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MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

Family Planning Waiver Renewed

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MS Division of Medicaid

The Mississippi Division of Medicaid (DOM) has secured a three-year extension of its Family Planning Waiver Demonstration Program (FPW) from the Centers for Medicare and Medicaid Services (CMS), which went into effect January 1, 2015. The initial FPW demonstration was approved on January 31, 2003, and implemented October 1, 2003. Since then, over 334,000 women have accessed family planning services. The estimated annual enrollment is approximately 26,000 individuals.

The extension of FPW includes two important changes: The waiver now covers men as well as women, and also covers medications for treatment of sexually transmitted infections (STIs), sexually transmitted diseases (STDs), in addition to contraceptives written by any Medicaid participating provider to be filled at their local Medicaid participating pharmacy.

At its initial approval, the waiver only covered women ages 13 through 44 who were not eligible for regular fee-for-service Medicaid coverage. The renewed waiver allows women and men to receive limited Medicaid benefits, which include four annual visits during the federal fiscal year (October–September), family planning and family planning-related services to women losing Medicaid pregnancy coverage after the 60-day postpartum period, treatment of STIs and STDs, abnormal pap smears and voluntary sterilizations.

This means that instead of just covering the testing of a beneficiary for STIs and STDs, the waiver now covers medications prescribed to treat the STIs and STDs. The goal is that the FPW renewal will increase the use of Medicaid family planning services, improve the health outcome of men and women who need those services and decrease unplanned and teen pregnancies.

Mississippi has among the highest rates of STDs and teen pregnancy in the nation. Access to contraceptives plays a key role in dealing with both issues. The waiver covers a wide range of contraceptives giving beneficiaries the freedom of choice, and also covers vasectomies for men.

Ultimately, our goal is to be proactive and do our part to prevent serious health consequences in the future.

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FPW Eligibility Requirements

Women and men, between the ages of 13 through 44 will be eligible for the FPW program, if they meet the following eligibility requirements:

- Must be capable of reproducing
- Family income is at or below 194% of the federal poverty level (FPL)
- Must not have Medicare, Children's Health Insurance Program (CHIP) coverage, or any other health insurance or third party medical coverage
- Women cannot be pregnant

Loss of eligibility for FPW occurs when a beneficiary moves from the state of Mississippi, becomes eligible for another Medicaid category, becomes eligible for Medicare, CHIP or other health Insurance, becomes pregnant or reaches 45 years of age.

FPW Resources

For easy reference, a listing of FPW covered drugs is posted on DOM's website (http://www.medicaid.ms.gov/providers/pharmacy/, select the Pharmacy tab and click on the Pharmacy Resources, Specific Drugs and select Family Planning drugs, January 1, 2015.

Additionally, covered FPW diagnosis and procedure codes are located on DOM's website on the Family Planning webpage at: http://www.medicaid.ms.gov/wp-content/uploads/2015/01FPW-CODES-UPDATES-2015.pdf.

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.

MississippiCAN and MississippiCHIP Changes

Effective January 1, 2015, MississippiCHIP members may be enrolled in either Magnolia Health or UnitedHealthcare.

Beginning May 2015 through July 2015, Medicaid Fee-for-Service children will be enrolled in MississippiCAN with either Magnolia Health or UnitedHealthcare.

