Volume 20, Issue 3 September 2014

MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

Understanding CHIP Income-Eligibility Changes

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MS Division of Medicaid

Beginning December 1 of this year, about 25,000 children in Mississippi between the ages of 6-19 will transition from the Children's Health Insurance Program (CHIP) to the Division of Medicaid's Mississippi Coordinated Access Network (MississippiCAN). This represents a significant and complex change for Medicaid, and we are working hard to minimize any impact on providers and beneficiaries.

As we have touched on previously in the Provider Bulletin, this and many other changes are the result of the Affordable Care Act (ACA).

At the end of July, just over 71,000 children in the state were enrolled in CHIP. Due to implementation of ACA mandates, the income limit for CHIP has changed for children from 6-19 years old from 100-200 percent of the federal poverty level (FPL) to 134-209 percent. This change relates to new Modified Adjusted Gross Income (MAGI) limits, which went into effect January 1. This means families with slightly higher incomes will continue to be eligible for coverage under CHIP, but it also creates a coverage gap from the 100-133 percent range. This coverage gap affects more than 25,000 children, which Medicaid will now cover through our MississippiCAN program. Our plan is to roll those children into MississippiCAN starting in December.

We already have a category of children in the managed care environment – those under one year of age, as they are covered under the pregnant women category. For children who remain Medicaid-eligible after their first birthday, we will continue their coverage under MississippiCAN. We are able to do this because the 2014 Legislature authorized us to enroll eligible children of all ages in our managed care program. As detailed before, these changes are the right thing to do, both for the long-term health and wellbeing of eligible children and because it allows the agency better cost-predictability.

Those children who were previously in MississippiCAN under the age of one year will remain in MississippiCAN after their first birthday if they remain Medicaid-eligible and others, ages 6-19 with lower family incomes, will be added who have been previously covered by CHIP. Eventually our plan is to enroll all of the children in Medicaid into our managed care environment.

Any changes to categories of eligibility are bound to be complicated and difficult to explain, which is why DOM held informational workshops for providers throughout July across the state to answer MississippiCAN questions. From August through September, we held another round of workshops aimed at current and potential beneficiaries.

As we continue to work out the details throughout the fall, we are committed to making this transition as smooth and coordinated as we possibly can.

IN THIS ISSUE

Case Mix Training Revisions and Updates for Nursing Facilities

Mississippi Division of Medicaid will be transitioning to the RUG-IV 48-group classification model effective for the January 1, 2015 Medicaid rates. Beginning January 1, 2015 case mix reviews and Roster Reports will reflect this grouper model change. In preparation for this transition, DOM has contracted with Myers and Stauffer LC, to conduct provider training. Training is scheduled in three locations as follows:

- October 27; Hilton-County Line Road, Jackson
- October 28; Lake Terrace Convention Center, Hattiesburg
- October 30; BancorpSouth Convention Center, Tupelo

Registration information will be available soon by logging into mslc.com/Mississippi/ and select Resources, and then location preferred. Seats will be limited, so early registration is recommended.

Topics to be discussed in training:

- RUG-IV 48 Grouper Model
- Supportive Documentation Guidelines
- Case Mix Review Protocol
- Time-Weighted Roster Report Methodology With Roster Report Samples
- New Portal For Bed Hold Reporting

MISSISSIPPI DIVISION OF MEDICAID

OFFICE OF THE GOVERNOR

Walter Sillers Building | 550 High Street, Suite 1000 | Jackson, Mississippi

MISSISSIPPI DIVISION OF MEDICAID

Facility:_____ **Provider Type:**_____ **County:**_____

We need your help to tell us how well the Mississippi*CAN* program is doing. Please take a few minutes to complete this survey by placing a checkmark beside your response about your experience with Mississippi*CAN*. If you have any questions, please contact the Office of Coordinated Care at (601) 359-3789.

