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MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

2015 Medicaid Milestones

DR. DAVID DZIELAK
Executive Director
MS Division of Medicaid

LOOKING BACK ON A YEAR OF CHANGES AT MEDICAID

It has been a busy year for the Mississippi Division of Medicaid (DOM) with a lot of changes impacting health-care providers around the state. Some of these changes have already taken effect, while others are still in the works spilling over into 2016 and beyond.

In this issue of the Provider Bulletin, we decided to include a look back at some of the highlights from this year, which hopefully will give readers a quick recap of the most important and notable developments impacting Mississippi Medicaid programs.

First, I want to mention two of the most complicated projects we have tackled this year: the switch to International Classification of Diseases (ICD-10) and transitioning inpatient services into managed care.

As most health-care providers are well aware of, the practice of medicine has dramatically changed in the last several decades. Many new health conditions have been discovered, ground-breaking treatments developed and various types of medical devices have been made more widely available to patients.

Because of these innovations, the U.S. health-care system and DOM transitioned from using ICD-9 to ICD-10 for clinical diagnosis codes and inpatient hospital procedures. This change took effect October 1, 2015 at DOM and around the nation.

ICD-10 codes were adopted by the World Health Organization in 1994. Most of the countries throughout the world transitioned their health-care systems to ICD-10 more than a decade ago, leaving the U.S. as one of the last to adopt this diagnosis coding set.

The earlier ICD-9 code set was not designed to capture the latest advances in health care and, as such, was bogged down with modifications in an attempt to capture this additional information. The ICD-10 code set is much better at describing the current practice of medicine and has the flexibility to adapt to future changes.

Diagnosis and procedure codes permeate almost every system and business process, in both health-plan and provider organizations. Diagnosis codes are crucial for determining coverage and are used in treatment decisions. From plan to design to statistical tracking of disease, these codes are an essential part of the way health plans and DOM run their programs.

DOM put a great deal of effort into the transition to ICD-10 and has monitored the changeover on a daily basis and so far so good. For the first full week of October, the Office of Medical Services received 300,379 claims and finalized all of them.

Meanwhile, we also are working on the transition to include inpatient hospital services into our managed care program, the Mississippi Coordinated Access Network (MississippiCAN).

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During the 2015 legislative session, DOM received authority to roll inpatient care into MississippiCAN through Senate Bill 2588. Additionally, the bill includes the creation of the Mississippi Hospital Access Program as a transition from the hospital upper limit Program. Inpatient care is our largest provider payment type and this change took place December 1, 2015. This change impacts claims submission, newborn reporting requirements and other procedures. We are diligently monitoring this transition to ensure it is as smooth as possible.

This change requires a lot of collaboration between providers, the CCOs and DOM to ensure that all of the proper billing codes, prior authorization protocols and processes such as using the correct billing grouper are in place for this transition.

Webinars were held in October and November to explain the details of the transition plan, which still has to be approved by the Centers for Medicare and Medicaid Services (CMS). In an effort to make this transition as smooth as possible, we posted information on the DOM website at medicaid.ms.gov, along with a list of frequently asked questions. There is also a dedicated e-mail box for the inpatient transition. If you have questions or concerns, please e-mail us at inpatient@medicaid.ms.gov

CHANGES TO THE MEDICAID RENEWAL PROCESS

Beginning in January, the process to renew Division of Medicaid benefits changed. Medicaid and Children's Health Insurance Program (CHIP) recipients generally must be reviewed every twelve months for continued eligibility. The Affordable Care Act (ACA) calls these reviews "renewals" of eligibility. Annual renewals using Modified Adjusted Gross Income (MAGI) methodology, which are being completed for the first time in 2015, is a new way of conducting business for both our eligibility staff and beneficiaries.

The first step in this two-step process is an attempt to renew eligibility administratively without requiring information from the recipient. In the administrative review, information from the case is used to determine household composition by calculating the eligibility of parents and their children. Countable income is determined through various Federal Data Services Hub sources and matching with Mississippi Department of Employment Security (MDES). If income remains below the Medicaid or CHIP limit based on the applicable household size, the family is approved.

If eligibility cannot be determined through the administrative review, DOM issues a pre-populated renewal form for the second step of the process. The form contains household and income information available to the agency.

The family is asked to review the information and respond within thirty days. Renewal information can be provided online, by phone, mail, fax, or in person. When the information is provided, the eligibility process can proceed. If the information needed for renewal is not provided, eligibility is terminated after a 15-day advance notice. Eligibility can be reinstated with no loss of benefits if information for the renewal is submitted within 90 days of termination and eligibility otherwise exists.

IMPROVEMENTS AND UPDATES MADE TO MEDICAL SERVICES PROGRAMS

Throughout the past year, DOM offices of Clinical Support Services, Community Based Services, Hospital Programs and Services, Medical Services, Mental Health and Long Term Care made progress on a number of different waiver and grant-funded programs.

