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MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

Free Online Service Offers Medicaid Providers Access to Patient Information

DR. DAVID DZIELAK
Executive Director
MS Division of Medicaid

Health-care providers across the state have a new digital tool to help them track their Medicaid patients' medical histories and medications with the aim of delivering high-quality and cost-effective care—and it's available to them free of charge.

The Mississippi Division of Medicaid (DOM) began offering Mede/Provider Access during the summer, a service created by outside vendor MedeAnalytics, to provide up-to-date patient information in an easy-to-access online application. The service differs from an electronic health record (EHR) because it's a view-only access specifically designed for Medicaid providers, containing transformed claims-based clinical information for Mississippi Medicaid beneficiaries over a seven-year period, regardless of where the beneficiary has received treatment during that time.

Mede/Provider Access will help providers monitor their patients' medical history, prescription medication filling habits and minimize duplicate treatments.

"The advantage is that users can see another Medicaid provider's treatment of that patient, which assists them in their treatment because they can see where their patient has been treated, see their diagnoses and what medications have been prescribed and filled by that patient," said Cheryl Mize, lead clinical business analyst in the Office of Information Technology at DOM. "It's another tool to assist them in their individual treatment of that patient."

The service also allows Medicaid providers to view all claims submissions (both paid and denied) for the individual. The additional information is valuable as it helps to provide a more detailed picture of the individual patient's medical history. Only viewing paid claims may not accurately reflect the patient's actual history of clinical diagnoses, as clinical data are sometimes modified upon denial of the claim in order to achieve payment.

"It gives providers a lot of avenues to deliver better treatment, better outcomes and more accurate reimbursement," Mize said.

The service went into effect June 30, 2014 and is not only limited to Mississippi providers; those in neighboring states also are encouraged to take advantage of the system, as Mississippi Medicaid beneficiaries may seek treatment in nearby cities such as Memphis, New Orleans or Baton Rouge.

"The Centers for Medicare and Medicaid Services (CMS) and the federal government has mandated that states begin to share information and participate with each other in providing the most cost-efficient and effective care for our patients and beneficiaries," Mize explained. "Mississippi has a high percentage of Medicaid beneficiaries. That makes it even more important to us that we give our providers as much information as we can to assist them in treating their patients."

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Mede/Provider Access is funded through the Health Information Technology initiative, with the federal government covering 90 percent of the cost. So far, 226 individual users representing 30 providers/facilities have signed up to use the system.

Since launching Mede/Provider Access, Mize says, "providers have been extremely positive, including responses from providers at the University of Mississippi Medical Center (UMMC)."

"Parents and patients almost always claim they are adherent with their medications," said Dr. Anne Yates, professor of pediatric allergy, asthma & immunology at UMMC. "When we can see what they actually filled at the pharmacy, it gives us an opportunity to discuss with them the importance of taking their meds as prescribed. It also keeps us from over prescribing. If we know they are not really taking the meds already prescribed, then we won't put them on even more medications."

"Also, with (UMMC's) EHR, I have access to all medications, diagnoses, and clinic visit dates and information from other providers in the UMMC system, but no access to data for visits outside of UMMC," she added. "Mede/Provider Access helps to fill in those gaps, as many of our patients come from other parts of the state."

Various state and federal regulations, as well as DOM policy, require additional protections on the use and disclosure of health information without authorization of the beneficiary. For beneficiaries who choose to participate in Mede/Provider Access, certain categories of health information have been identified as sensitive and will not be available through the service.

Unlike a typical electronic health record system, Mede/Provider Access is a view-only service, Mize explained. Providers cannot change or update a patient's information, but the advantage is they can see another Medicaid provider's treatment of that patient.

"Mede/Provider Access enables users to get a comprehensive sense of the patient's care," said Dr. John Showalter, assistant professor of medicine and chief medical information officer at UMMC. "Knowing which medications a patient has actually picked up from the pharmacy is very powerful information. The portal compliments an EHR nicely and allows for a more 360 degree view of the patient. It is easy to use and I would recommend it to other providers."

If you are a current Medicaid provider and would like to learn more about Mede/Provider Access, contact Nancy Barton-Marini at nancy.bartonmarini@medeanalytics.com, 662-231-7715.