*Mississippi*CAN Provider Survey

1. How would you describe your overall experience with the Mississippi*CAN* Program?
[ ]Excellent [ ]Good [ ]Fair [ ]Poor

2. In general, do you think the quality of care for the eligible Mississippi Medicaid beneficiaries has improved?
[ ] Improved Very Much [ ] Somewhat Improved
[ ] Not Improved

3. How long have you been a Mississippi*CAN* Provider?
[ ] More than a year [ ]Six months
[ ] Recently became a Provider [ ] Not a Mississippi*CAN* Provider
If you marked not a Mississippi*CAN* Provider ***STOP***

4. In which plan are you enrolled?
[ ] Magnolia Health Plan [ ] United Healthcare
[ ] Both

5. Have you ever been visited by a provider representative from the plans?
[ ] Yes [ ] No

6. Do you receive a member roster panel from the plan or Coordinated Care Organization? [ ] Yes [ ] No
If so, how often? [ ] Daily [ ] Weekly [ ] Monthly [ ]Never

7. Do you receive notifications of changes from the plans?
[ ] Yes [ ] No
If so, how often? [ ] Monthly [ ] Quarterly [ ] Annually [ ] Other

8. How do you receive provider notifications?
[ ] Web Portal [ ] Email [ ] Mail [ ] Fax [ ] Never

9. Are you a CHIP Provider?
[ ] Yes [ ] No

10. When do you check eligibility for your patients?
[ ] Week before [ ] Day before [ ] Date of service [ ] Other

		Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
11.	My claims are processed in a timely manner.	☐	☐	☐	☐	☐
12.	Claims have been paid at the correct rate (no less than what Medicaid would pay).	☐	☐	☐	☐	☐
13.	Claims inquiries are answered promptly.	☐	☐	☐	☐	☐
14.	When I call the Plans, I am able to speak directly with someone and get my questions answered.	☐	☐	☐	☐	☐
15.	Denial notifications consistently provide denial reasons.	☐	☐	☐	☐	☐
16.	The plan's Provider Grievance & Appeals process is effective.	☐	☐	☐	☐	☐
17.	The Prior Authorization process is working efficiently.	☐	☐	☐	☐	☐
18.	My staff and I are familiar with the Mississippi*CAN* program and the services they provide.	☐	☐	☐	☐	☐
19.	I would recommend Mississippi*CAN* to eligible Mississippi Medicaid beneficiaries and other providers.	☐	☐	☐	☐	☐
20.	My facility utilizes the Disease and Care Management programs.	☐	☐	☐	☐	☐
21.	I think Mississippi Medicaid beneficiaries understand the Mississippi*CAN* program.	☐	☐	☐	☐	☐

COMMENTS:

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NEWS

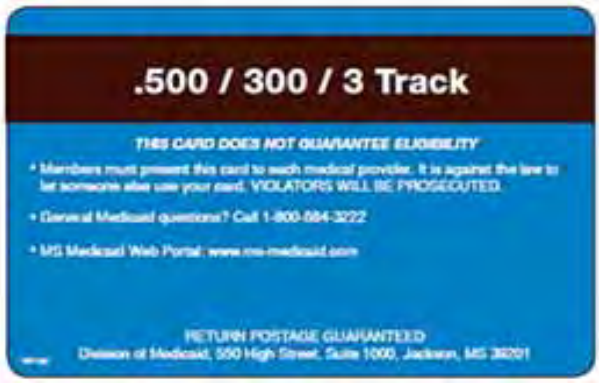
Mississippi Medicaid Issues New Beneficiary Identification Card

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

- Medicaid beneficiaries were issued new blue ID cards, which replaced their current green ID cards
- Family Planning Waiver beneficiaries received 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.



Tips for Individual Providers When They Relocate

Your Mississippi Medicaid Provider number belongs to you, the individual provider, not the practice. Often times providers' numbers are established with the address and banking information that belongs to the practice that is initiating the enrollment rather than the individual provider. When the individual provider changes practices, the information of his/her prior practice remains on his/her Medicaid provider file until he/she submits the required forms to change the addresses and banking information.

When the individual provider changes practices or affiliations, the provider should check their addresses and banking information on file with DOM. Verifying the information on their provider file will prevent the non-receipt of important letters/notices and payment to incorrect accounts.

SUBMITTING CHANGE OF BANKING INFORMATION

The Direct Deposit Authorization Agreement form should be printed from the web portal at https://msmedicaid.acs-inc.com/msenvision/downloadenrollmentPackage.do and should be completed and signed by the individual provider. A preprinted voided check or deposit slip or a letter on bank letterhead signed by a bank official should be submitted to verify the accuracy of the information noted on the form. The Direct Deposit Authorization agreement and the bank verification can be faxed to Xerox Provider Enrollment at 888-495-8169 or can be mailed to the following address:

Xerox Provider Enrollment Department
P. O. Box 23078
Jackson MS 39225

Once the update to your individual file has been completed, at any point that you bill claims on your individual number you will receive a paper check mailed to your billing address on file for 2-3 payment cycles. Ongoing, you will began receiving your Mississippi Medicaid Reimbursement electronically deposited according to the information on your provider file.