PAYER	POPULATION	CHANGES
MS Medicaid Fee-for Service 800-421-2408 or 601-359-6050 www.medicaid.ms.gov 800-884-3222 www.ms-medicaid.com	Beneficiaries qualify based on income, resources, age and/or medical disability. Coverage for children, families, pregnant women, elderly and disabled persons. Covered Services: • Medicaid services • MississippiCAN Inpatient Hospital services	**Children will be transitioned from the MS Medicaid Fee-for-Service to MississippiCAN May 1 through July 31, 2015**
MississippiCAN 800-421-2408 or 601-359-3789 www.medicaid.ms.gov/programs/mississippican **Magnolia Health-MSCAN** 866-912-6285 magnoliahealthplan.com **UnitedHealthcare-MSCAN** 877-743-8731 uhccommunityplan.com	Beneficiaries in certain Medicaid categories of eligibility (SSI, Disabled Children at Home, Working Disabled, Breast/Cervical, Newborns and Children) Covered Services: • Medicaid services, plus additional services such as case management	**MississippiCAN - Children May 1 through July 31, 2015** Children ages 1 to 19, who are presently on Medicaid Fee-for-Service will be enrolled in the MississippiCAN program, except those excluded as members: • on Medicare • on Waivers • in institutions care facilities or • Native Americans MississippiCAN children may be enrolled with either CCO, therefore, **Providers** must be enrolled separately with each CCO and DOM to receive payment.
MississippiCHIP 800-421-2408 or 601-359-3789 www.medicaid.ms.gov **Magnolia Health-MSCHIP** 866-912-6285 magnoliahealthplan.com **UnitedHealthcare-MSCHIP** 800-557-9933 uhccommunityplan.com	Children ages 0-19 whose income exceeds Medicaid maximum, 133% to 209% Federal Poverty Level. Covered Services: • Same CHIP services	**CHIP** **January 1, 2015** Children enrolled in the CHIP program beginning CY2015 will receive service from the two Coordinated Care Organizations (CCOs) rather than one contracted vendor; UnitedHealthcare and Magnolia Health. CHIP children may be enrolled with either CCO, therefore, **Providers** must be enrolled separately with each CCO to receive payment.
Enrollment Broker Xerox 800-884-3222 FAX 601-206-3015	**Verifying Beneficiary Eligibility** **Xerox AVRS** (Automated Voice Response System) • **Call 800-884-3222** and enter information as a Beneficiary with Medicaid ID/DOB/etc. **or** • **Call 800-884-3222** as a provider and enter your Provider ID.	**Enrollment with CCO** MississippiCAN and MississippiCHIP Initial Enrollment Form • A member has 30 days to submit the initial enrollment form to Xerox with a CCO selection, or they will be auto-assigned to a CCO.

	Envision Web Portal • www.ms-medicaid.com and enter their provider user ID and password and access eligibility. • The specific program MSCAN or MSCHIP will be displayed with the CCO Magnolia or UnitedHealthcare. • Enter the present month for eligibility (Example 1-1-2015 to 1-31-2015).	MississippiCAN and MississippiCHIP Change Form • A member has 90 days to change CCOs after enrollment with a CCO. Otherwise, member must wait until annual open enrollment.

PAYER	CONTRACTOR	SUBCONTRACTOR
MS Medicaid **Fee-for Service** 800-421-2408 or 601-359-6050 www.medicaid.ms.gov 800-884-3222 www.ms-medicaid.com	UM/QIO **eQHealth Solutions** Toll Free: 866-740-2221 Local: 601-352-6353 Advanced Imaging **MedSolution** Toll Free: 877-791-4106 **Provider Credentialing** Toll Free: 800-884-3222	Non-Emergency Transportation **MTM** Toll Free: 866-331-6004
Magnolia Health MSCAN and MSCHIP • 866-912-6285 magnoliahealthplan.com	**Magnolia Health Plan** Toll Free: 866-912-6285 Behavioral Health **Cenpatico** Toll Free: 866-912-6285 Pharmacy **US Script** Toll Free: 866-912-6285 Dental **DentaQuest** Toll Free: 866-912-6285 Vision **OptiCare** Toll Free: 866-912-6285	Non-Emergency Transportation **MTM** Toll Free: 866-912-6285 Toll Free: 866-331-6004 Disease Management **Nurtur** Toll Free: 866-912-6285 Advanced Imaging **NIA** Toll Free: 866-912-6285 **Nurse Wise** Toll Free: 866-912-6285
UnitedHealthcare MSCAN • 877-743-8731 MSCHIP Provider • 800-557-9933 MSCHIP Member • 800-992-9940 uhccommunityplan.com	Behavioral Health **UBH-Optum Healthcare** Toll Free: 877-673-6315 Pharmacy **Optum RX** Toll Free: 877-305-8952 Dental **Dental Benefit Prov** Toll Free: 800-508-4862	Non-Emergency Transportation **MTM** Toll Free: 866-331-6004 Vision **Vision Services Prov** Toll Free: 800-877-7195 Case Management **Optum Health Care** Toll Free: 877-743-8731 **Care Core National** Toll Free: 866-889-8054

DOM suggests posting these charts nearby for quick and easy reference.