If you would like to become a Medicaid provider, contact Provider Enrollment toll-free at 800-884-3222.

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.

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	

Attention All Assisted Living (AL) Waiver Providers

These webinars are for you!

The Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding new regulations on home and community based service (HCBS) settings requirements to all States. The effective date of the final rule is March 17, 2014. Mississippi Division of Medicaid (DOM) has submitted a transition plan to CMS regarding AL facilities and the final rules on HCBS settings requirements. In order to meet the HCBS settings requirements, several reviews specific to the HCBS settings requirement will be conducted of all AL providers.

DOM will conduct webinar trainings and also provide information regarding the HCBS settings requirements. All AL providers will be required to conduct self-assessments. The self-assessment tool will be provided by DOM. The webinar will also provide training on the self-assessments and how it must be conducted.

The webinars will be conducted on the following dates and times:

December 10, 2014	**December 10, 2014**	**December 11, 2014**
9:00am–11:00am	**1:00pm–3:00pm**	**2:00pm–4:00pm**

Information regarding accessing the webinars will be available on the Envision Web Portal under Late Breaking News at https://www.ms-medicaid.com/msenvision/. If you have any questions, please contact James Horton at 601-359-9544.

Attention All Elderly and Disabled (E&D) Waiver Adult Day Care (ADC) Providers

These webinars are for you!

The Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding new regulations on home and community based service (HCBS) settings requirements to all States. The effective date of the final rule is March 17, 2014. Mississippi Division of Medicaid (DOM) has submitted a transition plan to CMS regarding ADC's and the final rules on HCBS settings requirements. In order to meet the HCBS settings requirements, several reviews specific to the HCBS settings requirement will be conducted of all ADC providers.

DOM will conduct webinar trainings and also provide information regarding the HCBS settings requirements. All ADC providers will be required to conduct self-assessments. The self-assessment tool will be provided by DOM. The webinar will also provide training on the self-assessments and how it must be conducted.

The webinars will be conducted on the following dates and times:

December 17, 2014	**December 17, 2014**	**December 18, 2014**
9:00am–11:00am	**1:00pm–3:00pm**	**3:00pm–5:00pm**

Information regarding accessing the webinars will be available on the Envision Web Portal under Late Breaking News at https://www.ms-medicaid.com/msenvision/. If you have any questions, please contact Sandra Bracey-Mack at 601-359-9549

NEWS

Updates to the Claim Reconsideration Form

DOM and Xerox have recently updated the Reconsideration Form (previously called "Claim Check Reconsideration Form"). The Reconsideration form is utilized to clearly indicate what the provider would like to be reconsidered (CPT code, HCPCS code, edit override, etc.) after a claim has gone through initial processing. This form should be completed & attached to all claim(s) that are sent to Medical Review for reconsideration. To ensure that your claim is processed in a timely manner, please discard the old forms and use the new form which is located on the Mississippi Medicaid website www.medicaid.ms.gov under "Resources/Forms." ***An example is below.***

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

xerox

Claim Reconsideration Form

Instructions- Read carefully: Please ensure the reconsideration request is fully completed and, signed, and paper claim forms are returned with all required documentation/attachments, reports, and consent forms. If the claim was previously submitted electronically, a paper claim is still required. Reconsiderations submitted without proper documentation and/or without a completed claim form will be returned to the provider.

Beneficiary Name:_____ MS Medicaid ID #: _____

TCN #: _ _ _ _ _ _ _ _ _ _ _ Paid Date: _____ Date of Service:_____

Provider#: _____ Provider Name:_____

Provider Contact:_____ Telephone#:_____

Provider Address:_____

Procedure Codes:_____ Diagnosis Codes:_____

Claim Exception Code Edit(s): Please indicate the edit(s) which was indicated on your remittance advice:

0104 0238 0280 0297 0432 0434 0435 0438 0439 0612 0673

0675 3222 6560 6562 Other:_____

Please include detailed information regarding the reason your claim has been resubmitted for reconsideration. If your claim has been corrected and attached please specify corrections that have been made.