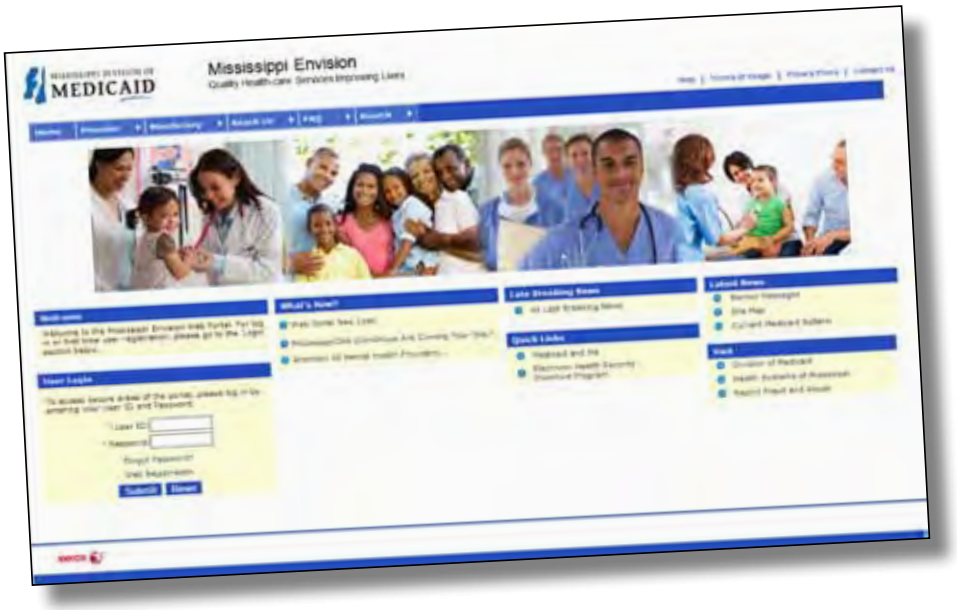
Reminder for All MS Cool Kids (EPSDT) Providers

DOM does not cover routine physical examinations, such as school, sports, or employment physicals unless performed in conjunction with the MS Cool Kids (EPSDT) well check screening program for EPSDT-eligible beneficiaries. ***All age appropriate screening components for the annual screening visit must be performed and documented in the medical record for MDOM reimbursement.***

Cool Kids (EPSDT) providers are also reminded that the EPSDT annual screenings do not count against the office visit service limits. Examinations included in the annual Cool Kids (EPSDT) screenings are:

- A comprehensive health and developmental history/ assessment
- An unclothed physical examination
- Appropriate immunizations
- Age appropriate laboratory tests
- Adolescent counseling
- Health education, including anticipatory guidance
- Vision, hearing, and dental screen

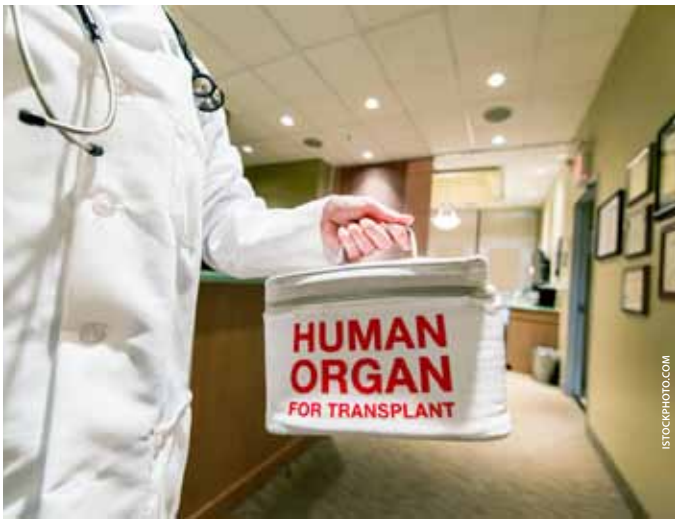
The documentation requirements for the EPSDT Program can be found in the Mississippi Administrative Code, Title 23, Part 223 – EPSDT Services at www.medicaid.ms.gov. For questions relating to MS Cool Kids, please contact the Office of Medical Services at 601-359-6150 or 1-800-421-2408.



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.