As part of Mississippi's overall efforts to rebalance the state's Long Term Care system, DOM entered into a contract with a vendor to develop a comprehensive electronic Long Term Services and Supports (eLTSS) system. This project aims to establish a Core Standardized Assessment, a No Wrong Door System, a Case Management tracking system, a quality framework for all waivers and an Electronic Visit Verification System.

The Assisted Living Waiver was implemented into the eLTSS system in March, the Intellectual Disability/Developmentally Disabled (ID/DD) Waiver was implemented in July, and the Elderly and Disabled Waiver was implemented in September. Evidentiary reports to renew the Independent Living and Elderly and Disabled waivers were submitted this fall.

The Traumatic Brain Injury/Spinal Cord Injury (TBI/SCI) waiver was renewed effective July 1, 2015. The TBI/SCI Waiver provides services to beneficiaries who would typically require the level of care found in a nursing facility.

The services covered by all of these waivers are undergoing a process to ensure they meet the requirements of a 2014 CMS rule regarding home and community based settings. This Statewide Transition Plan will be implemented over the next few years.

Additionally, the agency secured a three-year extension of its Family Planning Waiver from CMS, which went into effect January 1, 2015. The waiver now covers men as well as women, and the waiver now covers medications for treating sexually transmitted infections (STI) and diseases (STD) in addition to contraception.

The Mississippi Youth Programs Around the Clock Waiver (MYPAC), funded through CMS as a waiver, expired in 2014. However, the state Legislature gave DOM authority to continue the program through the agency's annual budget as a Medicaid State Plan service.

Lastly, the Healthier Mississippi Waiver was renewed in July of 2015. This applies to individuals 65-years-old or older, or disabled with no Medicare coverage.

For more information about waiver eligibility, visit the DOM website at www.medicaid.ms.gov.

CHILDREN TRANSITIONED INTO MANAGED CARE

Last year, the Mississippi Legislature authorized DOM to include eligible children in DOM's managed care program, MississippiCAN.

One of the main components of managed care is case management, which not only encourages beneficiaries to visit their physician for routine exams, wellness screenings and preventive services, but also follow up on those visits to ensure prescribed medications are taken as directed and other therapeutic interventions are followed.

Children make up DOM's largest category of eligibility and represent 60 percent of the Mississippi Medicaid population. Children under age one, those who transitioned from CHIP to Medicaid as a result of Affordable Care Act mandates, and those in foster care are currently enrolled in managed care. From May through July of this year, nearly 300,000 additional children were transitioned to one of two coordinated care programs participating in MississippiCAN, Magnolia Health and UnitedHealthcare Community Plan.

DOM conducted informational and educational outreach events for beneficiaries and providers regarding this transition during the summer.

Mississippi has the worst health statistics in the country. DOM believes that the managed care approach can help improve health outcomes for beneficiaries, and including children is the best way to begin the process for a healthier Mississippi.

FISCAL AGENT PROCUREMENT IN THE WORKS

Contract negotiations are being held for the next Medicaid Enterprise Solution (MES) procurement, a long-term process of determining who will be the next fiscal agent for DOM.

The fiscal agent is a private company that provides many operational and support services to help keep DOM running efficiently. DOM's current fiscal agent, Xerox, helps with a number of operations, including the maintenance of our Medicaid Management Information System (MMIS) and Decision Support System/Data Warehouse (DSS/DW).

MMIS facilitates processing and paying provider claims, the eligibility determination and enrollment process (MEDS/MMEDS), pharmacy benefits management, reporting and provider incentive payments. The DDS/DW facilitates program integrity and reporting requirements for CMS.

Negotiations are still ongoing with the leading contender for the next contract, HP Enterprise Services. Once an agreement is reached, it still must be approved by CMS and the Personal Services Contract Review Board.

Xerox continues to provide fiscal agent services until the next fiscal agent contract is awarded and the new system is implemented. The current contract with Xerox was extended through legislative approval, due to the fact that the procurement process is lengthy and complex. DOM's goal is for the next contract to meet the agency's growing needs with the best information system and services to suit Mississippi. The next contract is expected to take effect by the middle of 2016.

LEGISLATIVE BUDGET OFFICE HEARING

On September 21, DOM had its annual hearing before the Joint Legislative Budget Committee and presented its budget request for fiscal year (FY) 2017. Also included in the presentation was a request for $71 million in additional funds to complete the current fiscal year which began July 1, 2015.

Funding shortfalls from the previous legislative session and the ever-escalating costs of medical services made it necessary to request additional money, known as a deficit appropriation.

For the second year in a row the DOM budget request was slightly over $1 billion, which represents about 18 percent of the total funds for the state appropriated by the Legislature each year. Only the budget for education is greater than ours.