_____

_____

_____

Please indicate all applicable documents you have submitted with the reconsideration request:

- ☐ Consent Form
- ☐ H & P Assessment
- ☐ Operative/Procedure Notes
- ☐ Ultrasound Report(s)
- ☐ Corrected Claims
- ☐ Lab Report(s)
- ☐ Pathology Report(s)
- ☐ Other: (Please specify) _____
- ☐ Description of Unlisted Code
- ☐ Medication Administration Record (MAR)
- ☐ Proof of Timely Filing

Please Check:

- ☐ Have you completed the Reconsideration Form?
- ☐ Have you attached a completed and signed original paper copy claim?
- ☐ Have you attached any additional substantiating information for review?

Mail to: Xerox, P.O. Box 23080, Jackson,MS 39225 or fax to 1-888-495-8169,Attn: Medical Review

Revision Date November 2013

PROVIDER COMPLIANCE

Reminder for Paper Claim Submissions

Providers who are unable to submit their claims electronically are encouraged to use the Mississippi Web Portal for easy access to up-to-date information. The Web Portal provides rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The Web Portal is available 24 hours a day, 7 days a week, 365 days a year via the Internet at http://msmedicaid.acs-inc.com.

If claims must be submitted on paper, please be reminded that CMS-1500 and UB04 claims must adhere to the following guidelines:

- Claims must be submitted on original, red CMS-1500 or UB04 claim forms
- No black and white or photocopied forms will be accepted (This does not apply to Dental Claims, Crossover Claims, or UB Continuation Claims)
- Use blue or black ink to complete the forms
- Data must be clearly legible
- Do not use highlighters, correction fluid, or correction tape
- Ensure data is printed in the designated fields and properly aligned
- Claims must be signed; Rubber stamps are acceptable
- Medical records and other documentation should not be included unless requested (this does not apply to EOBs)

Failure to adhere to these guidelines may result in delays to claim payment or claim returns.

Please refer to section 2.0, 3.0 and 4.0 of the Medicaid Provider Billing Handbook located at http://www.medicaid.ms.gov/providers/billing-manual/.

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.

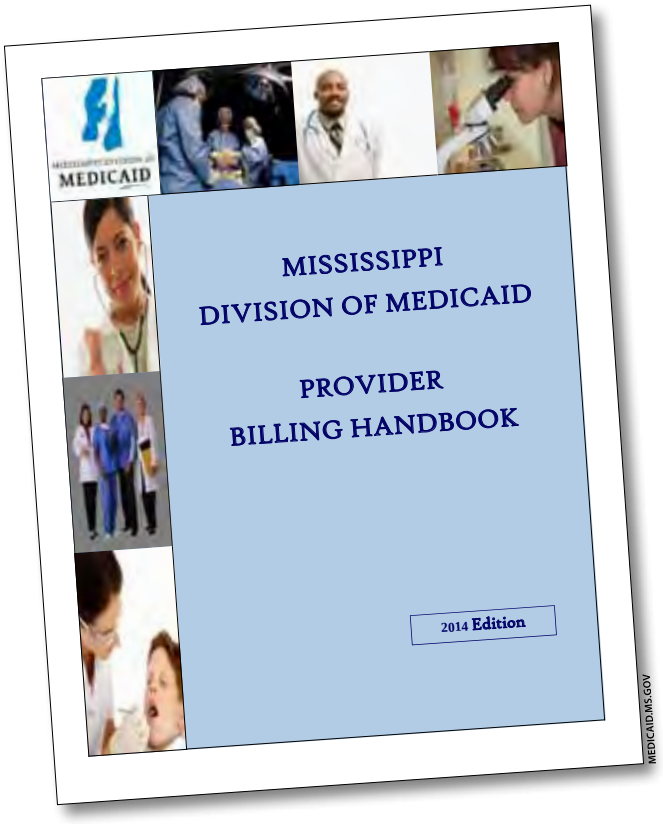
2. Please sign the claim in ink. The vast majority of the claims are Returned to the Provider (RTP) because they are not properly signed.
3. Providers are sending claims with Medicare Explanation of Benefits (EOB) showing that payment has been received by Medicare. Please submit requests for Medicaid 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-04s and Crossover As.
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.

