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MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

What Is a Fiscal Agent?

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The Mississippi Division of Medicaid (DOM) is responsible for administering Mississippi Medicaid health benefits for nearly 800,000 Mississippians through a number of programs: Medicaid, the Children's Health Insurance Program (CHIP), and our managed care program MississippiCAN.

Similar to an insurance company, DOM is complex and multifaceted. We work within many constraints from state and federal law, as well as the Centers for Medicare and Medicaid Services (CMS).

To keep operations running smoothly and handle all that is required of us, DOM works in conjunction with a private contractor that helps the agency handle certain services known as a fiscal agent.

Xerox State Healthcare LLC (Xerox) is DOM's current fiscal agent. Their technical and operations staff work in conjunction with ours to process Medicaid claims, pay providers for services rendered, operate both a provider and beneficiary call center and help us with other aspects of customer service as well. These aspects include mass mailings, education and outreach, drug rebate analysis and utilization review and provider credentialing and enrollment. They help us keep track of our beneficiaries' contact information, category of eligibility and health benefits.

Although DOM operates like an insurance company, we do not have the resources to handle many of these daily functions efficiently, which is why our partnership with Xerox is so important.

During the 2015 legislative session, DOM was granted authority to extend its contract with Xerox for a period up to five years. This request was to ensure provider and beneficiary services, including payments and eligibility determinations, will not be interrupted during the Medicaid Enterprise System (MES) replacement project.

DOM and Xerox have several systems in place to make contacting our offices easier for the provider and beneficiary. Having multiple points of contact and avenues in place for providers to obtain needed information eases the time and effort providers spend manually completing forms.

IN THIS ISSUE

Providers can call the information service line toll-free at 1-800-884-3222, or they can reach Xerox by mail, email or by visiting the Mississippi Medicaid web portal at www.ms-medicaid.com.

The web portal has two areas that can be accessed from the initial home page. One is non-secure and allows access to the general public without registration. No confidential provider or patient-related data is disclosed on the portal's public pages. The second area is a secure site that requires registration. Details on how to register can be found on the home page under "Web Registration."

It is important to remember, even though it might not have the DOM logo, if your office receives anything in the mail from Xerox don't assume that it is junk mail — it may be an important message from Mississippi Medicaid! In order to stay informed about Medicaid, please make sure you open and read any mail from Xerox or the Division of Medicaid.

Ultimately, our goal is to maintain a good working relationship with health-care providers around the state who are providing much needed health services to our fellow Mississippians.

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 Children's Health Insurance Program (CHIP) Changes

Effective January 1, 2015, CHIP 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-MississippiCAN** 866-912-6285 magnoliahealthplan.com **UnitedHealthcare-MississippiCAN** 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-services will be enrolled in the MississippiCAN program, except those excluded as members: • on Medicare • on Waivers • in institutional 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.
CHIP 800-421-2408 or 601-359-3789 www.medicaid.ms.gov **Magnolia Health-CHIP** 866-912-6285 magnoliahealthplan.com **UnitedHealthcare-CHIP** 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 CHIP 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 MississippiCAN or CHIP 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 CHIP 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-services** 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 MississippiCAN and CHIP • 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 MississippiCAN • 877-743-8731 CHIP Provider • 800-557-9933 CHIP 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.

MODIFIER 59

from the Centers for Medicare and Medicaid Services

The Medicaid National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when two Healthcare Common Procedure Coding System (HCPCS)/ Current Procedural Terminology (CPT) codes should not be reported together either in all situations or in most situations. For PTP edits that have a Correct Coding Modifier Indicator (CCMI) of "0," the codes should never be reported together by the same provider for the same beneficiary on the same date of service. If they are reported on the same date of service, the column one code is eligible for payment and the column two code is denied. For PTP edits that have a CCMI of "1," the codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers. (Refer to the *National Correct Coding Initiative Policy Manual for Medicaid Services*, Chapter 1, for general information about the NCCI program, PTP edits, CCMIs, and NCCI-associated modifiers.) One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are "separate and distinct." Modifier 59 is an important NCCI-associated modifier that is often used incorrectly.

The *CPT Manual* defines modifier 59 as follows:

> "**Distinct Procedural Service:** Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25."

Modifier 59 and other NCCI-associated modifiers should NOT be used to bypass a PTP edit unless the proper criteria for use of the modifier are met. Documentation in the medical record must satisfy the criteria required by any NCCI-associated modifier that is used.

1. **Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.**

One of the common uses of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed at different anatomic sites, are not ordinarily performed or encountered on the same day, and that cannot be described by one of the more specific anatomic NCCI-associated modifiers – i.e., RT, LT, E1-E4, FA, F1-F9, TA, T1-T9, LC, LD, RC, LM, or RI. (See examples 1, 2, and 3) From an NCCI perspective, the definition of different anatomic sites includes different organs or, in certain instances, different lesions in the same organ. However, NCCI edits are typically created to prevent the inappropriate billing of lesions and sites that should not be considered to be separate and distinct. Therefore modifier 59 should only be used to identify clearly independent services that represent significant departures from the usual situations described by the NCCI edit. The treatment of contiguous structures in the same organ or anatomic region does not constitute treatment of different anatomic sites. For example:

- Treatment of the nail, nail bed, and adjacent soft tissue on *the same toe or finger* constitutes treatment of a single anatomic site. (See example 4)
- Treatment of posterior segment structures in the eye constitutes treatment of a single anatomic site. (See example 5)
- Arthroscopic treatment of structures in adjoining areas of the same shoulder constitutes treatment of a single anatomic site. (See example 6)

2. Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.

Another common use of modifier 59 is for surgical procedures, non-surgical therapeutic procedures, or diagnostic procedures that are performed during different patient encounters on the same day and that cannot be described by one of the more specific NCCI-associated modifiers – i.e., 24, 25, 27, 57, 58, 78, 79, or 91. (See example 7) As noted in the CPT definition, modifier 59 should only be used if no other modifier more appropriately describes the relationship of the two procedure codes.

3. Modifier 59 is used inappropriately if the basis for its use is that the narrative description of the two codes is different.