NEWS

DOM Hires First Medical Director

The Mississippi Division of Medicaid (DOM) has appointed its first medical director. Dr. Tami Brooks, associate professor of pediatrics at the University of Mississippi Medical Center, joined DOM on December 8 in a part-time role to advise the agency on clinical issues and to help communicate DOM policies and changes to providers across the state.

DR. TAMI BROOKS
Medical Director
MS Division of Medicaid

Brooks, a native Mississippian, earned her medical degree from the University of Mississippi Medical Center (UMMC) in 1993, and completed her residency in pediatrics at UMMC in 1996. She has taught students and residents while practicing medicine at UMMC's Blair E. Batson Children's Hospital, North Clinic, in Jackson, MS. Brooks also serves as the legislative chair for the Mississippi Chapter of the American Academy of Pediatrics.

Increased Primary Care Services Payment Continuation

During the 2014 regular Mississippi legislative session, the Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (ACA), for certain primary care services at 100 percent of the rate established under Medicare.

DOM submitted public notice to inform providers a State Plan Amendment (SPA) will be submitted, effective January 1, 2015, to continue reimbursement of Primary Care Services to providers who meet the requirements of 42 CFR § 447.440(a) at the same rate as in calendar year 2014. Effective July 1, 2015, reimbursement of primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule in effect as of January 1 of each year. The Medicaid Primary Care Provider Fee Schedule will be updated July 1 of each year based on one hundred percent (100%) of the Medicare Physician Fee Schedule in effect as of January 1 of each year.

Medicaid-enrolled primary care providers who qualify for the increased payment may continue to receive the increased payments after the federal program ended on December 31, 2014. To qualify, eligible providers must accurately self-attest by completing the 1/1/2015–6/30/2016 Self-Attestation Statement form.

HOW TO ATTEST

Providers must complete one 1/1/2015–6/30/2016 Self-Attestation Statement form for January 1, 2015 through June 30, 2016.

To receive the increased payment for dates of service (DOS) beginning 1/1/2015, eligible providers must send a completed and signed 1/1/2015–6/30/2016 Self-Attestation Statement form to Xerox Provider Enrollment by **3/31/2015**. Providers whose 1/1/2015–6/30/2016 Self-Attestation Statement forms are sent/postmarked after 3/31/2015, will receive the increased payment for DOS beginning on the date the form is sent/postmarked. Providers can verify the processing of the electronically submitted 1/1/2015–6/30/2016 Self-Attestation Statement forms by accessing the Envision Web Portal. Forms are processed within five business days from receipt.

The 1/1/2015–6/30/2016 Self-Attestation Statement form is located on the DOM website and Envision Web Portal or can be requested by calling the Xerox Call Center at 800-884-3222. Completed forms must be submitted to Xerox Provider Enrollment in one of the following ways:

- E-mailed to: msinquiries@xerox.com
- Mailed to: Xerox Provider Enrollment
  P.O. Box 23078
  Jackson, MS 39225
- Faxed to: Xerox Provider Enrollment
  (888) 495-8169

PROVIDER COMPLIANCE

Scheduling/Rescheduling Fees for Dental Providers

The Division of Medicaid considers scheduling/rescheduling to be an integral part of the surgical and/or dental service. Additional reimbursement is not provided for scheduling/rescheduling for any dental or oral surgical procedure in any treatment setting. These fees may not be billed to the beneficiary.