PROVIDER COMPLIANCE



Prior Approval for Solid Organ Transplants

Solid organs such as heart, heart/lung, liver, single or bilateral lung and small bowel require prior approval before the transplant is performed. This requirement does not apply to kidney, cornea, bone marrow and peripheral stem cell transplants unless performed in conjunction with another transplant. Prior approval is required regardless of the age of patient or diagnosis.

DOM has contracted with eQHealth Solutions to handle medical necessity review for transplants. Transplant facilities or physicians needing information regarding transplant services may contact Geraldine Bethley, R.N. at 601-359-9600 or email geraldine.bethley@medicaid.ms.gov.

Hysterectomy Consent

DOM covers a hysterectomy when deemed medically necessary in an inpatient or outpatient hospital setting. The Mississippi Administrative Code, Title 23, Part 202, Hospital Services, Rule 5.6 requires providers to complete the Sterilization Consent Form and the Hysterectomy Acknowledgement Form prior to the surgery. If prior acknowledgement is not possible due to a life-threatening emergency, the physician performing the hysterectomy must complete Section C of the form. The Sterilization Consent Form and the Hysterectomy Acknowledgement Form is located under the Resources section of the Medicaid website at www.medicaid.ms.gov by clicking on the Forms link.

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

Circumcision Coverage Policy Reminder

Providers are reminded of the DOM policy on coverage of circumcisions that has been in effect since August 1, 2000, as cited below.

Routine Newborn and Other Not Medically Necessary Circumcisions

No benefits will be provided for the routine circumcision of newborn infants or other circumcisions for whom medically necessity is not documented according to the criteria listed below.

Medically Necessary Circumcisions

Medically necessary circumcision will be covered based on documentation of medical necessity. Medically necessary circumcisions may be performed in the inpatient hospital setting (subject to precertification of all inpatient days), the outpatient hospital setting, ambulatory surgical center, or a physician's office. Each of the following criteria must be met for coverage:

1. Medical necessity for the procedure is fully documented in the medical records,

AND

2. Documentation in the medical records includes:
   - a diagnosis which justifies the medical necessity for circumcision. Examples include, but are not limited to, recurrent balanoposthitis or recurrent urinary tract infections, AND
   - failure of the patient to respond to conservative treatment, AND
   - the recurrent nature of the medical condition,

AND

3. The sole diagnosis is not phimosis. A diagnosis of phimosis alone will not be sufficient documentation of medical necessity,

AND

4. There is documentation such as physician progress notes and office records to justify the medical necessity. A pathology report alone will NOT be sufficient as documentation of medical necessity.

The medical documentation may be included either in the surgeon's report or the beneficiary's attending physician records. Documentation of conservative treatment must include, but is not limited to, teaching about appropriate drug therapy used to treat the condition. Documentation must be legible and available for review if requested.

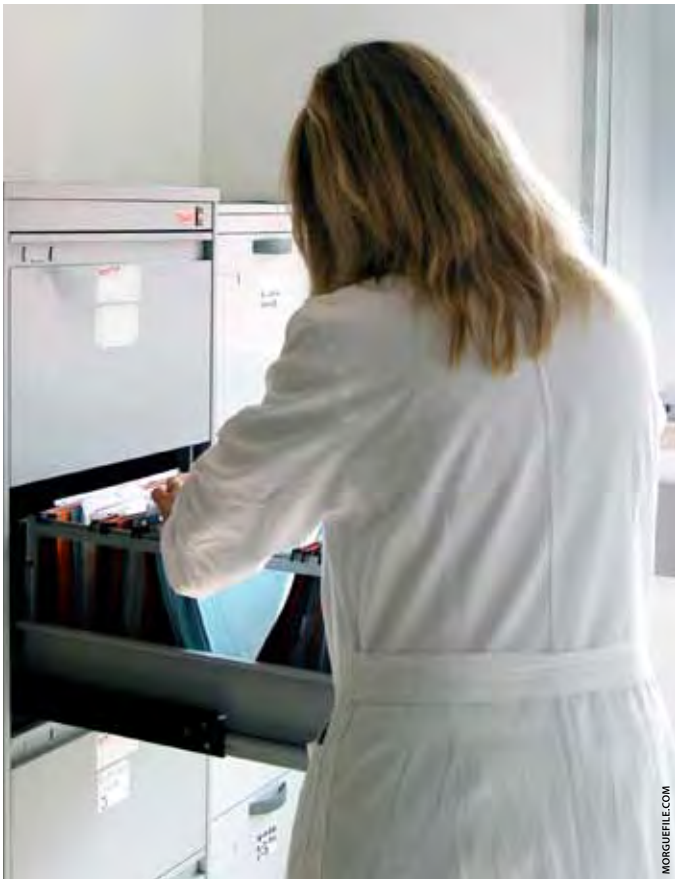
Reimbursement for hospital inpatient procedures will be included in the All Patient Refined Diagnosis Related Groups (APR-DRGs) payment and hospital outpatient procedures will be paid using the Outpatient Prospective Payment System (OPPS) payment method. Facility charges for procedures performed in the ambulatory surgical center are paid according to the Medicaid Ambulatory Surgical Center procedure schedule. Physician fees are reimbursed based on the Medicaid Physician Fee Schedule.