Mississippi Medicaid Provider Billing Handbook

The Mississippi Medicaid Provider Billing Handbook is designed to provide guidance and assistance to providers in submitting beneficiary claims to the Mississippi Division of Medicaid (DOM). The handbook 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 handbook 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 handbook may be downloaded at www.medicaid.ms.gov. This handbook 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.



Billing Tips to Avoid Duplicate Claims

DOM and Xerox 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 of the remittance advice. These messages tell why the claims denied. Always refer to Medicaid's Administrative Code, the Provider Billing Handbook 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.

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.

PHARMACY

Preferred Drug List (PDL) Update, January 1, 2015

DOM's Preferred Drug List or PDL undergoes an annual review each autumn. The revisions resulted from the annual review will become effective the following January 1st. DOM's universal/uniform PDL for fee for service (FFS) and MSCAN, Magnolia and UHC, plans start January 1, 2015.

To review the current PDL, go to http://www.medicaid.ms.gov/providers/pharmacy/ and select the MS Preferred Drug document from the menu on the right side of the page. To view the document in its entirety, go to 'MS PDL Effective January 1, 2015.' To reference the preferred/non-preferred additions and deletions, see 'MS PDL Changes-Provider Notice, effective January 1, 2015.' Providers are encouraged to add this link to your favorites as you will find it very helpful.

Medicaid and MSCAN Pharmacy PA Contact Information

PAYER	PROVIDER PHONE NUMBER	BENEFICIARY CONTACT INFORMATION
MS Medicaid Pharmacy PA *only*	**1-877-537-0722; 601-359-6685; Fax 1-877-537-0720**	**1-800-421-2408; or 601-359-6050**
MSCAN: Magnolia Pharmacy Help Desk	PBM is US Script, Inc. **1-800-460-8988**	**1-866-912-6285 or 601-863-0700**
MSCAN: UnitedHealthcare Pharmacy Help Desk	PBM is OptumRx **1-877-305-8952**	**1-877-743-8731**

Keep in mind that MSCAN claims and PA requests must be submitted to the respective PBM. Submitting claims and/or prior authorization requests to MS Medicaid rather than to the respective plan delays the process for Medicaid, providers, and beneficiaries.

Billing: Newborn Babies of Mothers Enrolled in MSCAN

It has come to the attention of DOM that prescription billing issues exist for newborn babies of mothers enrolled in MSCAN plans. The process is:

1. Pharmacy bills regular Medicaid using the mother's Medicaid identification number followed by the letter K (otherwise known as K baby). Use the baby's name and baby's date of birth or DOB on the claim.
2. Even though the mother is assigned to a coordinated care plan (Magnolia or UnitedHealthcare), bill the claim to Medicaid.
3. Claim should pay unless there are prior authorization requirements.
4. This process generates a temporary Medicaid Identification number which is assigned to the newborn overnight.
5. The Provider can call the Xerox Provider and Beneficiary Services toll-free at 800-884-3222 the next day to obtain the baby's temporary Medicaid identification number. This number should be used to bill Medicaid for the baby's subsequent claims until the baby is enrolled in MSCAN.

Friendly Pharmacy Reminders

- ✔ **Billing: Pharmacy claims from non-enrolled Medicaid providers will deny.** Effective November 1, 2014, pharmacy claims not affiliated with an active and accurate national prescriber identification (NPI) number linked to a MS Medicaid provider number deny. The Affordable Care (AAC) requires that services provided to a Medicaid beneficiary must be provided and/or referred by a Medicaid provider.

- ✔ **Using an incorrect/random NPI may be a fraudulent entry.** It is considered a fraudulent act to knowingly submit a prescriber identification number, such as a NPI, another prescriber's identification number, or a pharmacy provider number, that does not belong to the provider who has written the prescription. Remember, when a pharmacy is filling a prescription and the prescriber's identification number is not known or the number that pharmacy has does not work on the claim and pharmacy inserts a random provider/NPI number into the required field, then the pharmacy employee has just committed a fraudulent act against MS Medicaid which could lead to sanctions against them and the company.