Providers may reference the Mississippi Administrative Code, Part 204, Dental Services; Rule 1.4: Non-Covered Services at http://www.medicaid.ms.gov/AdminCode.aspx. If you have any questions or require additional information, please contact your Provider Field Representative. A list of the Provider Field Representatives is printed in the back of this bulletin.

Attention All Elderly and Disabled (E&D) Waiver Personal Care Services (PCS) Providers

There has been a PCS rate change. For dates of service on or after January 1, 2015, the Personal Care Services (PCS) rate is $4.16 per 15 minute unit. For dates of service on or after July 1, 2015, the PCS rate is $4.24 per 15 minute unit. This is the maximum rate allowed under the current CMS approved Elderly and Disabled Waiver. The procedure code for PCS is T1019 and must always be billed with a U1 modifier for services provided under the Elderly and Disabled Waiver.

Co-payment for Mental Health Services

Effective January 1, 2015, Mental Health services provided by a Psychologist, Licensed Clinical Social Worker (LCSW), or a Mental Health Group will require a $3 co-payment per visit. It is the provider's responsibility to collect this co-payment from the beneficiary. The $3 co-payment will automatically be deducted for all applicable services from the claim when it is processed. Providers should not enter the co-payment amount or reduce the submitted charge on the claim form.

Co-payments are not required for children under the age of 18, pregnant women, or individuals in nursing homes or facilities.

Please contact Kimberly Evans or Kim Sartin-Holloway at 601-359-9545 for more information.

New Modifiers for Mental Health Services for NCCI Edits

Effective January 1, 2015, NCCI will require the use of modifier XE or XP rather than modifier 59 with certain NCCI edits for Mental Health claims for dates of service on or after January

1, 2015. These modifiers have been developed to provide greater reporting specificity in situations where modifier 59 was previously reported. Modifiers XE or XP should be utilized in lieu of modifier 59 if the clinical situation described by one of these modifiers is present. Modifier 59 will remain a valid procedure to procedure (PTP) modifier, but it should only be utilized if a more specific modifier is not applicable.

The new modifiers are defined as follows:

XP – "Separate Practitioner, A service that is distinct because it was performed by a different practitioner."

XE – "Separate encounter, A service that is distinct because it occurred during a separate encounter." This modifier should only be used to describe separate encounters on the same date of service. Applies to services that are billed by a Federally Qualified Health Center or Rural Health Clinic.

All questions should be directed to Kim Sartin-Holloway at 601-359-9545.

CPT Code Changes for Mental Health Providers

Effective December 31, 2014, the procedure code for Medication Management (M0064) has been discontinued. This change is in accordance with the Centers for Medicare and Medicaid Services (CMS) decision to terminate the code.

For dates of service on or after January 1, 2015, pharmacological management and oversight must be billed using the most appropriate evaluation and management (E/M) procedure code as part of the E/M visit. Providers are encouraged to review the requirements for E/M codes in the current CPT Manual.

Claims for DOS on or after January 1, 2015, billing M0064 should be voided and re-submitted using the most appropriate E/M code.

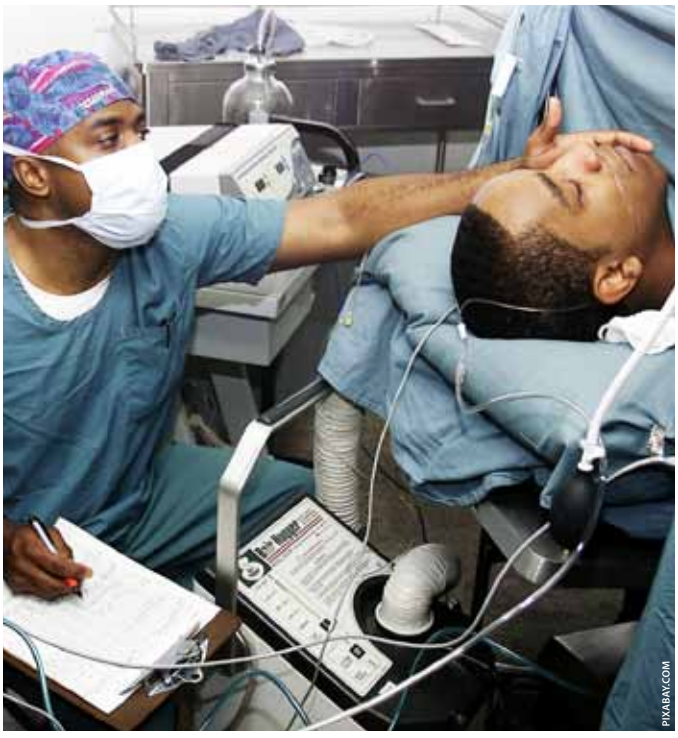
Please contact Kim Sartin-Holloway at 601-359-9545 if you have questions.