One of the common misuses of modifier 59 is related to the portion of the definition of modifier 59 allowing its use to describe a "different procedure or surgery." The code descriptors of the two codes of a code pair edit usually represent different procedures, even though they may be overlapping. The edit indicates that the two procedures *in general* should not be reported together if performed at the same anatomic site and same patient encounter as those procedures would not be considered to be "separate and distinct." The provider should not use modifier 59 for such an edit based on the two codes being "different procedures." (See example 8) However, if the two procedures are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier 59 may be appended to indicate that they are different procedures on that date of service. *Additionally, there may be limited circumstances sometimes identified in the National Correct Coding Initiative Policy Manual for Medicaid Services when the two codes of an edit pair may be reported together with modifier 59 when performed at the same patient encounter or at the same anatomic site. (Source: www.cms.gov)*

4. Other specific appropriate uses of modifier 59

There are three other limited situations in which two services may be reported as separate and distinct because they are separated in time and describe non-overlapping services even though they may occur during the same encounter.

a. Modifier 59 is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in blocks of time that are separate and distinct (i.e., the same time block is not used to determine the unit of service for both codes), modifier 59 may be used to identify the services. (See example 9)

b. Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure. When a diagnostic procedure precedes a surgical procedure or non-surgical therapeutic procedure and is the basis on which the decision to perform the surgical procedure is made, that diagnostic test may be considered to be a separate and distinct procedure as long as (a) it occurs before the therapeutic procedure and is not interspersed with services that are required for the therapeutic intervention; (b) it clearly provides the information needed to decide whether to proceed with the therapeutic procedure; and (c) it does not constitute a service that would have otherwise been required during the therapeutic intervention. (See example 10) If the diagnostic procedure is an inherent component of the surgical procedure, it should not be reported separately.

c. Modifier 59 is used appropriately for a diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure. When a diagnostic procedure follows the surgical procedure or non-surgical therapeutic procedure, that diagnostic procedure may be considered to be a separate and distinct procedure as long as (a) it occurs after the completion of the therapeutic procedure and is not interspersed with or otherwise commingled with services that are only required for the therapeutic intervention, and (b) it does not constitute a service that would have otherwise been required during the therapeutic intervention. (See example 11) If the post-

procedure diagnostic procedure is an inherent component or otherwise included (or not separately payable) post-procedure service of the surgical procedure or non-surgical therapeutic procedure, it should not be reported separately.

Use of modifier 59 does not require a different diagnosis for each HCPCS/CPT coded procedure. Conversely, different diagnoses are not adequate criteria for use of modifier 59. The HCPCS/CPT codes remain bundled unless the procedures are performed at different anatomic sites or separate patient encounters or meet one of the other three scenarios described above.

Modifiers XE, XS, XP, XU are effective January 1, 2015. These modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported and may be utilized in lieu of modifier 59 whenever possible. (Modifier 59 should only be utilized if no other more specific modifier is appropriate.) Although NCCI will eventually require use of these modifiers rather than modifier 59 with certain edits, providers may begin using them for claims with dates of service on or after January 1, 2015. The modifiers are defined as follows:

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.

XS – "Separate Structure, A service that is distinct because it was performed on a separate organ/structure"

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

XU – "Unusual Non-Overlapping Service, The use of a service that is distinct because it does not overlap usual components of the main service"

EXAMPLES OF MODIFIER 59 USAGE

Example 1: Column 1 Code / Column 2 Code – 17000/11100

>CPT Code 17000 – Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), all benign or premalignant lesions (eg, actinic keratoses) other than skin tags or cutaneous vascular proliferative lesions; first lesion
>CPT Code 11100 – Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

Modifier 59 may be reported with code 11100 if the procedures are performed at different anatomic sites on the same side of the body and a specific anatomic modifier is not applicable. If the procedures are performed on different sides of the body, modifiers RT and LT or another pair of anatomic modifiers should be used, not modifier 59.

Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

Example 2: Column 1 Code/Column 2 Code – 47370/76942

>CPT Code 47370 – Laparoscopy, surgical, ablation of one or more liver tumor(s); radiofrequency
>CPT Code 76942 – Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

CPT code 76942 should not be reported and modifier 59 should not be used if the ultrasonic guidance is for needle placement for the laparoscopic liver tumor ablation procedure. Code 76942 may be reported with modifier 59 if the ultrasonic guidance for needle placement is unrelated to the laparoscopic liver tumor ablation procedure.

Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

Example 3: Column 1 Code/Column 2 Code – 93453/76000

>CPT Code 93453 – Combined right and left heart catheterization including intraprocedural injections(s) for left ventriculography, imaging supervision and interpretation, when performed
>CPT Code 76000 – Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg, cardiac fluoroscopy)

CPT code 76000 should not be reported and modifier 59 should not be used for fluoroscopy that is used in conjunction with a cardiac catheterization procedure. Modifier 59 may be reported with code 76000 if the fluoroscopy is performed for a procedure unrelated to the cardiac catheterization procedure.

Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

Example 4: Column 1 Code / Column 2 Code – 11055/11720

>CPT Code 11055 - Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
>CPT Code 11720 – Debridement of nail(s) by any method(s); one to five

CPT codes 11720 and 11055 should not be reported together for services performed on the same toe. Modifier 59 should not be used if a nail is debrided on the same toe on which a hyperkeratotic lesion is pared. Modifier 59 may be reported with code 11720 if one to five nails are debrided and a hyperkeratotic lesion is pared on a toe other than one with a debrided toenail.

Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

Example 5: Column 1 Code / Column 2 code – 67210/67220

>CPT Code 67210 – Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation
>CPT Code 67220 – Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions

CPT code 67220 should not be reported and modifier 59 should not be used if both procedures are performed during the same operative session because the retina and choroid are contiguous structures of the same organ.

Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

Example 6: Column 1 Code / Column 2 Code – 29827/29820

>CPT Code 29827 – Arthroscopy, shoulder, surgical; with rotator cuff repair
>CPT Code 29820 – Arthroscopy, shoulder, surgical; synovectomy, partial

CPT code 29820 should not be reported and modifier 59 should not be used if both procedures are performed on the same shoulder during the same operative session because the shoulder joint is a single anatomic structure. If the procedures are performed on different shoulders, modifiers RT and LT should be used, not modifier 59.

Modifier 59 is used appropriately for different anatomic sites during the same encounter only when procedures which are not ordinarily performed or encountered on the same day are performed on different organs, or different anatomic regions, or in limited situations on different, non-contiguous lesions in different anatomic regions of the same organ.

