WHAT'S NEW?

ATTENTION: All Providers
10/5/2022 10:20 a.m.

***Prior Authorization update for Physician Administered Drugs ***

Effective October 1, 2022, the Division of Medicaid (DOM) will require prior authorization (PA) of 4 additional physician administered drugs (PADs). The chart below reflects the PADs that will require PA. Alliant Health Solutions is responsible for authorization requests for fee-for-service (FFS) Medicaid beneficiaries. Please call Alliant directly at 1-888-224-3067 for assistance with the PA process for these 4 PADs.

Q2053 brexucabtagene autoleucel (Tecartus)

Indication	Infusion Bag NDC	Metal Cassette NDC
MCL	71287-0219-01	71287-0219-02
ALL	71287-0220-01	71287-0220-02

Q2054 lisocabtagene maraleucel (Breyanzi)

Product	NDC
Vial	73153-0900-01
CD8 Component	73153-0901-08
CD4 Component	73153-0902-04

Q2055 Idecabtagene vivleucel (Abecma)

Product	NDC
50 ml infusion bag and metal cassette	59572-0515-01
250 ml infusion bag and metal cassette	59572-0515-02
500 ml infusion bag and metal cassette	59572-0515-03

Q2056 ciltacabtagene autoleucel (Carvykti)

Product	NDC
70 ml infusion bag and metal cassette	57894-0111-01
30 ml infusion bag and metal cassette	57894-0111-02

WHAT'S NEW?

ATTENTION: All Providers
09/27/2022 10:20 a.m.

Claims Denial Edit 0001

The Division of Medicaid and its Fiscal Agent Conduent have completed work on several claim reprocessing projects. Please note that claims that normally would suspend were denied with new edit 0001-CLMS TO DENY IN ENVISION as part of this special project. These denials would have been noted on your RA dated September 26, 2022. Providers will need to resubmit denied claims and submit adjustments to any paid claim in the new MESA system after October 3, 2022. Thank you for your patience and understanding during this process as DOM transitions Fiscal Agent operations and services.

ATTENTION: All Providers
09/26/2022 09:22 a.m.

EDI Medical Claims can be Submitted to new Fiscal Agent Effective 9/23/2022

As part of the Mississippi Division of Medicaid's (DOM) transition to a new Fiscal Agent system, Electronic Data Interchange (EDI) medical claims can now be submitted to Gainwell Technologies effective September 23, 2022. Claims submitted between September 23, 2022, and October 3, 2022, will begin to be processed the week of October 3, 2022. Trading Partners can now access and enroll in the MESA Provider Portal at: **https://portal.MS-Medicaid-MESA.com/MS/Provider**. ***Providers are not required to enroll as a trading partner and can register for the portal beginning October 3, 2022.*** Please refer to the Division of Medicaid's website at https://medicaid.ms.gov/the-mississippi-medicaid-mmis-replacement-project/ for current information relating to the implementation of the new Medicaid Management Information System.

WHAT'S NEW?

ATTENTION: All Providers
09/22/2022 02:00 p.m.

Conduent to cease acceptance of all medical claims on Thursday, Sept. 22, 2022, as part of Fiscal Agent transition

In preparation for the Oct. 3 transition to a new Fiscal Agent, including a new provider portal known as MESA, the Mississippi Division of Medicaid (DOM) will cease the acceptance of all EDI medical claims submissions by the current Fiscal Agent, Conduent, at 5:00 p.m. CST on Thursday, Sept. 22, 2022.

- Previously, the acceptance of paper claims ceased on Monday, Sept. 12, 2022.
- The acceptance of claims submitted through Conduent's Provider Portal ceased at 5 p.m. CST on Wednesday, Sept. 21, 2022.

The acceptance of pharmacy point-of-sale (POS) claims will cease at 9 p.m. CST on Thursday, Sept. 29, 2022. (See our Sept. 15 notification regarding pharmacy POS claims at **https://medicaid.ms.gov/conduent-pharmacy-point-of-sale-claims-system-to-shut-down-on-thursday-sept-29-2022-as-part-of-fiscal-agent-transition)**

Conduent's Provider Portal will remain accessible for eligibility/claim status inquiries until 5 p.m. CST on Monday, Oct. 3, 2022.