ICD-10 Implementation

For dates of service on and after **October 1, 2015**, entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to use the International Classification of Diseases, 10th Edition (ICD-10) code sets in standard transactions adopted under HIPAA.

The Division of Medicaid will be in compliance with the final rule issued by the U.S. Department of Health and Human Services (HHS) and encourages all Medicaid providers and vendors to test. DOM is accepting test packages with dates of service on or after May 1, 2014. For more information on testing and FAQ's please go to http://www.medicaid.ms.gov under Providers "ICD10 Preparation".

Please email all questions to: ICD10@medicaid.ms.gov.



Medicare Part C Advantage Claim Submission – Prior to July 24, 2014

The Division of Medicaid will now accept Medicare Part C advantage Plan claims for dates of services June 11, 2007 through July 24, 2014, that were previously returned to providers. These claims will be reprocessed and considered for reimbursement.

Some Medicare Part C Advantage Plans have a co-pay/co-insurance field, a co-pay/deductible field, a co-pay/co-insurance/deductible field or a member/patient responsibility field on their Explanation of Medicare Benefits (EOMB). Claims with these types of EOMBs should be submitted by the provider. All claims to be processed for consideration of timely overrides must be received by **May 29, 2015** and submitted to:

Division of Medicaid
Attention: Office of Recovery (TPL)
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201


PIXABAY.COM

To expedite the processing of these back claims in a timely manner, please follow the dates listed below for paper claim/EOMB submission for Special Batch.

Claims Date	Week of Submission
06/11/07 – 12/31/08	05/04/15 – 05/08/15
01/01/09 – 12/31/10	05/11/15 – 05/15/15
01/01/11 – 12/31/12	05/18/15 – 05/22/15
01/01/13 – 07/24/14	05/25/15 – 05/29/15

Providers should indicate across the bottom of the crossover claim form that this is for an "Advantage Plan".

Note: Claims that are not sent to the Office of Recovery (TPL) by the above required deadline **will not** be reimbursed by the Division of Medicaid.

For additional questions and assistance, contact Xerox Call Center, Provider/Beneficiary Relations at 800-884-3222.

Often the contractual amount sometimes referred to as "co-pay/co-insurance", "co-pay/deductible", "co-pay/co-insurance/deductible", or "member-patient responsibility" will be indicated on the Medicare Part C Advantage Plan EOMB. However, if not specifically stated use the criteria below to enter amount in appropriate field (s).

The following are examples of Medicare Part C Advantage Plan EOMB scenarios for TPL payment.

Scenario 1: If EOMB states co-pay/co-insurance only, enter amount on claim in Field 17.

Scenario 2: If EOMB states co-pay/deductible only, enter amount on claim in Field 17.

Scenario 3: If EOMB states co-pay only, enter amount on claim in Field 17.

Scenario 4: If EOMB states amounts separately for co-pay/co-insurance/deductible, enter amount for deductible on claim in Field 16 and combined amounts for both co-pay/co-insurance on claim in Field 17.

Scenario 5: If EOMB states amounts separately for co-pay, no amount for co-insurance and amount for deductible, enter amount on claim in Field 16 for deductible and Field 17 for co-insurance.

Scenario 6: If EOMB states member-patient responsibility only, enter amount on claim in Field 17.