All Medicaid programs receive matching dollars from the federal government known as the Federal Medical Assistance Percentage (FMAP). The FMAP varies by state, and Mississippi has the highest FMAP in the country at 74.17 percent. The FMAP increased to 74.17 percent on October 1, 2015. When combined with federal matching dollars, Medicaid's total projected expenditure for fiscal year 2017 is $6.143 billion, an amount nearly equal to the entire appropriated state budget for this coming year.

Developing and presenting the DOM budget to the Joint Legislative Budget Committee is a monumental task, and a great deal of hard work goes into it by those DOM offices which play an integral part in this process. This presentation is the first in a series of recommendations to elected officials who will decide how much Medicaid is appropriated during the 2016 legislative session in the spring.

DOM OBSERVES 50TH ANNIVERSARY OF LAW THAT CREATED MEDICAID

This summer marked 50 years since the enactment of the Social Security Amendments of 1965, which established the Medicare program for the elderly and the Medicaid program for certain vulnerable, low-income populations.

From the beginning, Medicaid has been a voluntary program and states are not required to participate. However, all 50 states, the District of Columbia and the five territories participate in Medicaid. Mississippi was one of the last states to decide to participate in the program. In 1969, a special session was called in late summer to deal with Medicaid participation and the recovery efforts from Hurricane Camille. As a result, enabling legislation was passed and funds were appropriated to the newly created Mississippi Medicaid Commission for this purpose.

The modern era of Medicaid in Mississippi began in 1984 with the passage of the Mississippi Administrative Reorganization Act. This legislation transferred the powers and responsibility of the Medicaid Commission to DOM in the Office of the Governor, making DOM the sole state agency designated to administer the Medicaid program.

While it's not quite the 50th anniversary for Mississippi's participation in the Medicaid program, the agency took time to research and do its part to preserve these historic events that transformed the delivery of health care in the United States.

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.

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.

NEWS

Mental Health Provider Enrollment Announcement

Effective January 1, 2016, Licensed Professional Counselors (LPCs) can submit an application to become an individual Mississippi Medicaid provider. LPCs will be allowed to provide Therapeutic and Evaluative Mental Health Services to Medicaid beneficiaries throughout the state.

The Envision website lists the application instructions and steps to become a Medicaid provider, required documentation and necessary forms. The provider may begin the enrollment process by completing the Mississippi Medicaid Provider Enrollment Application located at the following link: https://msmedicaid.acs-inc.com/msenvision/pef/Login.do.

If you have any questions about the enrollment application and/or process, contact a Xerox provider enrollment specialist toll-free at **800-884-3222**.

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. The information of your prior practice remains on your Medicaid provider file until you submit the required forms to change the addresses and your banking information.

If you change practice or affiliations, you should check your addresses and banking information on the file with Medicaid. Verifying the information on your 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 **888-495-8169** or can be mailed to the following address:

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

Once the update to your individual file has been completed, at any point that you bill claims on your individual number you will receive a paper check mailed to your billing address on file for two or three payment cycles. Ongoing, you will begin 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 provider. The Change of Address form can be faxed to Xerox Provider Enrollment at **888-495-8169** or 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 **800-884–3222**.
Note: If the 1099 address is being updated, a W9 will be required.

PROVIDER COMPLIANCE

ICD-10 Post Implementation Provider Resource Guide and Contact List

On October 1, 2015, the U.S. health care system and the Mississippi Division of Medicaid (DOM) transitioned to the International Classification of Diseases, 10th Revision – ICD-10. DOM is monitoring ICD-10 daily and, to date, it has been a successful implementation. We will remain proactive in tracking issues and making corrections as necessary. DOM is prepared and available to assist MS Medicaid providers to accurately resolve any issues they may be having with the ICD-10 transition. If these issues persist, the Centers for Medicare & Medicaid Services (CMS) has established an ICD-10 Ombudsman and ICD-10 Coordination Center, an impartial advocate with a dedicated team of experts, to provide additional assistance in tracking, triaging, and resolving issues.

Listed below are Resources to help you work through any issues:

MS DIVISION OF MEDICAID:

- For general information and helpful resources:
  - http://www.medicaid.ms.gov/preparing-for-the-international-classification-of-diseases-10th-edition-icd-10/
  - E-mail issues to: ICD10@medicaid.ms.gov
  - To contact DOM directly: **601-359-6150**

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS):

- For general ICD-10 information and helpful resources:
  - https://www.cms.gov/Medicare/Coding/ICD10index.html
  - http://www.roadto10.org/
- E-mail questions for the ICD-10 Ombudsman to: ICD10_Ombudsman@cms.hhs.gov. Responses are typically sent within 3 business days of receipt.

Attention All Nursing Facility Providers and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

BILLING REMINDER!