Claims may be submitted through the new Provider Portal developed by Gainwell Technologies, known as MESA, beginning Monday, Oct. 3, 2022. More details will be shared soon on registering and accessing the new Provider Portal.

Thank you for your patience and understanding during this process as DOM transitions Fiscal Agent operations and services.

WHAT'S NEW?

ATTENTION: All Providers
08/30/2022 09:55 a.m.

Suspension of paper claims to take effect Sept. 12, 2022

In preparation for the Oct. 3 transition to a new Fiscal Agent, including a new provider portal known as MESA, the Mississippi Division of Medicaid (DOM) will suspend the acceptance of paper claims by the current Fiscal Agent, Conduent, on Sept. 12, 2022. Please note that claims submitted via Pharmacy Point of Sale, the current Provider Portal, and Electronic Data Interchange (EDI) will not be affected by this suspension date. The last date for submission of those claims will be communicated as soon as those details are finalized. Thank you for your patience and understanding during this transition period as DOM transitions Fiscal Agent operations and services.

ATTENTION: Pharmacy Providers
08/22/2022 02:45 p.m.

Effective July 1, 2022, the Mississippi Division of Medicaid (DOM) reestablished payment methods for the ingredient costs of prescription drugs that existed prior to the July 1, 2021 rate freeze. This change removed the freeze for dates of service on or after July 1, 2022. On **8/22/2022**, Conduent will begin adjusting claims with dates of service of 7/1/2021 through 6/30/2022 to reflect the ingredient **cost** of the drug in effect on the claim's date of service.

WHAT'S NEW?

ATTENTION: All Providers
08/19/2022 05:23 p.m.

The Division of Medicaid will be reprocessing paper claims that denied for edit 0118 (Medicare Allowed Amount Conflict). These paper claims will be manually reviewed to determine whether they meet the Division of Medicaid's policy criteria for payment. DOM will reprocess claims that denied from August 1, 2021, through May 15, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION: Notice to Pharmacy Providers
08/19/2022 02:00 p.m.

Effective July 1, 2022, the Mississippi Division of Medicaid (DOM) reestablished payment methods for the ingredient costs of prescription drugs that existed prior to the July 1, 2021 rate freeze. This change removed the freeze for dates of service on or after July 1, 2022. On 8/22/2022, Conduent will begin adjusting claims with dates of service of 7/1/2021 through 6/30/2022 to reflect the ingredient cost of the drug in effect on the claim's date of service.

ATTENTION: ALL PROVIDERS – NCCI 2nd Quarter 2022 files
08/19/2022 01:41 p.m.

In accordance with Section 6507 of the Patient Protection and Affordable Care Act, the Division of Medicaid (DOM) utilizes National Correct Coding Initiative (NCCI) methodologies in claims processing. CMS issues replacement files for the NCCI 2nd quarter 2022 Edit files. DOM will reprocess claims for dates of service April 1st, 2022, through April 20th, 2022. The mass adjustment will appear on your remittance advice dated August 22, 2022. No further action on the part of the provider is needed. If you have questions, please Contact Provider and Client relations at 1-800-884-3222.

ATTENTION: Private Duty Nursing Providers - Updated CMN Form
08/11/2022 10:00 a.m.

The Division of Medicaid (DOM), in collaboration with Alliant Health Solutions, revised the Private Duty Nursing (PDN) and Personal Care Service (PCS) certificate of medical necessity (CMN) form. The new form will be effective September 1, 2022 and is located on Alliant's website (https://ms.allianthealth.org/). PDN and PCS services are for early and periodic screening, diagnosis, and treatment (EPSDT) eligible beneficiaries, when medically necessary and prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO). Failure to obtain prior authorization will result in denial of payment. Please call Alliant with questions about the new CMN for FFS beneficiaries 1-888-224-3067.

WHAT'S NEW?

ATTENTION: EPSDT Providers
08/05/2022 03:37 p.m.