Example 7: Column 1 Code / Column 2 Code – 93015/93040

>CPT Code 93015 – Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with physician supervision, with interpretation and report
>CPT Code 93040 – Rhythm ECG, one to three leads; with interpretation and report

Modifier 59 may be reported if the rhythm ECG is performed at a different encounter than the cardiovascular stress test. If a rhythm ECG is performed during the cardiovascular stress test encounter, CPT code 93040 should not be reported and modifier 59 should not be used.

Modifier 59 is used appropriately when the procedures are performed in different encounters on the same day.

Example 8: Column 1 Code/Column 2 code – 34833/34820

>CPT code 34833 - Open iliac artery exposure with creation of conduit for delivery of aortic or iliac endovascular prosthesis, by abdominal or retroperitoneal incision, unilateral
>CPT code 34820 - Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral

CPT code 34833 is followed by a *CPT Manual* instruction that states: "(Do not report 34833 in addition to 34820)." Although the CPT code descriptors for 34833 and 34820 describe different procedures, they should not be reported together for the same side. Modifier 59 should not be appended to either code to report the two procedures for the same side of the body. If the two procedures were performed on different sides of the body, they may be reported with modifiers LT and RT as appropriate.

Modifier 59 is used <u>inappropriately</u> if the basis for its use is that the narrative description of the two codes is different.

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Example 9: Column 1 Code / Column 2 Code – 97140/97530

>CPT Code 97140 – Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
>CPT Code 97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Modifier 59 may be reported if the two procedures are performed in distinctly different 15 minute time blocks. For example, one service may be performed during the initial 15 minutes of therapy and the other service performed during the second 15 minutes of therapy. Alternatively, the therapy time blocks may be split. For example, manual therapy might be performed for 10 minutes, followed by 15 minutes of therapeutic activities, followed by another 5 minutes of manual therapy. CPT code 97530 should not be reported and modifier 59 should not be used if the two procedures are performed during the same time block.

Modifier 59 is used appropriately when *two timed* procedures are performed in different *blocks of time* on the same day.

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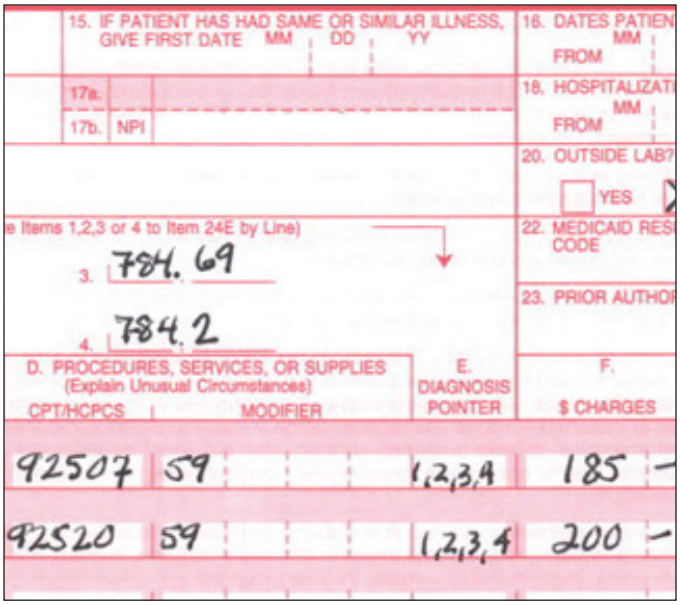
Example 10: Column 1 Code / Column 2 Code – 37220/75710

>CPT Code 37220 – Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty
>CPT Code 75710 – Angiography, extremity, unilateral, radiological supervision and interpretation

Modifier 59 may be reported with CPT code 75710 if a diagnostic angiography has not been previously performed and the decision to perform the revascularization is based on the result of the diagnostic angiography. The *CPT Manual* defines additional circumstances under which diagnostic angiography may be reported with an interventional vascular procedure on the same artery.


15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY
16. DATES PATIEN MM FROM
17a.
17b. NPI
18. HOSPITALIZAT MM FROM
20. OUTSIDE LAB? YES
e Items 1,2,3 or 4 to Item 24E by Line)
3. 784.69
4. 784.2
22. MEDICAID RES CODE
23. PRIOR AUTHO
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER
E. DIAGNOSIS POINTER
F. $ CHARGES
92507 59 1,2,3,4 185 –
92520 59 1,2,3,4 200 –

Modifier 59 is used appropriately for a diagnostic procedure which precedes a therapeutic procedure only when the diagnostic procedure is the basis for performing the therapeutic procedure.

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Example 11: Column 1 Code / Column 2 Code – 32551/71020

>CPT Code 32551 – Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open
>CPT Code 71020 – Radiologic examination, chest, 2 views, frontal and lateral

Modifier 59 may be reported if, later in the day following the insertion of a chest tube, the patient develops a high fever and a chest x-ray is performed to rule out pneumonia. CPT code 71020 should not be reported and modifier 59 should not be used for a chest x-ray that is performed following insertion of a chest tube in order to verify correct placement of the tube.

Modifier 59 is used appropriately for a diagnostic procedure which occurs subsequent to a completed therapeutic procedure only when the diagnostic procedure is not a common, expected, or necessary follow-up to the therapeutic procedure.

NEWS

Hospital Inpatient Update Alert

The Mississippi Division of Medicaid will adopt V.32 of the 3M Health Information System APR-DRG Grouper and V.32 of the Health Care Acquired Conditions (HCAC) utility for payment of hospital inpatient claims for discharges on or after July 1, 2015. APR-DRG parameters may also change effective for hospital inpatient discharges on or after July 1, 2015.

Hospitals are not required to purchase 3M software for payment of claims; however, all hospitals that have purchased the 3M software should ensure their internal systems are updated to reflect all changes that occur for hospital discharges beginning on or after July 1, 2015.

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

Hospital Outpatient Update Alert

Pursuant to Mississippi Annotated Code §43-13-117, A.2(c), the Mississippi Division of Medicaid will implement Phase 2 of the Outpatient Prospective Payment System (OPPS) effective July 1, 2015. OPPS Phase 2 changes will consist of the following:

1. Implementation of status indicators for procedure codes billed by outpatient hospital providers following the APC payment methodology.
   - ❖ A status indicator is a CMS or DOM approved indicator which is included on a claim to identify how the APC fee should be calculated for a particular procedure code or group of codes.
   - ❖ This change only impacts outpatient hospital providers for claims with dates of service on or after 07/01/15.
   - ❖ As of 07/01/15, claims with multiple procedure codes with a 'T' or 'MT' status indicator will pay at 100% for the first procedure code and 50% for any other 'T' or 'MT' status codes.