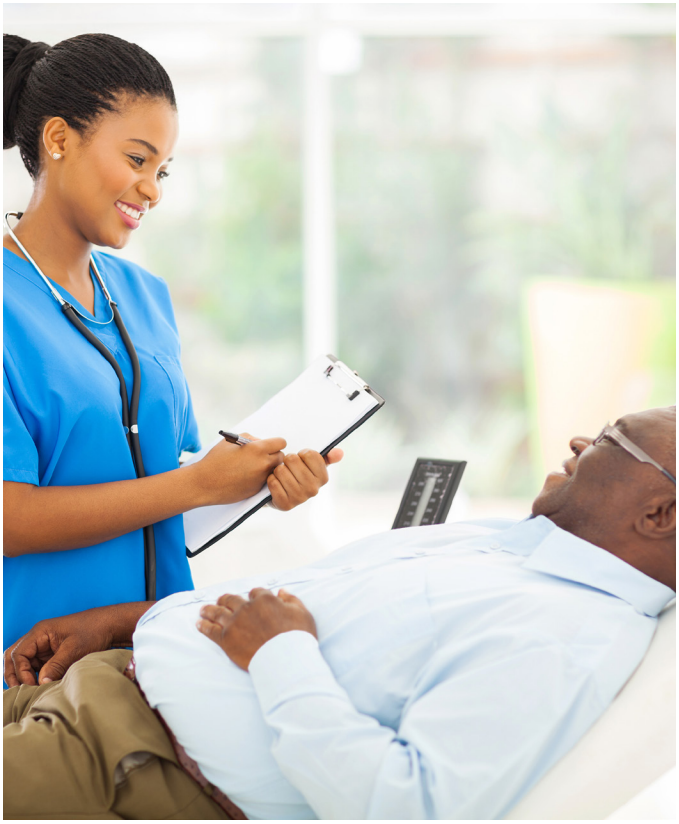
Nursing facilities and ICF/IID billing for bed hold inpatient days and/or therapeutic leave days should use the actual date span of the leave on the respective lines, when filing for those services.

If additional information is required, contact the Office of Long Term Care Institutional Division at **601-359-6141**.

Providers of Therapeutic and Evaluative (T&E) Mental Health Services for Children

Presentations from DOM's T&E Provider workshop held September 23, 2015, are available on eQHealth Solutions' website, under the Education tab, and may be accessed by clicking on the following link: http://ms.eqhs.org/Education.aspx.

After reviewing the presentations, if there are any questions and/or concerns regarding this information, you may contact Kimberly Evans at **601-359-3830**.



Healthier Mississippi Waiver

Effective July 24, 2015, Mississippi Division of Medicaid (DOM) secured a three-year extension of the Healthier Mississippi Waiver (HMW) Demonstration Program from the Centers for Medicare and Medicaid Services. The initial HMW demonstration was approved on October 1, 2004, and implemented January 1, 2006.

The HMW Demonstration operates statewide and provides coverage for individuals 65 years of age or older, or disabled with income at or below 135 percent of the Federal Poverty Level (FPL). Persons eligible for the HMW must not be eligible for Medicare and do not otherwise qualify for Medicaid.

The extension includes two important changes: The waiver now covers chiropractic, podiatry, dental, and vision services for eligible HMW beneficiaries. Additionally, the enrollment cap has increased from 5,500 to 6,000 beneficiaries.

All State Plan services are covered for beneficiaries enrolled in the HMW program except long-term care services (including nursing facilities and home and community based waivers), swing-bed in a skilled nursing facility and maternity and newborn care. For more information regarding HMW, please visit the DOM website at http://www.medicaid.ms.gov/ or contact the Office of Medical Services at **601-359-6150**.

Update on Immunization and Pregnancy: Tetanus, Diphtheria, and Pertussis Vaccination

On October 2011, the Advisory Committee on Immunization Practices (ACIP) recommended that unvaccinated pregnant women receive a dose of tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap). This recommendation did not include the use of Tdap during every pregnancy. On October 24, 2012, ACIP voted to recommend the use of Tdap during every pregnancy. New data indicates that maternal anti-pertussis antibodies are short-lived and Tdap vaccination in one pregnancy will not provide protection during subsequent pregnancies. The ACIP updated recommendations aim to optimize strategies for preventing pertussis morbidity and mortality in infants.

Vaccination of the mother during pregnancy should provide protection to the infant until the infant is old enough for vaccination. The Tdap vaccine stimulates development of maternal anti-pertussis antibodies, which pass through the placenta providing protection against pertussis to the infant. The vaccine should also protect the mother from pertussis around the time of delivery, which will make the mother less likely to become infected and transmit pertussis to her infant.