The Division of Medicaid (DOM) will reprocess claims for dates of service July 1, 2015, through June 13, 2022, that incorrectly denied for Edit 3711 - PHYS ASSESSMENT PREV PD EPSDT ONLY. DOM will also reprocess claims for dates of service September 1, 2021, to June 13, 2022, that were paid incorrectly and should have denied for Edit 3711 - PHYS ASSESSMENT PREV PD EPSDT ONLY. The mass adjustment will appear on your remittance advice dated August 8, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222

ATTENTION: All Providers
08/03/2022 12:50 p.m.

IMMEDIATE ACTION REQUIRED

Medicaid Providers must follow instructions for EDI registration and testing to prepare for new Provider Portal

The Mississippi Division of Medicaid (DOM) is in the process of implementing a new Medicaid Management Information System (MMIS) – which will include a new **Provider Portal** – known as MESA: Medicaid Enterprise System Assistance. The new system, going live at the beginning of October, is being developed by Gainwell Technologies.

Before switching over to the new system, **every Medicaid-enrolled provider, clearing house or billing services vendor that currently submits electronic data transactions (for example, filing claims) to DOM must undergo Electronic Data Interchange (EDI) registration and testing with Gainwell Technologies.** This process for ensuring the secure transmission of electronic information is required of all states when implementing a new system.

Medicaid providers are asked to identify their designated staff member, someone who is already involved in the submission of claims or other electronic transactions within the current provider portal, and direct them to this page on DOM's website:

https://medicaid.ms.gov/electronic-data-interchange-edi-testing/

This also applies to any trading partner or billing services vendor that submits claims on behalf of a provider.

The website provides step-by-step instructions and supporting materials on how to register as a trading partner through an online portal and test electronic transactions. **Providers are asked to begin this process as soon as time allows.**

If providers have any questions about which representatives should be designated to follow these steps, please contact Gainwell's Help Desk at:
MS_EDI_Helpdesk@gainwelltechnologies.com

WHAT'S NEW?

ATTENTION: All Providers
07/22/2022 10:28 a.m.

Announcement of MESA Workshop Webinars and Registration Details

As part of the Mississippi Division of Medicaid's (DOM) transition to a new Medicaid Management Information System (MMIS), we are excited to announce a series of workshop webinars will be available in August and September to train providers in how to use the new system, MESA: Medicaid Enterprise System Assistance.

Details about those webinars and instructions on how to register for them can be found on Gainwell Technology's new Learning Management System (LMS), which is now available online.

Only current Medicaid-enrolled providers will be able to access the LMS and register for trainings (the webinars are not intended for CHIP-only providers). In order to verify your status as a Medicaid provider, you are asked to:

Please only send us the current (Conduent/Envision) Medicaid Provider ID Number and email address for the individuals that you would like to attend the trainings to the following: **ms_provider.inquiry@mygainwell.onmicrosoft.com**.

- Please include "LMS Registration" in the email subject line. We will use this information to validate your participation in the Mississippi Medicaid program.
- Once validated we will then send LMS registration instructions which will include the link and registration key for accessing the LMS.
- The instructions will also include how to sign up for the upcoming workshop webinars in August and September.

Additionally, there will be Computer Based Trainings (CBTs) available beginning Aug. 1, 2022. We recommend you review these CBTs prior to the MESA go-live date of Oct. 3, 2022.

Providers can also learn more about MESA and find the latest updates and FAQs on the system implementation on DOM's website at **https://medicaid.ms.gov/about/the-mississippi-medicaid-mmis-replacement-project/**.

WHAT'S NEW?

ATTENTION: All Providers
07/19/2022 9:10 a.m.

Su**spension of Provider Enrollments**

The Mississippi Division of Medicaid (DOM) requests that all providers currently planning to enroll as a Mississippi Medicaid Provider submit their application and all supporting documentation no later than **August 15, 2022.** DOM must temporarily suspend application processing on August 15th in preparation for the October 3rd launch of the agency's new MMIS, known as MESA: Medicaid Enterprise System Assistance, which will replace Envision. Applications previously received that are incomplete on August 16th will be denied and will require submission of a new enrollment application. Beginning October 3, 2022, providers can utilize a new and improved provider portal with upload functionality for supporting documentation eliminating the necessity for paper applications. Thank you for your patience and understanding during this transition period as the Division transitions Fiscal Agent operations and services.