2. Implementation (for specific services only) date bundling when billed by outpatient hospital providers following the APC payment methodology. These services include:
   - Chemo – 31 days
   - Observation – 3 days
   - ER – 2 days
   - Therapies – 31 days
   - ❖ This change only impacts outpatient hospital providers with claims (for the aforementioned services) with dates of service on or after 07/01/15.
   - ❖ As of 07/01/15, claims for these specific services billed outside of the date ranges listed will **deny**. Therefore, providers should include all services rendered to a beneficiary for the specific services on a claim and be mindful of the "from" and "to" dates.

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

Especially for You . . . Our Providers

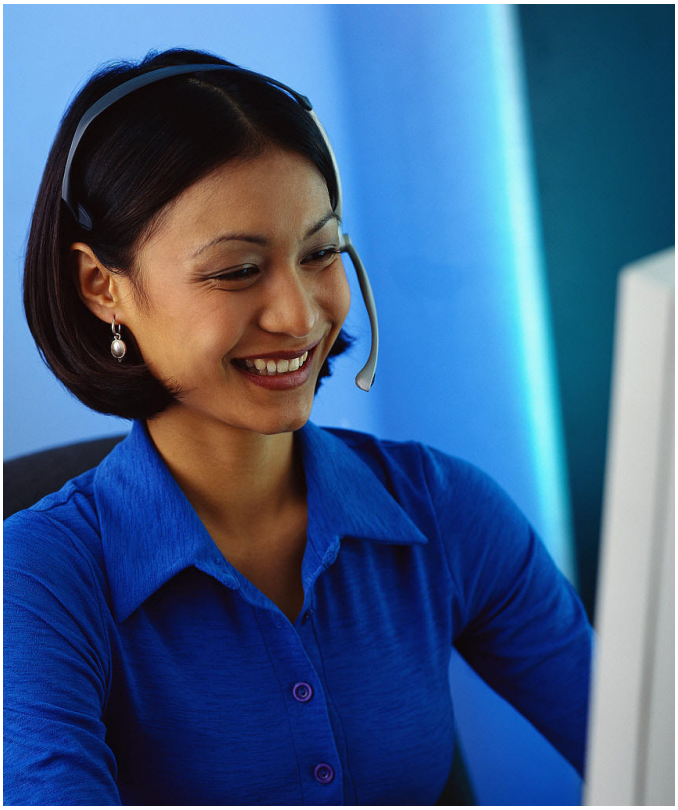
The Mississippi Division of Medicaid (DOM) is diligent in keeping its providers informed and updated on all Medicaid related federal and state Regulations. There are various avenues through which the DOM distributes and makes available updates to its providers. The Envision Web Portal, "your One-Stop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

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

Mississippi Medicaid Provider Billing Handbook

The Mississippi Medicaid Provider Billing Handbook (PBH) is designed to provide guidance and assistance to providers in submitting beneficiary claims to the Mississippi Division of Medicaid (DOM). The PBH provides step-by-step instructions on completing claims forms to ensure providers are reimbursed in a timely manner for services rendered. Providers may obtain a hard copy of the PBH at a minimal cost, by contacting the fiscal agent's Provider and Beneficiary Services Unit at1-800-884-3222, or an electronic version of the Handbook may be downloaded at www.medicaid.ms.gov.

This PBH must be used in conjunction with the Mississippi Administrative Code (Admin. Code), Title 23. The Admin Code is a set of rules that dictate how the Medicaid agency is administered. The Code is divided into parts, chapters and rules which outlines policy and procedures and contains key Medicaid reimbursement information. A resource document designed to be a companion to the Admin Code is the Provider Reference Guide (PRG) which contains helpful hints, contact information, frequently asked questions and many other tools to assist in complying with the Admin Code. The Admin Code and fee schedules can be found on the DOM website at www.medicaid.ms.gov.



Tips for Individual Providers When They Relocate

Your Mississippi Medicaid Provider number belongs to you, the individual provider, not the practice. Often times provider 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, he or she should check their addresses and banking information on file with Medicaid. 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://www.ms-medicaid.com/msenvision/downloadenrollPackage.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 (601) 206-3015 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 two or three payment cycles. Ongoing, you will began receiving your Mississippi Medicaid Reimbursement electronically deposited according to the information on your provider file.

SUBMITTING CHANGE OF ADDRESS FORM INSTRUCTIONS

The Change of Address form should be printed from the web portal at https://www.medicaid.ms.gov/Forms/ProviderForms/ChangeofAddressform.pdf and must be completed and signed by the individual provider. The Change of Address form can be faxed to Xerox Provider Enrollment at 601-206-3015 or it may be mailed to the following address:

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

If you have questions, please contact the Xerox Provider Enrollment Department at 1-800-884–3222.
Note: If the 1099 address is being updated, a W9 will be required and the individual must sign.

Verifying Vision and Dental Services Via the Web Portal

Did you know that you can now check coverage for vision and dental services through the web portal? Here's how:

1. Access the Mississippi Envision Web Portal via the following link: (www.msmedicaid.acs-inc.com/msenvision)
2. Log in using your previously created/assigned username and password. You must have a web portal account, and you must login to your account to utilize the appropriate inquiry options.
3. After logging in, click the Provider heading.
4. Scroll to Inquiry Options.
5. Select Eligibility Inquiry.
6. Enter the patient's MS Medicaid beneficiary ID number and date(s) of service. If you do not have the beneficiary's ID number, you may use alternate identifying information such as the beneficiary's name, social security number, and date of birth.
7. Click submit, and the Beneficiary Eligibility Response page should be returned.
8. Scroll to the very bottom of that page to the Other Eligibility Information section. Here you will find the Dental and Vision coverage tabs.
9. Clicking the Dental Coverage tab will return the Dental Coverage Inquiry page.
10. Select the procedures you are inquiring about, and then click submit.
11. The Dental Coverage Response window should open displaying your results.
12. Clicking the Vision Coverage tab will return the Vision Coverage Inquiry page.
13. Select the procedures you are inquiring about, and then click submit.
14. The Vision Coverage Response window should open displaying your results.