- ✔ **Billing: Incorrect National Drug Code number or NDC.** The NDC is a number identifying a specific drug and manufacturer. This number is located on the drug container, such as vial, bottle, tube, etc. Be mindful that the NDC submitted on claims must be the NDC number on the package/container from which the medication was administered/dispensed. Providers shall not bill for one manufacturer's product and administer and/or dispense another. It is considered fraudulent billing to bill for a NDC other than the one administered/dispensed.

- ✔ **Billing: DOM Pharmacy claims and valid provider types.** Since June 1, 2013, all pharmacy claims must use a valid provider type's, a person, and not a building, i.e. clinic or hospital's national prescriber identification (NPI) number. A 'prescriber' must be a person, and not a building. Valid provider types are physicians, doctors of osteopathy, podiatrists, dentists, optometrists, nurse midwives, nurse practitioners and physician assistants. Pharmacy claims submitted with a non-person identification number will deny.

- ✔ **Billing: 72 hour emergency prescriptions.** It has come to the attention of DOM that pharmacy providers are unclear regarding billing of emergency prescriptions when a prior authorization is unavailable. For Medicaid pharmacy claims, the emergency fill applies to non-preferred drugs on the Preferred Drug List and any drug that is affected by a clinical or therapeutic edit that would require a prior authorization. The 72-hour emergency fill functionality should not be used for routine and continuous overrides, nor if the drug is not subject to a prior authorization and/or the claim meets the prior authorization criteria. Pharmacy providers that routinely use this function to go around PA requirements will be audited.

Help Slow Rising Prescription Costs

In order to slow rising drug costs, DOM's Pharmacy Program works to help improve quality and manage costs. In SFY, 2014, Pharmacy expenditures for Medicaid fee for service pharmacy claims were over $278M.

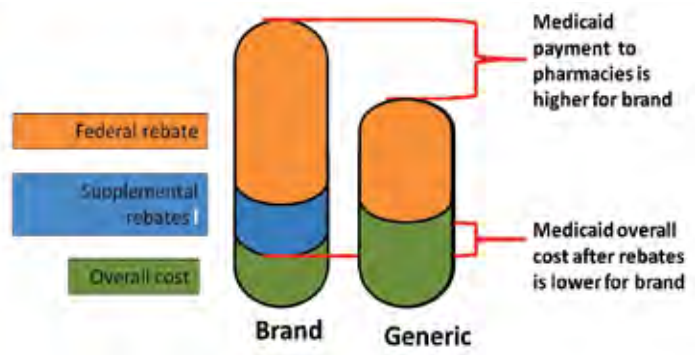
Prescribers can help slow rising prescription costs in DOM's Pharmacy program by:

(1) **Prescribing drugs on the Preferred Drug List or PDL:** In SFY14, MS Medicaid collected over $13M for supplemental rebates for branded drugs on the PDL. Over $121M was collected for federal rebates for all brand and generic drugs, dispensed in the pharmacy venue as well as for physician administered drugs.

(2) **Being aware that sometimes generic drugs are more costly to Medicaid than their branded counterparts:** In the commercial arena, generic drugs are inexpensive in relationship to the costs of their branded counterparts. Due to federal and supplemental rebates sometimes branded products are less expensive than the generic. For a comprehensive list of the PDL, refer to Pharmacy Services' web page at http://www.medicaid.ms.gov/providers/pharmacy/. DOM encourages providers to check the PDL routinely to stay current with preferred and non-preferred drugs.

Remember: Every time a prescription is written for a non-preferred PDL drug or filled with a non-preferred drug, MS Medicaid and the State of MS lose money.

Occasionally the overall cost for a brand may be less than for the generic.