Currently, only 3.9% of pregnant Medicaid beneficiaries receive the Tdap vaccination during pregnancy. The Division of Medicaid (DOM) encourages providers to assist in efforts to increase protection and to minimize the significant burden of pertussis disease in vulnerable newborns.

DOM covers the Tdap vaccine for pregnant and postpartum beneficiaries when:

1. Administered to pregnant beneficiaries, during each pregnancy, twenty-seven (27) to thirty-six (36) weeks of the treating physician's expected date of delivery, **or**

2. Administered to a postpartum beneficiary immediately after delivery only if the beneficiary:
   a) Did not get a dose of a Tdap vaccine during her pregnancy, **and**
   b) Has never received a Tdap vaccine.

The Division of Medicaid does not reimburse a Tdap vaccine administration fee. Modifier TH must be reported to identify obstetrical treatment/services.

For more information regarding vaccine coverage, please refer to the DOM website at http://www.medicaid.ms.gov/ or contact the Office of Medical Services **601-359-6150**.

Attention Family Planning Waiver (FPW) Providers

Mississippi Division of Medicaid (DOM) updated the list of covered diagnosis codes for Family Planning Waiver (FPW) services to include the ICD-10 codes. Effective 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. All MS Medicaid enrolled providers must comply. ICD-9-CM codes will not be accepted for dates of service on or after October 1, 2015. The updated list of covered diagnosis and procedure codes are available on the Division of Medicaid website located at: http://www.medicaid.ms.gov/wp-content/uploads/2015/04/Family-Planning-Waiver-Procedure-Codes-2015.pdf.

Please submit questions related to ICD-10 to ICD10@medicaid.gov or contact the Office of Medical Services **601-359-6150**.

Centers for Medicare and Medicaid Services (CMS) renewed DOM's FPW on January 1, 2015. The FPW now includes coverage for males and females age 13-44 with family income at or below 194 percent of the Federal Poverty Level. FPW applicants must not have had a procedure that prevents them from reproducing. FPW applicants must not be covered under Medicare, CHIP or other health insurance. In addition to contraceptives, FPW now includes coverage for drugs to treat sexually transmitted infections (STI)/sexually transmitted diseases (STD) when prescribed as part of a family planning visit/treatment.

For more information regarding FPW drugs for the treatment of STI/STD, please refer to the DOM website at http://www.medicaid.ms.gov/family-planning-waiver-renewal-changes or contact the Office of Medical Services at **601-359-6150**.

Reminder: Dental Providers

The Division of Medicaid covers alveoloplasty as a separate procedure from extractions or in conjunction with extractions when there is a need for significant bone re-contouring in the quadrant to prepare the ridge for a prosthetic appliance if there:

A) Are three (3) or more tooth spaces present per quadrant, or three (3) or more teeth extracted per quadrant, or

B) Are less than three (3) tooth spaces present per quadrant, or less than three (3) teeth extracted per quadrant if prior authorized as medically necessary by the Utilization Management/Quality Improvement Organization (UM/QIO), or designee.

For more information regarding alveoloplasty coverage, please refer to the Administrative Code, Title 23: Part 204, Chapter 2, Rule 2.4 or contact the Office of Medical Services **601-359-6150**.

Reminder for Paper Claim Submissions

Providers who are unable to submit their claims electronically are encouraged to use the Mississippi Envision Web Portal for easy access to up-to-date information. The Envision 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/msenvision/.

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 www.medicaid.ms.gov/providers/billing-manual/.

Improving Claims Processing

The Division of Medicaid (DOM) is working to improve claims processing. DOM wants to ensure that every provider's claim is processed correctly and expeditiously. In order to improve this process, DOM request that providers:

1. Do not staple your claims together. Providers can simply place their attachments behind the associated claims and place them in an envelope.
2. Sign the claim in ink. The vast majority of the claims are Returned to the Provider (RTP) because they are not properly signed.
3. Submit requests for Medicaid payment on Crossover form. Providers should send claims with Medicare Explanation of Benefits (EOB) showing that payment has been received from Medicare.
4. List the Third Party Liability (TPL) payment in the appropriate field. For all claims submitted with TPL payments, the payment must be shown in the prior payments (UB-04) field and the amount paid in the (CMMS-1500) field on the claim.
5. Do not send a stack of claims and one copy of the attachment that goes with each claim. If there is an attachment that is critical to the processing of the claim, copy the attachment for each claim and place it with the associated claim before submitting those claims for processing.
6. Submit standard 8 x 11 attachments. Strips, cutouts and the like are not acceptable.
7. Put the bill date on each claim.
8. Place bill types on UB-04s and Crossover Part A forms.
9. Mail or electronically submit your claims. WE DO NOT ACCEPT FAXED CLAIMS.

All of the above will result in timely processing of your claims. We appreciate your time and cooperation with these matters. If you have any questions, please call Provider and Beneficiary Services are **1-800-884-3222** or **1-888-495-8169.**

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 1-800- 884-3222, if you have questions or need additional information.