WHAT'S NEW?

ATTENTION: Hospice Providers
06/22/2022 9:52 a.m.

Reminder about 90-Day Election Periods

The hospice benefit is limited to two 90-day election periods during an individual's lifetime, in accordance with Administrative Code Part 205. An individual may elect to receive hospice care during an initial 90-day period and a subsequent 90-day period, followed by an unlimited number of 60-day periods. To ensure the Mississippi Division of Medicaid (DOM) follows the federal requirement, hospice providers who are uncertain if a beneficiary has received hospice services in the past should contact the DOM's Office of Medical Services to verify the appropriate benefit election period for the beneficiary. This does not apply to dual eligible beneficiaries.

Questions concerning Hospice benefit periods should be directed to the Office of Medical Services at (601) 359-6150.

ATTENTION: All DME Providers
06/22/2022 8:04 a.m.

Updates for Certain Wheelchair Codes

In October of 2021 DOM advised Durable Medical Equipment (DME) providers to begin utilizing the most appropriate Healthcare Common Procedure Coding System (HCPCS) codes when submitting authorization requests and claims for wheelchairs or wheelchair accessories. At that time, the Division of Medicaid (DOM) was unable to update the DME Fee Schedule which resulted in the list of wheelchair K-codes as a temporary workaround that was placed on DOM's Provider Resources page under "Medical Services".

The status of these codes has been changed to open in DOM's claims processing system and no longer require Manual Paper Claim processing. The list of HCPCS wheelchair and wheelchair accessory K-codes may be used in addition to existing wheelchair/wheelchair accessory codes already open for coverage on DOM's DME Fee Schedule. Requests must be reviewed and approved for medical necessity by DOM's Utilization Management and Quality Improvement Organization (UM/QIO), Alliant Health Solutions.

The list includes the rate at which DOM will reimburse each code. Those HCPCS codes with "MP" will be manually priced in accordance with the payment methodology outlined in the DOM State Plan, Attachment 4.19-B Exhibit A, VII. Durable Medical Equipment. Questions should be directed to the Office of Medical Services at 601-359-6150.

WHAT'S NEW?

ATTENTION: ARPA HCBS 1915(c) Waiver Direct Care Workforce One Time Supplemental Payment Announcement
06/16/2022 2:28 p.m.

The Mississippi Division of Medicaid (DOM) will be issuing one-time supplemental payments to eligible 1915(c) Home and Community Based Services (HCBS) Direct Care Workforce providers to increase access to HCBS by stabilizing and strengthening the HCBS workforce and building provider capacity to meet the needs of individuals receiving HCBS in these programs. This opportunity is possible through federal savings available under Mississippi's American Rescue Plan Act (ARPA) Section 9817 HCBS Spending Plan and authorized through a CMS approved Appendix K. More information on the Spending Plan and the One Time Payment is available at https://medicaid.ms.gov/american-rescue-plan-act-hcbs-enhancement-opportunities/.

Completed attestations must be emailed to DOM at LTSSPrograms@medicaid.ms.gov no later than 8/15/2022 to receive a supplemental payment.

ATTENTION: Attention Pharmacy Providers
(DME or Pharmacy Disease Management Providers ARE NOT included)
06/15/2022 8:13 a.m.

There will be a point of sale (POS) system outage on Saturday, Jun 18th from 11:00PM CT until Sunday, Jun 19th 5:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 5:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

ATTENTION: Attention All Outpatient Hospital Providers!
06/10/2022 8:00 a.m.

The Division of Medicaid will reprocess claims for dates of service July 1, 2020 through February 23, 2021 to correct certain Outpatient Prospective Payment System (OPPS) fees. The mass adjustment will appear on your remittance advise dated June 13, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION: Attention MYPAC Providers
05/26/2022 4:15 p.m.

The Mississippi Division of Medicaid will reprocess MYPAC claims for dates of service July 1, 2021 through February 15, 2022 where the per diem rate for code H0037 was revised from $214 to $241. The mass adjustment will appear on your remittance advice dated May 30, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

ATTENTION: ALL PROVIDERS
05/26/2022 02:56 p.m.