Appropriate anesthesia, which is considered the standard of care, is covered in accordance with the Division of Medicaid's policies for anesthesia services.

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

Payment Error Rate Measurement (PERM) Federal Fiscal Year 2014

PERM was developed by Centers for Medicare and Medicaid Services (CMS) to measure improper payments in the Medicaid program and the Children's Health Insurance Plan (CHIP). PERM reviews will be conducted in three areas:



- Managed Care payments
- Fee-for-service claims review includes medical record collection, medical review, and data processing reviews.
- FY2014 through FY2016 cycles will not include an eligibility component.
  - To line up with the new Affordable Care Act eligibility environment, CMS will revise the PERM eligibility program in time to reinstate the eligibility component in the FY2017 cycle.

For more information regarding PERM, please refer to CMS website http://www.cms.gov/PERM.
PERM Reviewers include:

The Lewin Group – Statistical Contractor (SC) – is responsible for sampling and calculation of error rates.

A+ Government Solutions – Review Contractor (RC) – is responsible for medical reviews.

A+ Government Solutions will contact providers directly, via telephone, fax, and mail from a sample of providers to collect medical documentation for review to substantiate claims paid in federal fiscal year 2014 (October 1, 2013 through September 30, 2014).

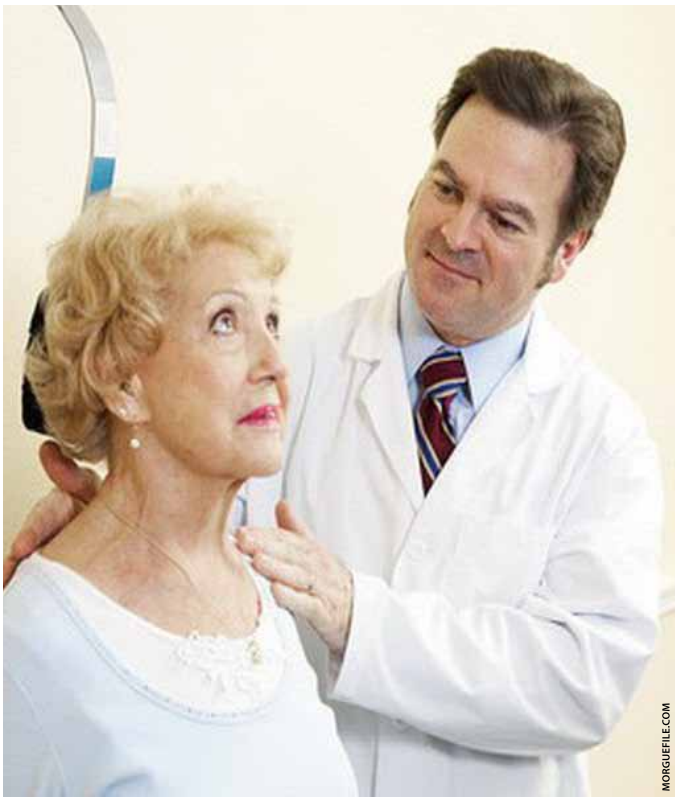
For assistance in faxing information or any other concerns to A+, please call 301-987-1100. The toll free number for records to be faxed to A+ is 1-877-619-7850.

The first request for documentation by A+ should be mailed to the providers starting September 2014. Providers must respond as soon as possible.

- **75 Days** – Provider must submit medical records to A+ within 75 days of date of letter.
- **14 Days** – Provider must submit additional medical records to A+ within 14 days of date of letter when the contractor makes a request for additional information.
- **Failure to comply will result is an automatic error and recoupment of paid claim.** The Mississippi Division of Medicaid (DOM) requests that providers also send a copy of the supplemental documentation to the attention of DOM PERM to confirm that documentation is complete. This will eliminate the problem of incomplete documentation from provider, and allows DOM to secure the additional documentation from the provider to avoid error assignments and subsequent claims recoupment or repayment.

