov/Pharmacy.asp.

❖ ***All Prescribers must be enrolled with Medicaid:*** Effective January 1, 2014, in accordance with Federal guidelines, prescribers who write prescriptions for Medicaid beneficiaries *must* be enrolled as Medicaid providers. If there are questions, please contact Xerox at 1-800-884-3222.

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

LONG-TERM CARE

2014 New Bed Values for Nursing Facilities, ICF-IIDs, and PRTFs

The new bed values for 2014 for nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs) and psychiatric residential treatment facilities (PRTFs) have been determined by using the R.S. Means Historical Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

Facility Class	2014 New Bed Value
Nursing Facility	$56,002
ICF-IIDs	$67,202
PRTF	$67,202

REMINDER TO ALL PROVIDERS

All providers are held accountable for information contained in the Mississippi Medicaid Provider Bulletins in accordance with Medicaid's Administrative Code.

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If you have any questions related to the topics in this bulletin, please contact Xerox at 1-800 -884 -3222

Mississippi Medicaid Administrative Code and Billing Manuals are on the Web
www.medicaid.ms.gov

Medicaid Bulletins are located on the Web Portal
www.ms-medicaid.com

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

JUNE 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2	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	26 EDI Cut Off 5:00 p.m.	27	28
29	30 CHECKWRITE					

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.