Billing Tips to Avoid Duplicate Claims

The Division of Medicaid (DOM) and Xerox have noticed a pattern in duplicate claims submitted by providers. To ensure that each claim is paid in a timely manner, providers should implement the following tips to avoid unnecessary denials.

- Bill all procedures provided on the same date of service on the same claim.
- Providers are required to bill multiple units for the same procedure code (and modifier, if applicable) when more than one of the same procedure or service is provided on the same date of service.
- Providers should not bill the same procedure codes for the same date of service on separate claim lines.
- Separate claims for the same date of service are only necessary if you run out of claim lines.
- Do not re-bill the same claim repeatedly.
- If all claim lines on the claim were paid, billing the same claim again will result in denials for duplicate services and may be considered fraudulent.
- If claim lines are denied, read the edit messages listed at the bottom of the remittance advice. These messages tell why the claims denied. Always refer to Medicaid's Administrative Code, the Provider Billing Handbook and the Medicaid Fee Schedules for detailed information about what services and procedure codes are covered as well as applicable service limits.
- Incorrect billing may result in claim denials for duplicate procedures.
- If you think a claim line was denied in error, contact the Xerox Call Center at 1-800-884-3222. Call Center Representatives are available to review, explain and if appropriate, provide instruction on how to reverse the denial to have the payment processed accordingly.

Updates/Changes to your Medicaid Provider File

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

- Address
- Phone Number
- Fax
- Contact name
- E-mail 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.

Fax Number: 888-495-8169

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

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

PHARMACY

Preferred Drug List (PDL) Update, January 1, 2016

DOM's Preferred Drug List (PDL) undergoes an annual review each autumn. The revisions brought about by this annual review will become effective the following January 1st. The universal PDL is effective for Medicaid fee for service, MSCAN and CHIP beneficiaries.

To locate the current PDL, go to http://www.medicaid.ms.gov/providers/pharmacy/ and select the MS Preferred Drug document. To view the document in its entirety, see 'MS PDL Effective January 1, 2015.' To locate the preferred/non-preferred additions and deletions, see 'MS PDL Changes-Provider Notice, effective January 1, 2016.' We recommend adding this link to your favorites as you will find it very helpful.

Pharmacy Permit Renewal, Expiration December 31, 2015

MS Medicaid requires that providers are in good standing with their regulatory authorities. Pharmacists are required to update their provider information with license renewal information, received from the MS Board of Pharmacy, with Division of Medicaid's (DOM) fiscal agent or Xerox. Most MS pharmacy permits expire on December 31, 2015.

Fax all of the following renewal information to Xerox's Provider Enrollment at 1-888-495-8169:

- Cover sheet with name of pharmacy and/or pharmacy DME, MS Medicaid provider number(s), NPI(s), and a copy of the renewal(s).
- To assure that the information DOM has on hand is accurate, be sure to include the servicing pharmacy's e-mail address, telephone number and facsimile number on the cover sheet.
- Documents sent to DOM will be returned to the sender.

Please verify if your permit expires on December 31, 2015. Pharmacy claims may **deny** after December 31, 2015 ***IF*** license renewal information has not been submitted to Xerox.

Call Wait Times Decreased for Pharmacy Providers: Revised Xerox Automatic Voice Response System (AVRS)

The automatic voice response system (AVRS) has been revised for pharmacy providers. This change will allow for quicker entry into the Pharmacy queue and bypass other messaging which will greatly reduce wait times for pharmacies that need quick resolution on questions regarding Point-of-Sale (POS) claims. Pharmacy Providers may continue to use AVRs by following these steps:

1. **Dial** 1-800-884-3222
2. **Select Medicaid Provider – option 2**
3. **Select Pharmacy – option 1**
4. Enter your Medicaid Provider ID
5. Validate your Medicaid Provider ID
6. Call will be transferred

Please keep this guide handy for future reference.

Pharmacy Billing for Immunizations

In the MS Medicaid Pharmacy program, influenza, pneumonia, and zoster immunizations are covered services for Medicaid beneficiaries ages 19 and older who are not residents of long-term care facilities.

These are the only vaccines/immunizations available via the Pharmacy Program. A valid prescription for immunizations must be on file as with other pharmacy services. Immunizations provided from a credentialed pharmacist will count against the service limits and co-payments are applicable. MS Medicaid reimburses for the drug's ingredient cost and pays a dispensing fee for immunizations administered in the pharmacy venue. No administration fee is paid for immunizations administered in the pharmacy venue.

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

As of January 1, 2016, Varivax or Varicella vaccine will be added as a covered service for Medicaid beneficiaries ages 19 and older who are not residents of long-term care facilities.