PERM reviewers/contractors will examine claims to determine whether the provider:

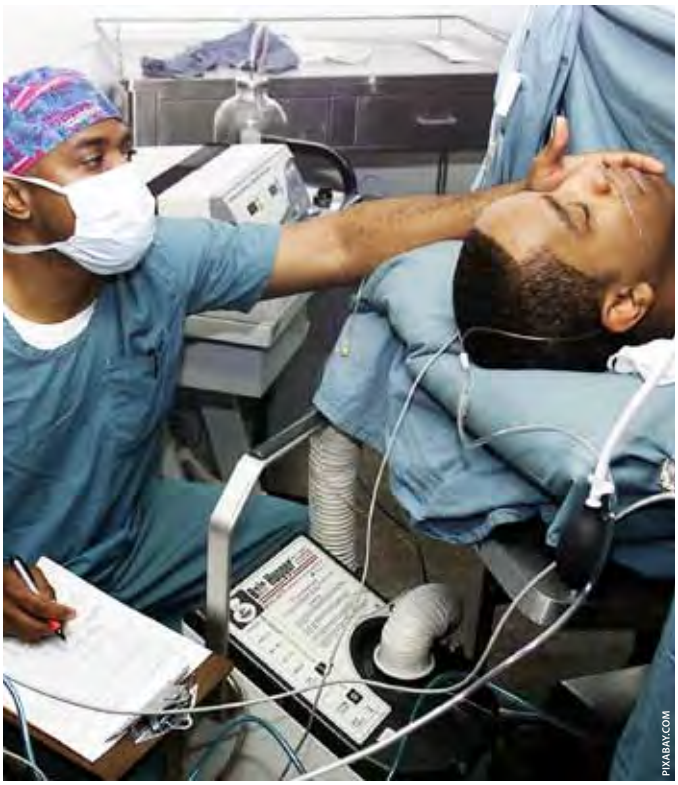
- Responded to the request for documentation within the required time frame;
- Submitted documentation, but the documentation did not support the procedure code that was reimbursed;



- Submitted insufficient documentation;
- Submitted a procedure code that was an error (such as, the provider performed a procedure but billed using an incorrect procedure code);
- Billed with an incorrect diagnosis;
- Billed for the separate components of procedure code when only one inclusive procedure code should have been billed;
- Billed for an incorrect number of units for a particular procedure or revenue code;
- Billed for a service determined to have been medically unnecessary based on the information in the medical/service record about the patient's condition;
- Billed and was paid for a service that was not in agreement with a documented policy, regulation or other requirement;
- Met all DOM, CMS and other applicable policies, procedures and regulations.

CMS will host a series of interactive PERM Provider Education webinars. Provider may also submit questions to the designated PERM Provider email address at: PERMProvider@cms.hhs.gov

For assistance from DOM, please call PERM representative Koteshya L. Guidry at 601-359-9128 or 1-800-421-2408, or email Koteshya.Guidry@medicaid.ms.gov



Recovery Audit Contractors (RACs) Changes to Abrasion Limits

Effective July 1, 2014, abrasion limits and calculations have changed. All DOM providers subject to audits by PRGX Global Inc., the RAC contractor for the State of Mississippi, will notice a reduction in the number of additional documentation requests (ADR) received from the RAC. The volume of records that can be requested in each wave is now calculated at 2.5% of the volume of claims submitted by the provider in the previous calendar year divided by five waves. As a result, ADR requests will be mailed every 72 days, for a total of five waves per year. The upper bound limit of the number of records the RAC can request has been capped at 200 for providers who submit a high volume of claims. The lower bound limit for providers who submit a fairly low volume of claims is 20. The RAC can request no more than 200 claims per wave and no less than 20 claims per wave depending on provider claim volume.

All changes are outlined on the DOM website located at http://www.medicaid.ms.gov/providers/recovery-auditor-contractors/. DOM encourages providers to monitor the website for updates and announcements regarding the Mississippi Overpayment Audit Recovery program. Additional opportunities for provider education and training will be forthcoming.