PROVIDER COMPLIANCE

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

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 will be $4.24 per 15 minute unit. This is the maximum rate allowed under the current Centers for Medicare and Medicaid Services (CMS) approved Elderly and Disabled Waiver. The procedure code for PCS is T1019 and must be billed with a U1 modifier for services provided under the Elderly and Disabled Waiver.

Reminder for All Assisted Living Waiver Providers

All waiver providers are required to report critical incidences of abuse, neglect, and exploitation within 24 hours of the occurrence or knowledge of the occurrence to the DOM Office of Long Term Care and other applicable agencies as required by law. Initial reports may be submitted to DOM by telephone at 601-359-6141, however a detailed written report is also required. Detailed written reports must be faxed to 601-359-9521 to the attention of the Office of Long Term Care, Assisted Living Waiver Director.

A vulnerable person is defined as any minor or adult, whose ability to perform the normal activities of daily living or to provide for his/her own care or protection from abuse, neglect, exploitation or improper sexual contact is impaired due to a mental, emotional, physical or developmental disability or dysfunction, brain damage or the infirmities of aging.

Abuse is defined as the following:

- The commission of a willful act, or the willful omission of the performance of a duty, which act or omission contributes, tends to contribute to, or results in the infliction of physical pain, injury or mental anguish on or to a vulnerable person
- The unreasonable confinement of a vulnerable person
- The willful deprivation by a caretaker of services which are necessary to maintain the mental or physical health of a vulnerable person
- The sexual abuse of a vulnerable person
- Does not mean conduct that is a part of the treatment and care of, and in furtherance of the health and safety of a patient or resident of a care facility, nor shall it mean a normal caregiving action or appropriate display of affection
- Includes, but is not limited to, a single incident

Neglect is defined as the following:

- The inability of a vulnerable person who is living alone to provide for themselves the food, clothing, shelter, health care or other services which are necessary to maintain their mental and physical health
- The failure of a caretaker to supply the vulnerable person with the food, clothing, shelter, health care, supervision or other services which a reasonably prudent person would do to maintain the vulnerable adult's mental or physical health
- Includes a single incident

Exploitation is defined as the following:

- The illegal or improper use of a vulnerable person or his or her resources for another's profit, advantage or unjust enrichment, with or without the consent of the vulnerable person, and may include actions taken pursuant to a power of attorney
- Includes acts committed pursuant to a power of attorney
- Includes, but is not limited to, a single incident
- "Illegal use" means any action defined under Mississippi law as a criminal act.
- "Improper use" means any use without the consent of the vulnerable person, any use with the consent of the vulnerable person if the consent is obtained by undue means, or any use that deprives the vulnerable person of his ability to obtain essential services or a lifestyle to which the vulnerable person has become accustomed and could have otherwise afforded.
- "Undue means" means the use of deceit, power, or persuasion over a vulnerable person resulting in the vulnerable person being influenced to act otherwise that by his own free will or without adequate attention to the consequences.

Reminder for All Elderly and Disabled Waiver Providers

All waiver providers are required to report critical incidences of abuse, neglect, and exploitation within 24 hours of the occurrence or knowledge of the occurrence to the Division of Medicaid (DOM) Office of Long Term Care and other applicable agencies, as required by law. Initial reports may be submitted to DOM by telephone at 601-359-6141; however, a detailed written report is also required. Detailed written reports must be faxed to 601-359-9521 to the attention of the Office of Long Term Care, Elderly and Disabled Waiver Nurse Administrator.

A vulnerable person is defined as any minor or adult whose ability to perform the normal activities of daily living or to provide for his/her own care or protection from abuse, neglect, exploitation or improper sexual contact is impaired due to a mental, emotional, physical or developmental disability or dysfunction, brain damage or the infirmities of aging.

Abuse is defined as the following:

- The commission of a willful act, or the willful omission of the performance of a duty, which act or omission contributes, tends to contribute to, or results in the infliction of physical pain, injury or mental anguish on or to a vulnerable person
- The unreasonable confinement of a vulnerable person
- The willful deprivation by a caretaker of services which are necessary to maintain the mental or physical health of a vulnerable person
- The sexual abuse of a vulnerable person
- Does not mean conduct that is a part of the treatment and care of, and in furtherance of the health and safety of a patient or resident of a care facility, nor shall it mean a normal caregiving action or appropriate display of affection
- Includes, but is not limited to, a single incident

Neglect is defined as the following:

- The inability of a vulnerable person who is living alone to provide for themselves the food, clothing, shelter, health care or other services which are necessary to maintain their mental and physical health
- The failure of a caretaker to supply the vulnerable person with the food, clothing, shelter, health care, supervision or other services which a reasonably prudent person would do to maintain the vulnerable adult's mental or physical health
- Includes a single incident

Exploitation is defined as the following:

- The illegal or improper use of a vulnerable person or his or her resources for another's profit, advantage or unjust enrichment, with or without the consent of the vulnerable person, and may include actions taken pursuant to a power of attorney
- Includes acts committed pursuant to a power of attorney
- Includes, but is not limited to, a single incident
- "Illegal use" means any action defined under Mississippi law as a criminal act
- "Improper use" means any use without the consent of the vulnerable person, any use with the consent of the vulnerable person if the consent is obtained by undue means, or any use that deprives the vulnerable person of his ability to obtain essential services or a lifestyle to which the vulnerable person has become accustomed and could have otherwise afforded
- "Undue means" is defined as the use of deceit, power, or persuasion over a vulnerable person resulting in the vulnerable person being influenced to act otherwise that by his own free will or without adequate attention to the consequences

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.

Notification of Updates on the State Plan, Administrative Code or Waivers

If a provider or individual would like to be added to the distribution list for notification of updates to the State Plan, Administrative Code, or Waiver please notify the Division of Medicaid at the appropriate e-mail addresses below.

- The State Plan – spa@medicaid.ms.gov
- Administrative Code – admincode@medicaid.ms.gov
- Waivers – waiver@medicaid.ms.gov

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 Explanation of Benefits (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, July 1, 2015

DOM's Preferred Drug List (PDL) will be updated on July 1, 2015. DOM's universal/uniform PDL was implemented on January 1, 2015 and applies for fee-for-service (FFS), MississippiCAN and the Children's Health Insurance Program (CHIP).

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 July 1, 2015.' To reference the preferred/non-preferred additions and deletions, see 'MS PDL Changes-Provider Notice, effective July 1, 2015.