Physician Administered Drug PA Requirement

J1426 - Amondys 45 to require Prior Authorization

Effective July 1, 2022, the Division of Medicaid (DOM) will require prior authorization (PA) of the following physician administered drug (PAD):

Amondys 45 - J1426, Injection, casimersen, 10 mg

Alliant Health Solutions is responsible for authorization requests for fee-for-service (FFS) Medicaid beneficiaries. Please refer to Alliant Health Solutions' provider portal at: https://ms.allianthealth.org/, or call Alliant directly at 1-888-224-3067 for assistance. Providers are encouraged to register with Alliant to submit authorization requests via the Alliant web-portal https://ms.allianthealth.org/.

For billing issues, call Conduent Provider and Beneficiary Services at 800-884-3222

ATTENTION: ALL PROVIDERS
05/23/2022 08:01 a.m.

UnitedHealthcare – Prior authorization and clinical decision letters going paperless

Beginning **May 20, 2022,** UnitedHealthcare will no longer mail prior authorization and clinical decision letters to providers. Instead, providers will be able to view them 24/7 through the UnitedHealthcare Provider Portal or an Application Programming Interface (API) system-to-system data feed. This change will affect network medical health care professionals (primary and ancillary).

The following letter types are going paperless:
Pre-service/prior authorization decision letters
Inpatient review letters, including concurrent, retrospective, length of stay and level of care
Extension for lack of clinical information letters
Complex care management and OrthoNet letters available in Document Library

Exceptions: You can request an exception if you do not have access to high-speed internet or have an approved exception from the Centers for Medicare & Medicaid Services (CMS) by contacting Provider Services at **877-743-8734,** TTY/RTT **711,** 7 a.m.–5 p.m. CT, Monday–Friday
Below are helpful UnitedHealthcare websites:
https://www.uhcprovider.com/digital
https://www.uhcprovider.com/en/resource-library/link-provider-self-service/paperless-delivery.html
https://www.uhcprovider.com/en/admin-guides.html

WHAT'S NEW?

ATTENTION: ALL PROVIDERS - Max units for CPT/HCPCS Codes aligned with MEDICAID NCCI MUEs

05/06/2022 08:16 a.m.

In accordance with Section 6507 of the Patient Protection and Affordable Care Act, the Division of Medicaid utilizes National Correct Coding Initiative (NCCI) methodologies in claims processing. The Division of Medicaid has aligned max units of all applicable CPT/HCPS codes with Medicaid NCCI MUEs. The effective date of this change is July 1, 2020; the Division has reprocessed all claims to align with the effective date of the change. The mass adjustment will appear on your remittance advice dated May 9, 2022. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary services at 1-800-884-3222.

ATTENTION: ALL PROVIDERS - NCCI 1st Quarter 2022 Replacement

05/06/2022 08:07 a.m.

In accordance with Section 6507 of the Patient Protection and Affordable Care Act, the Division of Medicaid (DOM) utilizes National Correct Coding Initiative (NCCI) methodologies in claims processing. CMS issues replacement files for the NCCI 1st quarter 2022 Edit files. DOM will reprocess claims for dates of service January 1, 2022, through February 23, 2022. The mass adjustment will appear on your remittance advice dated May 9, 2022. No further action on the part of the provider is needed. If you have questions, please Contact Provider and Client relations at 1-800-884-3222.

ATTENTION: Outpatient Hospital/Mental Health Providers

04/20/2022 11:24 a.m.

PA Required for All Outpatient Hospital Mental Health Services

Effective May 1, 2022, Title 23, Part 202: Hospital Services, Chapter 2: Outpatient Hospital, Rule 2.6: Mental Health Services is being revised to reflect the requirement for prior authorization of all mental health services provided in the outpatient hospital setting.

Please contact Kimberly Evans or Charlene Craft at 601-359-9545, should you have questions.

ATTENTION: Psychiatric Residential Treatment Facility/Mental Health Providers

04/20/2022 11:24 a.m.