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 www.ms-medicaid.com. 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.

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 www.ms-medicaid.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/.

PHARMACY

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

DOM's Preferred Drug List or PDL will be updated on April 1, 2015. DOM's universal/uniform PDL for fee for service (FFS) and MSCAN (Magnolia and UnitedHealthcare) plans started January 1, 2015.

To reference 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 April 1, 2015." To reference the preferred/non-preferred additions and deletions, see "MS PDL Changes-Provider Notice, effective April 1, 2015." We recommend adding this link to your favorites as you will find it very helpful.

Family Planning Waiver Changes, Effective January 1, 2015

Effective January 1, 2015, Division of Medicaid's Family Planning Waiver (FPW) was renewed by Centers for Medicare and Medicaid Services, or CMS. The FPW renewal stipulates that coverage now includes males and females aged 13-44 with family income at or below 194% of the Federal Poverty Level and must not have had a procedure that prevents them from reproducing or be covered under Medicare, CHIP or other health insurance. Another change is that in addition to contraceptives, drugs to treat sexually transmitted infections (STI)/sexually transmitted diseases (STD), when prescribed as part of a family planning visit/treatment by any Medicaid participating provider, are included.

Beneficiaries enrolled in the FPW have a yellow Medicaid card are only eligible for family planning and family planning related pharmacy services.

Beneficiaries in the FPW program can get the following medications at their local participating Medicaid pharmacy:

- **Contraceptives (drug classes below follow the DOM PDL)** – *for females*
  1. ***Contraceptive Patches***
  2. ***Self-inserted contraceptive products*** *(like NuvaRing)*
  3. ***Oral contraceptive agents*** *(refer to PDL for preferred agents)*
  4. ***Injectable contraceptives*** *(like Depo Provera)*

- **STI/STD treatments –** *for females or males*
  1. ***Drugs listed for treatment of STI/STD are exempt from the PDL,*** i.e. non-preferred drugs do not require a prior authorization for FPW beneficiaries only. *Injectable antibiotics for STI/STD only covered through medical claims and not through POS.*
  2. ***Listing of STI/STD FPW covered agents can be referenced on agency's website under the Pharmacy section found at http://www.medicaid.ms.gov/providers/pharmacy/.***

If there are questions regarding the FPW, contact the Office of Medical Services at 601-359-6150 or 800-421-2408.

Pharmacy Reminders

✔ **Fraudulent 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. ***The NDC submitted on claims must be the NDC number on the package/container from which the medication was administered and/or dispensed. This rule is applicable for medical claims as well as point of sale pharmacy claims.*** *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 for both pharmacy point of sale and medical claim venues. Some examples include

- *Billing for a preferred branded drug, and dispensing a non-preferred generic drug.*
- *Auto-populating the NDC numbers on medical claims and not verifying that the NDC billed is the NDC which was administered.*

Be advised that audits are ongoing.

✔ **Billing: Using incorrect Medicaid identification numbers**

The MS 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.

✔ **Beneficiary Access issues: Doxycycline**

It has come to our attention that beneficiaries are experiencing difficulties getting prescriptions for doxycycline filled. Drug shortages and availability issues have created significant price increases for the *hyclate* formulation. Reimbursement of *doxycycline hyclate* is based upon the federal upper limits (FUL) which cannot be overridden. However, *doxycycline monohydrate* is a readily available formulation without an assigned FUL.

As an option for our beneficiaries and providers, the following *doxycycline monohydrate* formulations have been moved to preferred status. We encourage providers to prescribe, stock, and dispense *doxycycline monohydrate* when appropriate for their MS Medicaid beneficiaries:

Doxycycline Monohydrate 50mg Caps:
00591041001
49884072601

Doxycycline Monohydrate 100mg Caps:
00591041150
49884072703
49884072704

For your easy reference, this document is posted in the Pharmacy section of the agency's website at http://www.medicaid.ms.gov/providers/pharmacy/.