Pharmacy Provider Information for Medicaid Beneficiaries Transitioning to MississippiCAN Beginning May 1, 2015

From May 1, 2015 through July 31, 2015, beneficiaries in categories of eligibility primarily consisting of children up to the age of 19 will be transitioned from fee-for-service Medicaid to the MississippiCAN program. Transition will occur incrementally in the months of May, June, and July. Beneficiaries excluded from the MississippiCAN program include those who are dually eligible (Medicaid/Medicare), enrolled in a waiver, residing in a long term care (LTC) facility including but not limited to a PRFT or ICF/IDD facility, and those beneficiaries with hemophilia. There are no changes to coverage or any loss of benefits.

What do pharmacists need to know?

- Beneficiaries receive notices via mail and may choose between Magnolia Health and United Healthcare.
- If beneficiaries do not complete a selection form, they will be automatically assigned to one of two companies. Beneficiaries who are automatically assigned to a company have a 90 day grace period to change plans. If no change is made during the grace period, the beneficiary must wait until the annual open enrollment period in October to change plans (with that change becoming effective the following January 1st).
- Health care providers should verify eligibility and plan at each date of service to ensure proper coverage and reimbursement. To verify eligibility and MississippiCAN assignment, providers can:
  - Use Xerox's Automated Voice Response System (AVRS), at 1-800-884-3222. The beneficiary's social security number and/or Medicaid ID# are needed to determine enrollment in Magnolia Health or UnitedHealthcare.
  - Use Xerox's Web Portal. If a provider is not registered to use the Web Portal, contact Xerox at 1-800-884-3222 to request assistance.
- Point of Sale (POS) claims processed to DOM for beneficiaries enrolled in MississippiCAN:
  - NCPCP Reject Code '41-SUBMIT BILL TO OTHER PROCESSOR' with the following NCPDP 526 (Free Text Messages):
    - If enrolled in UHC – BILL MississippiCAN PLAN: UNITED HEALTHCARE, 1-877-305-8952; BIN#610494: GROUP ACUMS
    - If enrolled in Magnolia – BILL MississippiCAN PLAN: MAGNOLIA HEALTH PLAN INC, 1-800-460-8988; BIN#008019: GROUP 14101

DOM suggests that you print and keep information nearby for easy reference.

Hurricane Preparedness: Pharmacy Billing Procedures in Times of Officially Declared Emergencies

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

- Two (2) Brand/Five (5) Prescription Limit
- Early Refill

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

Pharmacy Reminders

340B CONTRACT PHARMACIES

A contract pharmacy, defined by the Division of Medicaid (DOM) as an agent of a 340B covered entity and ineligible to be a freestanding 340B covered entity, cannot dispense and bill the Division of Medicaid for 340B outpatient drugs for Medicaid beneficiaries. Please refer to DOM Administrative Code, Rule 4.10: 340B Providers.

DRUG DEVICES = NON-PHARMACY COVERAGE

The determination of covered outpatient drugs under Medicaid Drug Rebate Program generally depends on whether the drug has been approved as a prescription drug by the FDA under Section 505 or 507 of the Federal Food, Drug, and Cosmetic Act. Products issued device approvals do not meet the definition of a covered outpatient drug as defined in Section 1927(k) of the Social Security Act and are not eligible for Medicaid coverage in the Pharmacy Program.

While most products are easily identifiable as devices, other products could commonly be misidentified as a drug. Some of the more common topical devices presumed to be drugs include, but are not limited to, Atopiclair™ cream, Biafine® emulsion, Bionect® products, Hylatopic™ plus cream, and sodium hyaluronate lotion. These products, as well as all devices with an American Society of Health-Systems (AFHS) code of 940000, are not covered through pharmacy services. If a claim is processed for a medical device, Edit 4114-Drug/Product Not Covered, will post with a denial.

This article was originally published in the April 2009, DOM Provider Bulletin.

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.

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.

FAMILY PLANNING WAIVER (FPW)

Beneficiaries enrolled in the FPW have yellow Medicaid cards. FPW beneficiaries are only eligible for family planning and family planning related pharmacy services, such as:

- Contraceptives (drug classes below follow the DOM-Preferred Drug List (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)
- Sexually Transmitted Infections/Sexually Transmitted Diseases (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 point of sales (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 1-800-421-2408.

BILLING AND CORRECTIONAL FACILITIES

The Mississippi 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.

BILLING AND USING INCORRECT MEDICAID IDENTIFICATION NUMBERS

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.

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.

STATEWIDE MEDICAID PROVIDER CONFERENCE

The Division of Medicaid (DOM) is in the beginning stages of planning a statewide Medicaid Provider Conference and we need your input! This Conference will be designed to offer interactive discussion sessions as well as classes targeted to the medical professional and their supporting administrative and billing office staff. We need your input to ensure our presented topics meet your needs as our network providers, and will also answer the questions of those providers still in the deciding stage of whether to enroll with Medicaid.

DOM is committed to building a better working relationship with its provider community. The statewide Medicaid Provider Conference will present an opportunity for all providers to come together and network with medical colleagues, in addition to receiving updates on Medicaid policies, codes, claims billing guidelines and procedures. To enhance this experience, we hope to be able to offer Continuing Education Units (CEUs).

Your feedback is important to us! Please indicate which topics you would like to see presented in the statewide Provider Medicaid Conference by checking all the applicable boxes below.

- ☐ Crossover Claims
- ☐ Provider Enrollment
- ☐ Dental Services
- ☐ Durable Medical Equipment
- ☐ EPSDT Services
- ☐ EQ Health Solutions – Prior Authorizations
- ☐ Electronic Health Records
- ☐ Home Health
- ☐ Hospice
- ☐ Hospital
- ☐ Nursing Facility
- ☐ Physician Services
- ☐ Mental Health Services
- ☐ MississippiCAN – Magnolia Health and UnitedHealthcare
- ☐ Med Solutions – Prior Authorization
- ☐ Verifying Eligibility
- ☐ Third Party Recovery
- ☐ Waiver Programs
- ☐ Web Portal
- ☐ Therapy Services
- ☐ CHIP – Magnolia Health and UnitedHealthcare

Other suggested topics and comments: _____

Please complete and return this page by July 31, 2015, via Fax to: 601-359-4185, Attention: Provider Relations.

Provider Name:_____ Contact Name:_____

Provider Number:_____ Phone Number:_____

Fax Number:_____ Email Address:_____

If you have questions, contact the office of Provider Relations at 601-359-3696. DOM appreciates its providers for your input and continued participation in the Mississippi Medicaid program. Thank you!