Billing Updates for Mental Health Providers

2014 Annual Rate Updates

Effective July 1, 2014, DOM revised the rates for providers based on 90% of the current Medicare rate, as defined in State Law. The new rates are listed in the chart below:

Code	Previous Rate	New Rate		Code	Previous Rate	New Rate
90785	4.13	12.54		96372	20.82	20.21
90791	128.61	116.73		99201	36.05	35.60
90792	108.59	125.90		99202	61.67	61.65
90832	53.76	56.66		99203	89.70	89.66
90833	36.24	57.78		99204	137.57	138.72
90834	70.38	75.18		99205	170.98	173.50
90836	58.88	73.13		99211	16.61	16.34
90837	103.28	112.55		99212	36.05	35.88
90838	95.04	96.48		99213	60.51	60.71
90846	64.83	100.58		99214	89.10	89.90
90847	77.76	103.86		99215	119.58	120.83
90849	28.85	29.31		99354	82.75	85.16
90853	21.24	24.97		99355	81.16	83.48
90870	141.23	108.69		M0064	45.77	44.22
96111	108.45	117.90				

NCCI Edits for Group Therapy and Interactive Complexity

DOM claims processing procedures for Group Therapy (90853) and Interactive Complexity (90785) has been modified to be in compliance with the National Correct Coding Initiative (NCCI). NCCI mutually exclusive ruling mandated certain codes cannot be billed simultaneously by a provider for a beneficiary on the single date of service. Effective July 1, 2013, NCCI mandated the following:

- Group Therapy (90853) is only allowed to be billed once per date of service.
- Interactive Complexity (90785) is only allowed to be billed once per date of service.

Medicaid NCCI Edit files and reference documents are updated quarterly and can be viewed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html.

Please contact Kimberly Evans, Kimberly Sartin Holloway, or Charlene Toten-Hobson at 601-359-9545, should you have questions.

Attention All Medicaid Audiologists and Hearing Providers

Effective December 1, 2013, the following CPT codes for digital hearing aids were opened for coverage: V5254, V5255, V5256, V5257, V5258, V5259, V5260, and V5261. The codes require prior authorization through eQHealth Solutions, a Utilization Management/Quality Improvement Organization contracted with the Agency. A complete list of procedural codes requiring prior authorization may be found by accessing the hearing fee schedule at http://www.medicaid.ms.gov/FeeScheduleLists.aspx.

Providers may contact eQHealth Solutions by calling 1-866-740-2221 (local: 601-360-4961), via email at education@eqhs.org or by visiting their website at ms.eqhs.org.

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Update Your Provider File!

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

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

Billing Tips to Avoid Duplicate Claims

DOM 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 DOM 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

PDL Update October 1, 2014

Effective October 1, 2014, there will be a minor Preferred Drug List (PDL) update. To reference the current PDL, go to http://www.medicaid.ms.gov/providers/pharmacy/preferred-drug-list/ and select MS PDL. The current PDL and Provider Notice PDL changes, effective October 1, 2014, are located on the site. DOM recommends adding this link to your favorites as it is a helpful resource.

Preferred Drug List (PDL): Clarification

Please note that the PDL addresses drugs dispensed in the pharmacy or point of sale (POS) venue only. It is not applicable to drugs provided and billed by physician offices. Providers should refer to the prior authorization (PA) criteria column of PDL to determine specific PA criteria for non-preferred products.

Synagis Prior Authorization Update

DOM covers the administration of Synagis® for eligible beneficiaries who meet the American Academy of Pediatrics (AAP) criteria for Respiratory Syncytial Virus (RSV) immunoprophylaxis. On July 28, 2014, the AAP published a policy statement entitled, "Updated Guidance for Palivizumab Prophylaxis Among Infants and Young Children at Increased Risk of Hospitalization for Respiratory Syncytial Virus Infection" in Pediatrics. The new updated AAP guidance is available at http://pediatrics.aappublicaions.org/content/early/2014/07/23/peds.2014-1665/.

DOM is reviewing the new AAP guidelines and updating the prior authorization criteria for Synagis®. The proposed new guidelines will be reviewed at the DOM Drug Utilization Review (DUR) Board Meeting, August, 21, 2014. After input from the DUR Board, DOM will finalize the criteria and update the 2014-2015 Synagis® PA form that is posted on the Pharmacy Bureau web page. After it has been posted, the new PA form can be found at www.medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/. PA requests for beneficiaries enrolled in MSCAN are to be submitted to the respective pharmacy benefits manager (PBM) and not to DOM.