Pharmacy Prior Authorization Forms

The Medicaid fee for service Pharmacy Prior Authorization format is being modified to include drug and/or disease state specific instructions with the actual prior authorization (PA) forms. The modified Medicaid fee for service (FFS) Pharmacy forms are located at medicaid.ms.gov/Pharmacy.aspx and click on Prior Authorization. The Pharmacy PA FAX line is **1-877-537-0720.**

DOM encourages Medicaid providers to use preferred agents whenever possible. Most preferred drugs do not require PA. Drugs designated as preferred have been selected for their efficaciousness, clinical significance, cost effectiveness, and safety for Medicaid beneficiaries.

Note that there are multiple preferred alternatives for non-preferred drugs. Before submitting a PA request, remember to check for options not requiring PA on the current PDL which is located at medicaid.ms.gov/Pharmacy.aspx.

Friendly Pharmacy Reminders

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

It is considered fraudulent billing to bill for a NDC other than the one administered and/or dispensed regardless if billed as a medical or pharmacy point of sale claim.

- ✓ Return to stock/reversals: If a beneficiary does not receive a drug within fifteen calendar days from the date that the prescription is filled, the pharmacy must reverse the claim and refund payment to MS Division of Medicaid (DOM). For additional information regarding DOM's policy on Pharmacy Return to Stock/Claims Reversals, refer to the Pharmacy Reference Guide.

- ✓ 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 an 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.

Drug Utilization Review

The Omnibus Reconciliation Act of 1990 (OBRA) mandated that each State establish a drug use review program by January 1, 1993. The Drug Utilization Review (DUR) Board evaluates standards of drug use in Mississippi Division of Medicaid's (DOM) drug program and is responsible for conducting both retrospective and prospective drug use reviews. The purpose of the DUR program is to improve the quality of pharmaceutical care by ensuring prescriptions are appropriate, medically necessary, and are not likely to cause adverse medical results.

The Mississippi Evidence-Based DUR Initiative (MS-DUR) performs the retrospective drug utilization review for Mississippi Division of Medicaid. Based on activities of the DUR Board and claims reviews, MS-DUR provides educational outreach to health care practitioners on drug therapy to improve prescribing and dispensing practices for DOM beneficiaries. The MS-DUR website , found at http://www.pharmacy.olemiss.edu/cpmm/msdurresourcesforproviders.html, has resources for providers, including the "Mississippi Medicaid Pharmacy Update" newsletters and special initiatives developed to assist providers in selecting therapy, like the "Medicaid Cough and Cold Quick List."We recommend adding this link to your favorites as you will find it very helpful.

Authorized generics

An "authorized generic drug" is a listed drug as defined in § 314.3 that has been approved under subsection 505(c) of the act and is marketed, sold, or distributed directly or indirectly to retail class of trade with either labeling, packaging (other than repackaging as the listed drug in blister packs, unit doses, or similar packaging for use in institutions), product code, labeler code, trade name, or trade mark that differs from that of the listed drug.