PROVIDER MEMO

Medicaid Children Transition into MississippiCAN

What is going on with the transition of children from regular Medicaid to MississippiCAN?
Between May 1 and July 31, 2015, Medicaid-eligible children up to the age of 19 are set to be transitioned from regular Medicaid to the managed care program, Mississippi Coordinated Access Network (MississippiCAN).

One-third of the children will be enrolled effective May 1, 2015; One-third of the children will be enrolled effective June 1, 2015; One-third of the children will be enrolled effective July 1, 2015.

Who will be affected?
Medicaid-eligible children up to the age of 19 will be transitioned into MississippiCAN. The exceptions are children who are on Medicare, waivers or reside in institutions.

Why is this transition happening?
Of the nearly 800,000 Mississippians enrolled in Medicaid or the Children's Health Insurance Program (CHIP), children are the largest population we serve. Authorized by the Mississippi Legislature in 2011, MississippiCAN was established to create more efficiency and provide better access to health services, making Mississippi one of at least 26 other states to adopt a managed-care approach.

Ultimately, the three goals of MississippiCAN are to increase access to coverage, improve quality of care (through approaches like case management), and cost-effectiveness.

What do beneficiaries need to know? Have notification letters been mailed?
For the children being transitioned, this does not change their coverage and there is no loss of benefits.

Starting March (and continuing through May), a notification letter and form are being mailed to beneficiary households that will likely be affected. Beneficiaries must choose between Magnolia Health or UnitedHealthcare as their health plan on the form. (Unlike regular Medicaid, MississippiCAN is administered by two coordinated-care organizations.)

The form must be mailed back in the provided pre-paid envelope.

If the form is not completed and returned, the beneficiary is automatically assigned to one of the plans but they will have 90 days to switch plans. If they don't, any changes will have to wait until the annual open enrollment period in October, for an effective date of January 1, similar to the process with any other insurance provider.

For those receiving notification letters in March, the effective date for this change is in May.

What if beneficiaries do not receive notification?
The eligibility of each Mississippi Medicaid beneficiary is reviewed yearly. DOM works to let all beneficiaries know how important it is that the agency has their correct mailing address and contact information. If there has been a change throughout the year, beneficiaries might not receive important notifications which could impact their coverage. Beneficiaries need to contact their regional office caseworker to update their mailing address or contact information.

How do providers know to which program beneficiaries have been assigned?
Health-care providers who serve children covered by Medicaid or CHIP should verify their patients' eligibility and plan at each date of service, and make sure they are in their provider network. This is essential to receive proper reimbursement for services.

To check eligibility information, contact us by:
Xerox AVRS toll-free: 800-884-3222
Xerox Web Portal: ms-medicaid.com

Note: Mississippi Medicaid health benefits encompass multiple programs administered by DOM: Medicaid,

MississippiCAN and CHIP. Also, the MississippiCAN and CHIP programs are administered by two coordinated care organizations (CCOs). Providers voluntarily enroll with the programs and with these CCOs. However, DOM encourages all providers to enroll ensuring that your patients remain under your care, and you receive payment from the proper source.

Provider Enrollment Contact Information:

Medicaid Toll-free: 800-884-3222
or 800-421-2408
http://www.ms-medicaid.com

MississippiCAN

Magnolia Health: Toll-free: 866-912-6285
magnoliahealthplan.com

UnitedHealthcare: Toll-free: 866-574-6088
or 877-743-8731
swproviderservices@uhc.com

CHIP

Magnolia Health: Toll-free: 866-912-6285
magnoliahealthplan.com

UnitedHealthcare: Toll-free: 866-574-6088
or 800-992-9940
uhccommunityplan.com

How do we take care of beneficiaries who need to find a doctor in their assigned plan?

Call the CCOs and ask for a case manager. The case manager will assist beneficiaries to locate a physician with their assigned CCO and contact their current treating doctor. Beneficiaries may also contact case managers for assistance with medication and other services.

Physicians may also call case managers regarding beneficiaries needing follow-up care and assistance. Case management is available to all beneficiaries in managed care.

Also, both CCOs have Nurses available 24 hours, seven days per week to address beneficiary or provider issues:

Magnolia Health	1-866-912-6285	24/7 NurseWise
UnitedHealthcare	1-877-743-8731	NurseLine 24/7

How do providers obtain prior authorizations?

For children being transitioned, there will be a 90-day grace period for all existing prior authorizations issued prior to the transition from their effective date in MississippiCAN.

Therefore, if the beneficiary is enrolled May 1, then the prior authorization obtained from eQHealth will expire in 90 days or July 30, then a separate 90 days for those with effective dates June 1 and July 1. Within the 90-day grace period, providers should contact CCOs for a new prior authorization or for a renewal beyond this period

If prior authorization (PA) ends during the 90 day grace period, then a new PA must be obtained by the provider. PAs will not automatically be extended during that 90 day period if they were to expire during the 90-day grace period.

For example: PA period is January 1, 2015 to June 20, 2015, and beneficiary is enrolled May 1; then the provider would need a new PA by June 20, 2015. However, if the PA was January 1, 2015 to October 1, 2015, then the provider would need a new PA by August 1, 2015.

Is the primary care provider (PCP) on MississippiCAN card the only PCP that member can see?

No, the PCP on the member card is simply to direct them to an enrolled PCP, rather than seeking emergency treatment. Many members have their own PCPs, but they are not reflected in our records. Members should continue to be treated by their own PCPs, and call the CCOs to update their record with their actual treating provider.

Who do they contact for more information?