Pharmacy Billing for Influenza and Pneumonia

DOM covers influenza and pneumonia immunizations as a Pharmacy covered service benefit for eligible beneficiaries aged 19 and older who are not residents of long-term care facilities. Influenza, pneumonia, and zoster immunizations are the only vaccines or immunizations covered as a Pharmacy benefit. A valid prescription must be on file as with other pharmacy services. Immunizations provided from a credentialed pharmacist count against a beneficiary's service limits and co-payments are applicable. DOM reimburses for the drug's ingredient cost and pays a dispensing fee for immunizations administered in the pharmacy venue. No administration fee is paid for immunizations administered in the pharmacy venue.

All immunizations for children age 18 and younger must be handled through the Vaccines for Children Program (VFC). For additional information regarding immunizations and Medicaid policies, refer to Title 23: Medicaid, Part 224 Immunizations of the Administrative Code, which may be found at http://www.medicaid.ms.gov/providers/administrative-code/ or contact the Office of Medical Services at 601-359-6150.

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

Effective July 1, 2014, and in accordance with Mississippi code § 43-13-117(A) (9) (a), one (1) dispensing fee per drug (i.e. per national drug code or NDC) per month/resident may 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, past medications, and resident moving from one facility to another in the same month. Exclusions to one (1) dispensing fee per drug per month require prior authorization. The Pharmacy Prior Authorization unit may be contacted at 1-877-537-0722.

DOM Pharmacy Claims and Valid Provider Types

Since June 1, 2013, all pharmacy claims must have a valid prescribing provider type, a person, and not a building, i.e. clinic or hospital, national prescriber identification (NPI) number. A "prescriber" must be a person, and not a building.

Effective June 1, 2013, claims using a clinic or hospital NPI will deny. Valid provider types include physicians, doctors of osteopathy, podiatrists, dentists, optometrists, nurse midwives, nurse practitioners and physician assistants.

Pharmacy Manual PA Form

In accordance with state law passed in the 2013 legislative session, health benefit plans, including DOM, are directed to establish a standardized pharmacy prior authorization form. The new form is located at http://www.medicaid.ms.gov/providers/pharmacy/pharmacy-prior-authorization/. Previous versions of the forms are no longer accepted after January 1, 2014.

All Prescribers Must be Enrolled with Medicaid

Effective January 1, 2014, in accordance with Federal regulations at 42 CFR Subpart E, DOM requires that all ordering and referring physicians or other professionals providing services under the State plan or under a waiver of the Plan be enrolled as participating providers. Prescribers who write prescriptions for Medicaid beneficiaries must be enrolled as Medicaid providers.

Pharmacy claims will begin denying on November 1, 2014, if the Prescriber is not an enrolled Medicaid provider. Please direct all questions related to enrolling as a Medicaid provider to Xerox 1-800-884-3222.

Using Incorrect Medicaid Identification Numbers

DOM covers outpatient drugs in a pharmacy setting for eligible 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.

Denial of Pharmacy Point of Sale Claims written by a Non-Enrolled Provider

42 CFR 455.410(b) of the Affordable Care Act (ACA) requires state Medicaid agencies to 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.

DOM began implementation of this requirement effective January 1, 2014, and the current processes for pharmacy point of sale claims are noted below:

- 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 individual NPI number.
- After January 1, 2014, first time claims received for non-Medicaid providers "with a date written" on or 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 THE CLAIM MUST BE THE ACTUAL PRESCRIBER ON THE PRESCRIPTION (RX); ANY OTHER IS CONSIDERED FRAUD'.
- At the time that the first time claim with a date written on or after January 1, 2014, comes through the Medicaid system, a system generated notice with the most current address information for the prescribing provider NPI noted will be sent to the provider with information regarding the requirement and enrollment options.
- 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.
- If these prescribers do not enroll during their 90 day grace period, then on the 91st day and thereafter their Medicaid prescription will deny.

The initial deadline for denial of pharmacy claims was April 1, 2014. DOM has EXTENDED the deadline date for pharmacy claim denials to November 1, 2014 and after.

To prevent denial of the rendering provider claims AND to ensure access to pharmacy services for our Mississippi Medicaid beneficiaries, please make sure that the prescribing provider's individual NPI is noted on the prescription and all claims. It is required that all individual prescribing providers must be actively enrolled with DOM.

If you have any questions about enrollment, please contact Xerox Provider Services at (800)884-3222.

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 fall!

SEPTEMBER 2014

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

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.