Medicaid FFS (Fee for Service) and MSCAN Pharmacy Emergency Supply Procedures

Payer	Contact	Instructions
MS Medicaid: Pharmacy fee for service claims only. 72 hour supply is to be used any time a PA is not available and when Rx must be filled. Pharmacist should use professional judgment regarding whether or not there is an immediate need every time 72 hour option is used.	Pharmacy PA unit **1-877-537-0722;** Fax 1-877-537-0720	Billing instructions: (1) Input a value of '3" in the level of service (Field 418-DI); (2) Input a value of '3" in the day supply field (Field 418-DI); (3) Quantity submitted in the Quantity dispensed field (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the direction for administration given by prescriber. (4) For unbreakable packaging, including but not limited to, inhalers, antibiotic suspensions or otic drops, a pharmacy should follow the same directions for the 72 hour emergency supply including entering the full quantity dispensed and either entering the correct days' supply or a '3' day supply. (5) If applicable, pharmacist is to contact prescriber for the reminder of the prescription.
MSCAN: Magnolia Health Plan Pharmacies calling in for 72 hour emergency override supply have the ability to insert the override on their end without a call (for non-preferred, prior authorization required, and step therapy required rejections).	PBM is US Script, Inc. Pharmacy Help Desk 1-800-460-8988	PHARMACIES SHOULD SUBMIT: • '8' in "Prior Authorization Type Code" (Field 461-EU) • '3' in "Days' Supply" in the claim segment of the billing transaction (Field 405-D5) • The quantity submitted in "Quantity Dispensed" (Field 442-E7) should not exceed the quantity necessary for a three-day supply according to the directions for administration given by the prescriber. If the medication is a dosage form that prevents a three-day supply from being dispensed, e.g., an inhaler, it is still permissible to indicate that the emergency prescription is a three-day supply, and enter the full quantity dispensed.
MSCAN: UnitedHealthcare Dispense a 72 hour emergency medication supply via an override when our prior authorization phone line is not available	PBM is OptumRx Pharmacy Help Desk 1-877-305-8952	Emergency supply is limited to one 72 hour supply per 365 days per drug. If medication can't be dispensed as an exact 72 hour supply, dispense the minimum quantity as a 72 hour supply. Examples include, but are not limited to: metered dose inhalers, nasal sprays, topical preparations and powders for reconstitution. **Please include following information when submitting claims for a 72 hour supply:** • Prior Authorization Type code (Field 461-EU) = 8 • Prior Authorization number submitted (Field 462-EV) = 120 • Day Supply in the claim segment of the billing transaction (Field 405-D5) = 3