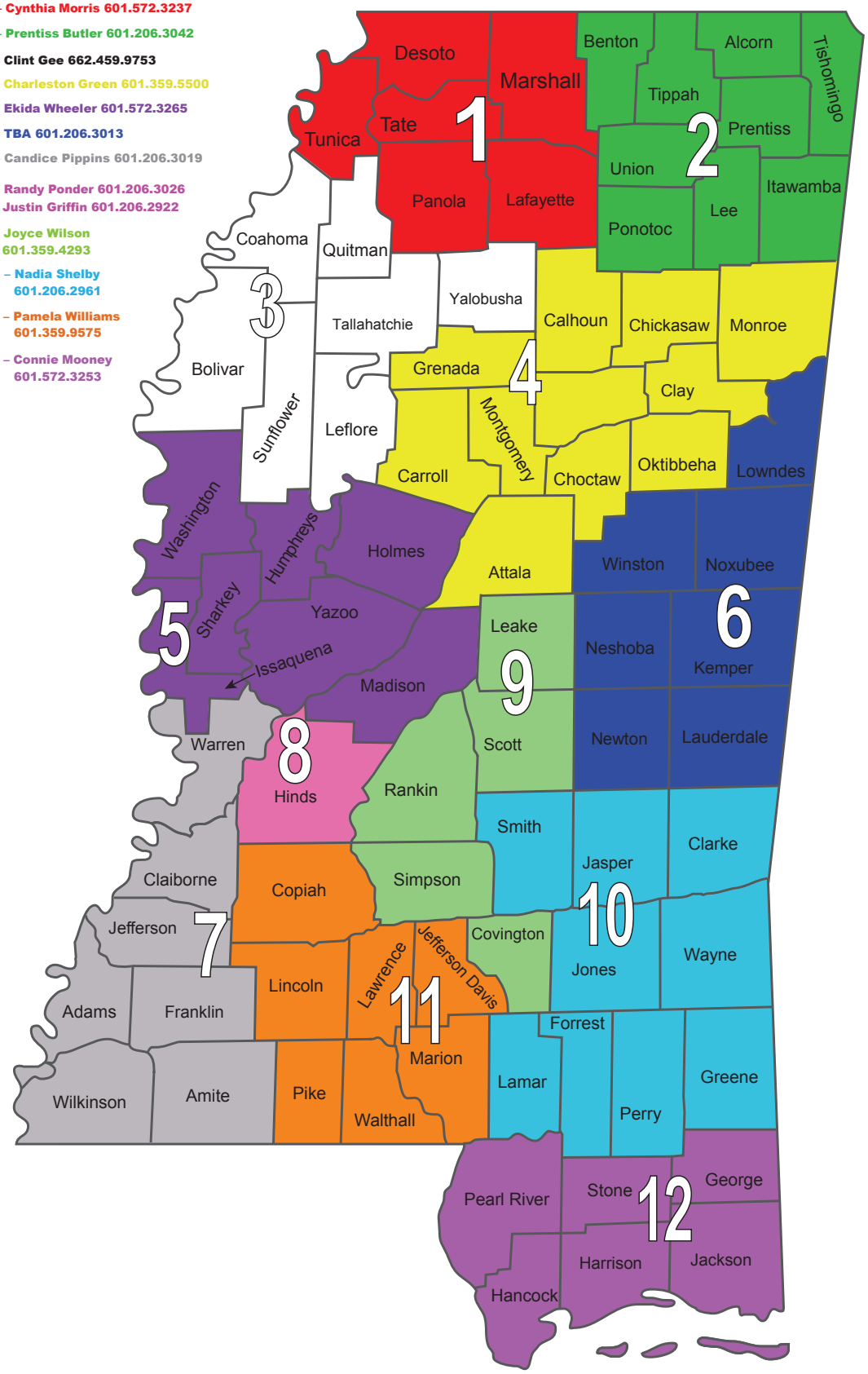
For more information, beneficiaries and providers are instructed to call our fiscal agent, Xerox, toll-free at 800-884-3222 or Division of Medicaid toll-free at 800-241-2408.

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** **TBA (601.206.3013)**
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 Pippins (601.206.3019)** **candice.pippins@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	Covington
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	Copiah	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 – TBA 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



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

The Division of Medicaid and Xerox State Healthcare, LLC. Welcome Summertime!

JUNE 2015

MON, JUNE 1	Checkwrite
THURS, JUNE 4	EDI Cut Off 5:00 p.m.
MON, JUNE 8	Checkwrite
THURS, JUNE 11	EDI Cut Off – 5:00 p.m.
MON, JUNE 15	Checkwrite
WED, JUNE 17	MississippiCAN Workshop* Pascagoula Senior Center Pascagoula, MS
THURS, JUNE 18	EDI Cut Off – 5:00 p.m.
MON, JUNE 22	Checkwrite
TUES, JUNE 23	MississippiCAN Workshop* Bancorp South Tupelo, MS
THURS, JUNE 25	EDI Cut Off – 5:00 p.m.
MON, JUNE 29	Checkwrite
TUES, JUNE 30	MississippiCAN Workshop* The Landers Center Southaven, MS

JULY 2015

THURS, JULY 2	EDI Cut Off – 5:00 p.m.
MON, JULY 6	Checkwrite
THURS, JULY 9	EDI Cut Off – 5:00 p.m.
	MississippiCAN Workshop* Alcorn State University Natchez, MS
MON, JULY 13	Checkwrite
TUES, JULY 14	MississippiCAN Workshop* Greenville Higher Education Center Greenville, MS
THURS, JULY 16	EDI Cut Off – 5:00 p.m.
MON, JULY 20	Checkwrite
WED, JULY 22	MississippiCAN Workshop* Forrest County Multipurpose Center Hattiesburg, MS
THURS, JULY 23	EDI Cut Off – 5:00 p.m.
MON, JULY 27	Checkwrite
TUES, JULY 28	MississippiCAN Workshop* Courtyard by Marriott Gulfport Beach Gulfport, MS

AUGUST 2015

MON, AUG. 3	Checkwrite
TUES, AUG. 4	MississippiCAN Workshop* Eagle Ridge Conference Ctr. Raymond, MS
THURS, AUG. 6	EDI Cut Off – 5:00 p.m.
MON, AUG. 10	Checkwrite
THURS, AUG. 13	EDI Cut Off – 5:00 p.m
MON, AUG. 17	Checkwrite
THURS, AUG. 20	EDI Cut Off – 5:00 p.m.
MON, AUG. 24	Checkwrite
THURS, AUG. 27	EDI Cut Off – 5:00 p.m.
MON, AUG. 31	Checkwrite

Checkwrites and Remittance Advices are dated every Monday. Provider Remittance Advice is available for download each Monday morning at www.ms-medicaid.com. Funds are not transferred until the following Thursday.
EDI cut off is 5 p.m. every Thursday.
*** All Workshops are two sessions per day, 9 a.m.–11 a.m. & 1 p.m.–3 p.m. The Workshop agenda, RSVP reply form and more Workshop details are located on DOM's website at www.medicaid.ms.gov.**