✔ **Billing and Correctional facilities:**

The MS Medicaid Program is prohibited by federal regulations, 42 C.F. §435.1009 and 42 C.F. §435.1010, from paying for services for Medicaid beneficiaries who, on the date of service are incarcerated in a correctional or holding facility for individuals who are prisoners, including juvenile correctional facilities, are detained pending disposition of charges, or are held under court order as material witnesses.

If medications are requested for incarcerated Medicaid beneficiary, the medications cannot be billed to the Medicaid pharmacy program and are subject to recoupment. Pharmacists should contact the correctional facility regarding the facility's reimbursement procedures for the requested medications.

Coming Soon!

New rebated over-the-counter drug (OTC) list complete with corresponding national drug code numbers or NDC: List will be published on Pharmacy section of agency's website at http://www.medicaid.ms.gov/providers/pharmacy/.

Billing For MSCAN, FFS, and CHIP Plans Effective January 1, 2015

It has come to our attention that some CHIP members are encountering problems getting their medications. Be advised that effective January 1, 2015, CHIP members may be enrolled in *either* Magnolia Health or UHC. For your easy reference, below is a chart of Pharmacy plan billing information for MSCAN, traditional or fee for service Medicaid and CHIP.

DOM suggests posting this chart nearby for quick and easy reference.

PLAN NAME	CLAIMS PROCESSOR	BIN (Banking Info Number)	PCN (Processor Control Number)	GROUP ID	PHARMACY POS CLAIMS HELPDESK	PRIOR AUTH. HELPDESK – Provider
MEDICAID FeeForService	XEROX	610084	DRMSPROD/SIPPI	N/A	800-884-3222	Phone: 877-537-0722 Fax: 877-537-0720
MAGNOLIA HEALTH PLAN – CAN	US Script	008019	N/A	14101	800-460-8988	Phone: 866-399-0928 Fax: 866-399-0929
UNITED HEALTHCARE – CAN	OptumRX	610494	9999	ACUMS	877-305-8952	Phone: 800-310-6826 Fax: 866-940-7328
CHIP – MAGNOLIA	US Script	008019	MSCHIP	14101	800-460-8988	Phone: 866-399-0928 Fax: 866-399-0929
CHIP – UNITED HEALTHCARE	OptumRX	610494	9999	ACUMS	877-305-8952	Phone: 800-310-6826 Fax: 866-940-7328

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.

LONG-TERM CARE

2014 Owner Salary Limits for Long-Term Care Facilities

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities as owner's salaries for 2014 are based on 150% of the average salaries paid to non-owner/ administrators that receive payment for services related to patient care. The limits apply to all salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2014 are as follows:

Small Nursing Facilities (1-60 Beds)	$127,937
Large Nursing Facilities (61 + Beds)	$146,652
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)	$136,050
Psychiatric Residential Treatment Facilities (PRTF)	$208,301

Allowable Board of Directors Fees for Nursing Facilities, ICF-IID's and PRTF's – 2014 Cost Reports

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2014 cost reports filed by nursing facilities (NF's), intermediate care facilities for individuals with intellectual disabilities (ICF-IID's), and psychiatric residential treatment facilities (PRTF's) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the

Consumer Price Index for all Urban Consumers – All Items. The amounts listed below are the per meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2014 are as follows

Category	Maximum Allowable Cost for 2014
0 – 99 Beds	$ 4,010
100 – 199 Beds	$ 6,015
200 – 299 Beds	$ 8,020
300 – 499 Beds	$10,024
500 Beds or More	$12,029