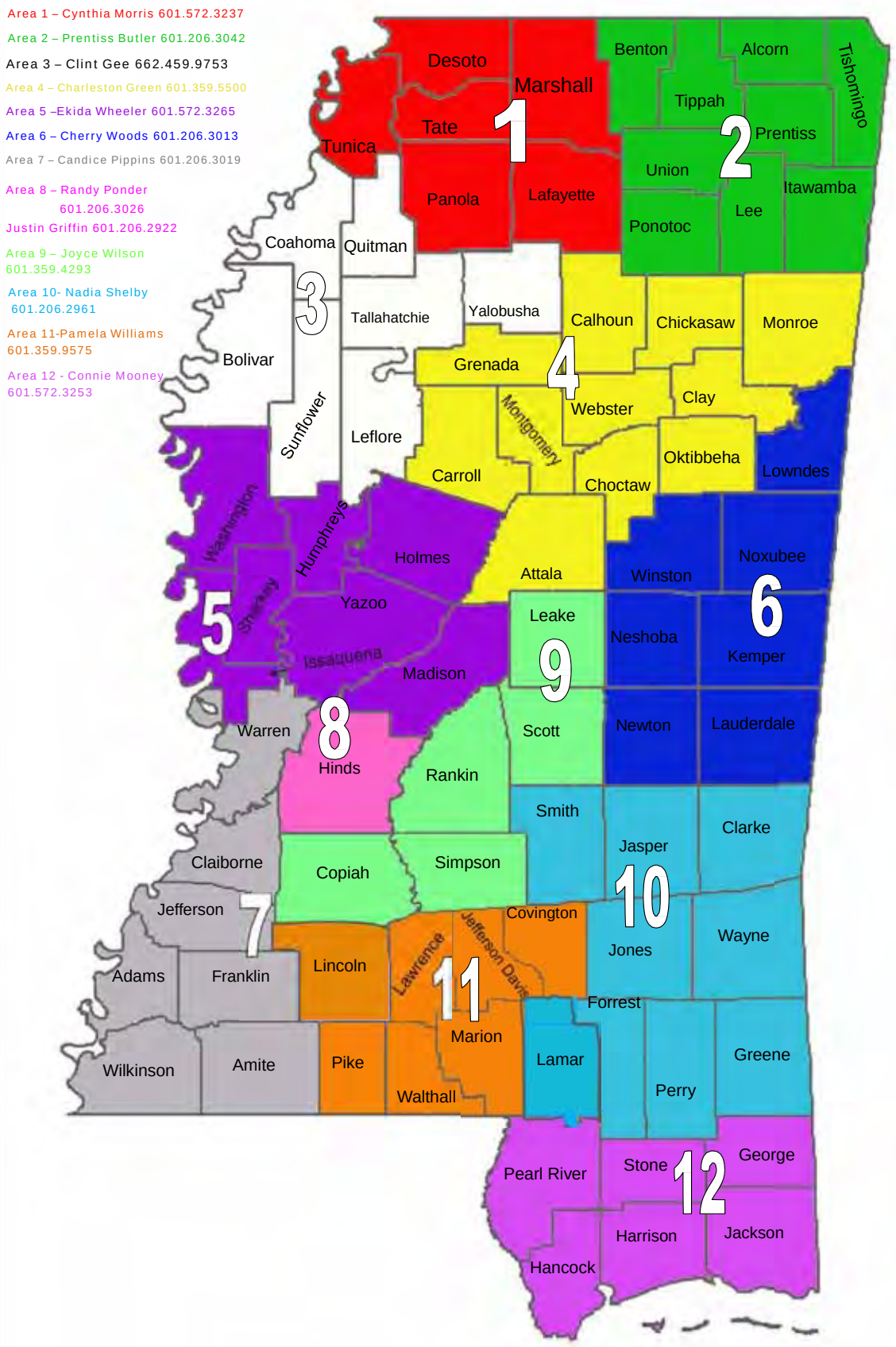
DOM suggests printing and keeping a copy nearby for your easy reference.

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**	

FIELD REPRESENTATIVE REGIONAL MAP

Area 1 – Cynthia Morris 601.572.3237
Area 2 – Prentiss Butler 601.206.3042
Area 3 – Clint Gee 662.459.9753
Area 4 – Charleston Green 601.359.5500
Area 5 –Ekida Wheeler 601.572.3265
Area 6 – Cherry Woods 601.206.3013
Area 7 – Candice Pippins 601.206.3019
Area 8 – Randy Ponder 601.206.3026
Justin Griffin 601.206.2922
Area 9 – Joyce Wilson 601.359.4293
Area 10- Nadia Shelby 601.206.2961
Area 11-Pamela Williams 601.359.9575
Area 12 - Connie Mooney 601.572.3253



LONG-TERM CARE

Attention All Providers of Elderly and Disabled (E&D) Waiver Services

If you have moved since establishing your provider agreement with Medicaid or plan to move, you are required to notify the Office of Long Term Care (LTC) in writing of any changes in address. All adult day care providers are required to notify the Office of LTC prior to moving and providing services in any new location. The new location must be approved by the Office of LTC to ensure compliance with the Centers for Medicare and Medicaid Services criteria for ADC services. You may notify DOM in writing at the following address:

Mississippi Division of Medicaid
Office of Long Term Care
Walter Sillers Building Suite 1000
550 High Street
Jackson, Mississippi 39201

In addition to notifying DOM, you are also required to update your provider file with Xerox. Updating your provider file will prevent the non-receipt of important letters and notices. Providers may update their provider file by utilizing the Change of Address form located on the Envision Web Portal at https://www.ms-medicaid.com/msenvision/. Once completed, the form should be faxed to the attention of Provider Enrollment at 1-888-495-8169. This helps to ensure that DOM has the most current and accurate information on your provider file.

REMINDER TO ALL PROVIDERS

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

XEROX STATE HEALTHCARE, LLC
P.O. BOX 23078
JACKSON, MS 39225

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

Mississippi Medicaid Administrative Code and Billing Handbook 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., wish you a Merry Christmas!

DECEMBER 2014

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

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.