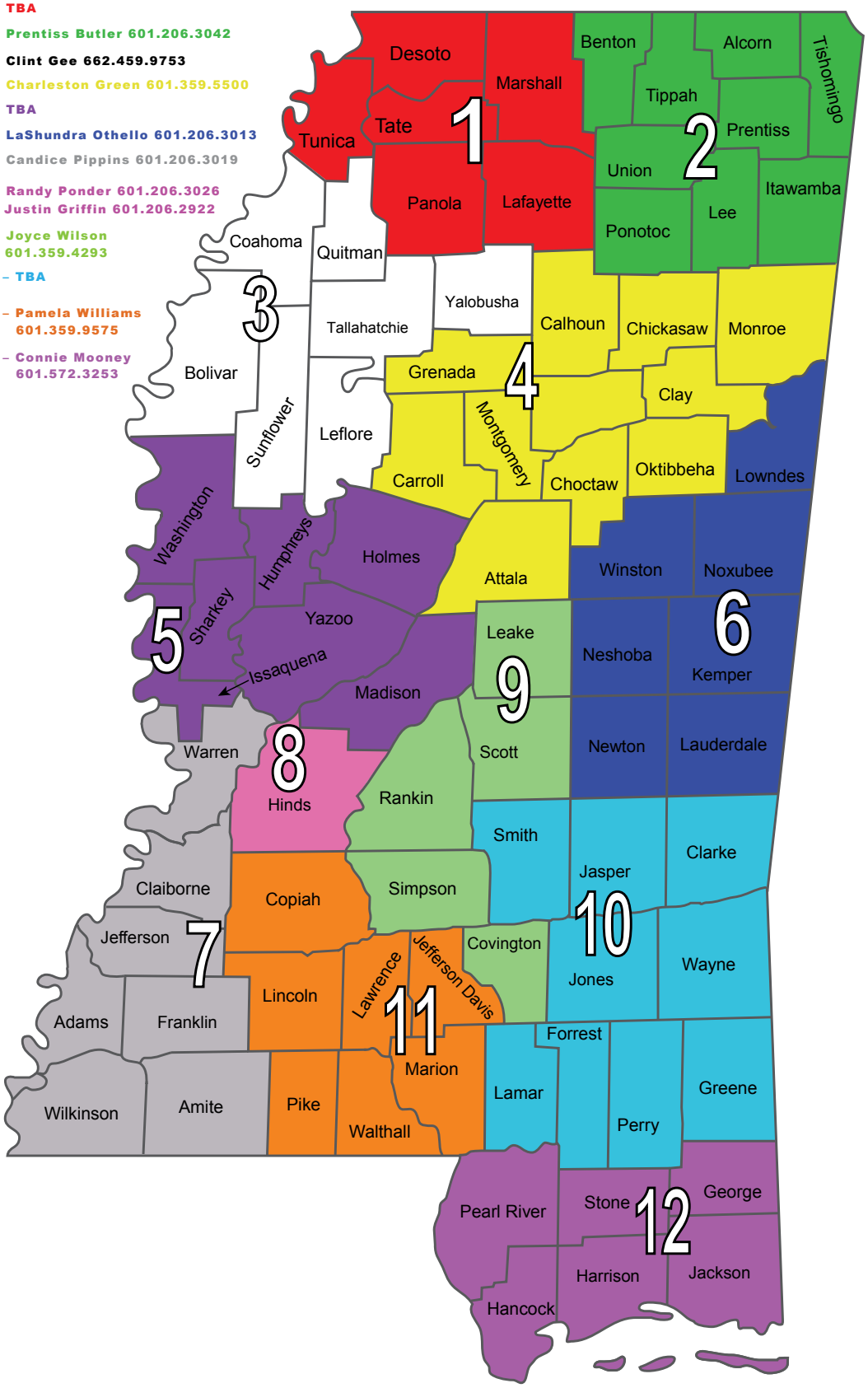
The term Authorized GenericsTM refers to prescription drugs that are produced by brand companies under a New Drug Application (NDA) and marketed as generics under private label. Because authorized generics offer Division Of Medicaid a better net price than non-authorized generic versions of a drug, Medicaid will designate some generics as preferred and others as non-preferred.

PROVIDER FIELD REPRESENTATIVES

PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY		
AREA 1 **To Be Announced (TBA)**	**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** **To Be Announced (TBA)**	**AREA 6** **LaShundra Othello (601.206.2996)** lashundra.othello@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 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 **To Be Announced (TBA)**	**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	**Jonathan Dixon (601.206.3022) jonathan.dixon@xerox.com**	

FIELD REPRESENTATIVE REGIONAL MAP

Area 1 – TBA
Area 2 – Prentiss Butler 601.206.3042
Area 3 – Clint Gee 662.459.9753
Area 4 – Charleston Green 601.359.5500
Area 5 – TBA
Area 6 – LaShundra Othello 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 – TBA
Area 11 – Pamela Williams 601.359.9575
Area 12 – Connie Mooney 601.572.3253



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

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. wish you a Happy Holidays

DECEMBER 2015

THURS, DEC. 3	EDI Cut Off – 5:00 p.m.
MON, DEC. 7	Checkwrite
THURS, DEC. 10	EDI Cut Off - 5:00 p.m
MON, DEC. 14	Checkwrite; Xerox New Provider Webinar
THURS, DEC. 17	EDI Cut Off - 5:00 p.m.
MON, DEC. 21	Checkwrite
THURS, DEC. 24	EDI Cut Off - 5:00 p.m.
MON, DEC. 28	Checkwrite
THURS, DEC. 31	EDI Cut Off - 5:00 p.m.

JANUARY 2016

MON, JAN. 4	Checkwrite
THURS, JAN. 7	EDI Cut Off – 5:00 p.m.
MON, JAN. 11	Checkwrite
THURS, JAN. 14	EDI Cut Off – 5:00 p.m.
MON, JAN. 18	Checkwrite
THURS, JAN. 21	EDI Cut Off – 5:00 p.m.
MON, JAN. 25	Checkwrite
THURS, JAN. 28	EDI Cut Off – 5:00 p.m.

FEBUARY 2016

MON, FEB. 1	Checkwrite
THURS, FEB. 4	EDI Cut Off – 5:00 p.m.
MON, FEB. 8	Checkwrite
THURS, FEB. 11	EDI Cut Off – 5:00 p.m
MON, FEB. 15	Checkwrite
THURS, FEB. 18	EDI Cut Off – 5:00 p.m.
MON, FEB. 22	Checkwrite
THURS, FEB. 25	EDI Cut Off – 5:00 p.m.
MON, FEB. 29	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.