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

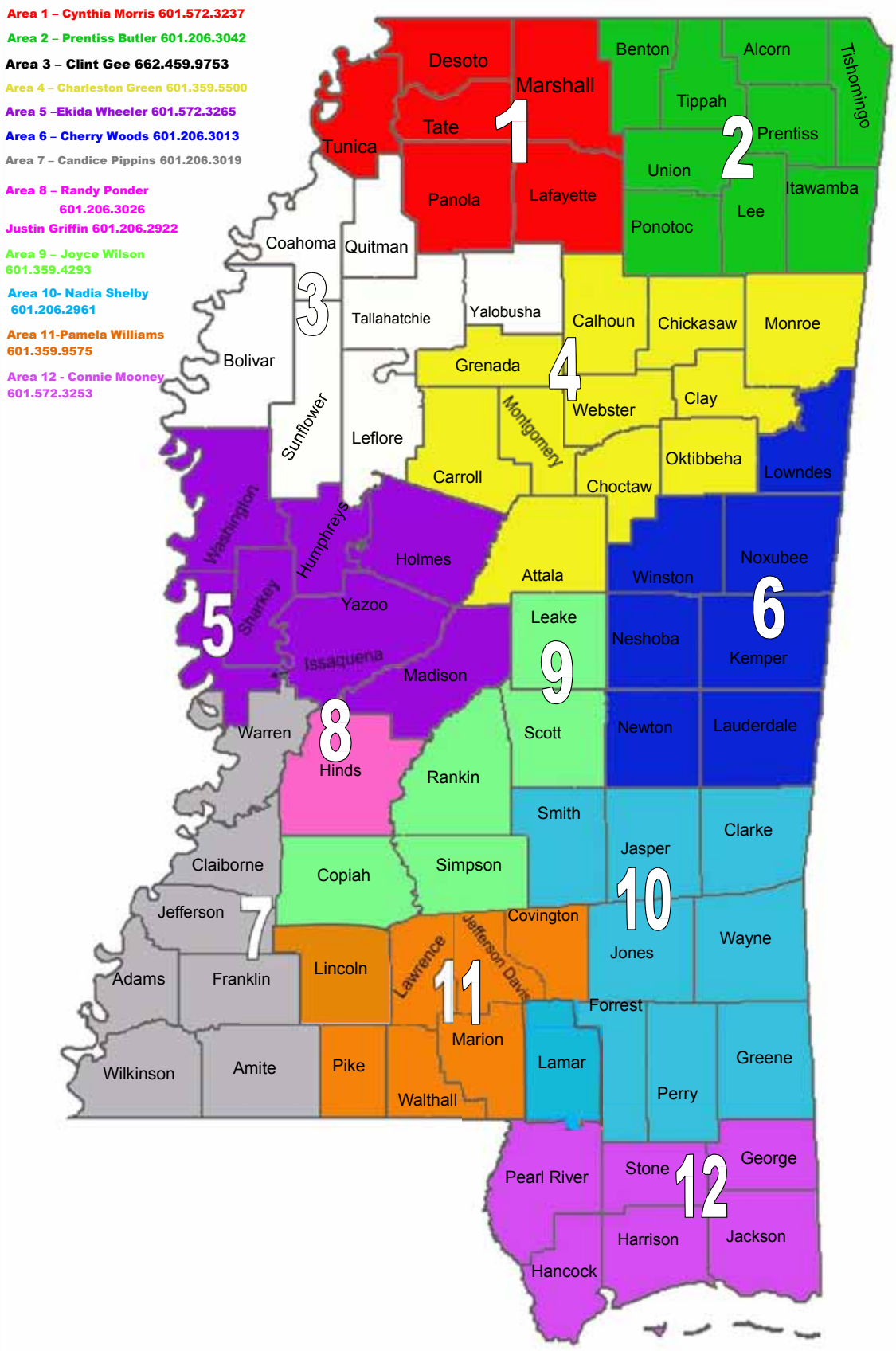
The amended new bed values for 2014 for nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs) and psychiatric residential treatment facilities (PRTFs) have been determined. These values are the basis for rental payments made under the fair rental system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

Facility Class	2014 New Bed Value
Nursing Facility	$91,200
ICF-IIDs	$91,200
PRTF	$91,200

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



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If you have any questions related to the topics in this bulletin, please contact Xerox at 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., welcome the spring season

MARCH 2015

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

Checkwrites and Remittance Advices are dated every Monday. The Remittance Advice is available for download each Monday morning at www.ms-medicaid.com while funds are not transferred until the following Thursday.