Minor Corrections to Language in Rule 4.9: Treatment Planning

Effective May 1, 2022, Title 23, Part 207: Institutional Long-Term Care, Chapter 4: Psychiatric Residential Treatment Facilities, Rule 4.9: Treatment Planning is being revised to reflect minor corrections, including corrections to correspond with the MS Department of Health Minimum Standards. In addition, the lifting of the rate freeze will be effective on the same date.

Please contact Kimberly Evans or Charlene Craft at 601-359-9545, should you have questions.

WHAT'S NEW?

ATTENTION: CPT code 78431 - add Z1 General Fee and TC Technical Components for Coverage Effective 1/1/2020.
03/25/2022 07:35 a.m.

The Mississippi Division of Medicaid will reprocess claims for dates of service January 1, 2020 through September 18, 2020. The mass adjustment will appear on your remittance advice dated March 28, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION: Professional Component Fee for CPT Code 70547
03/25/2022 07:35 a.m.

The Division of Medicaid will reprocess claims for dates of service July 01, 2018 through August 12, 2019 due to the professional component of CPT code 70547 not being loaded in the claims processing system. The mass adjustment will appear on your remittance advice dated March 28, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION: All Providers-NCCI 4th Quarter 2021 Replacement
03/24/2022 04:17 p.m.

In accordance with section 6507 of the Patient Protection and Affordable Care Act, the Division of Medicaid utilizes National Correct Coding Initiative (NCCI) methodologies in claims processing. CMS issued replacement files for the NCCI 4th quarter 2021 Edit Files. The Mississippi Division of Medicaid will reprocess claims for dates of service October 1, 2021, through November 22, 2021. The mass adjustment will appear on your remittance advice dated March 28, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

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

WHAT'S NEW?

ATTENTION: All Providers-Reporting COVID-19 Related Services
03/24/2022 01:49 p.m.

Effective immediately, the Division of Medicaid (DOM) is asking providers to add the CR modifier to the CMS-1500 billing form to identify COVID-19 related services. The use of the CR modifier is strictly for reporting purposes and should only be used on COVID-19 related claim lines.

Guidance regarding COVID Vaccine Counseling for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Eligible Beneficiaries

DOM covers current procedural terminology (CPT) code 99401-Counseling and/or Risk Factor for EPSDT beneficiaries. DOM advises providers to use CPT code 99401 billed with modifier CR, to identify vaccine counseling was rendered specifically for the COVID-19 vaccine. All CPT billing rules apply, as well as guidelines for Bright Futures Coding for Pediatric Preventive Care, which indicates CPT code 99401 cannot be billed with preventive medicine service codes (99381-99385 and 99391-99395).

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

ATTENTION: Hospital Providers
03/24/2022 04:17 p.m.

The Division of Medicaid will reprocess claims for dates of service January 1, 2017 through May 10, 2017, for claims related to the global package history claim check. The Mass Adjustment will appear on your remittance advice dated March 28, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION: Effective Date Changed to 1/27/2020 on HCPCS Code G2025 for Medicare Crossover Claims
03/24/2022 04:17 p.m.

The Division of Medicaid will reprocess Medicare Crossover claims for dates of service January 27, 2020 through July 1, 2020 due to change in effective date for HCPCS G2025. The mass adjustment will appear on your remittance advice dated March 28, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

ATTENTION: Hospice Provider Training Webinar on March 23, 2022

03/17/2022 11:01 a.m.

The Division of Medicaid (DOM), Alliant Health Solutions, and DOM's Coordinated Care Organizations (CCOs) will host a live provider training webinar on **March 23, 2022,** beginning at 9:00 AM for all Hospice providers. The purpose of this training session is to provide up-to-date and real-time information to Hospice providers, while offering an opportunity for providers to ask questions and seek clarity for the Hospice review process.

All hospice providers, including physicians, administrators, directors, managers, billing departments, and other staff involved in the delivery, management, and coordination of hospice care are encouraged to attend this session. A registration email invitation was sent by Alliant Health Solutions on Thursday, March 10th and the registration link is provided below. Please make plans to attend this important training opportunity.

Registration Link: Hospice Provider Updates and Training Webinar

Questions concerning the virtual training webinar can be directed to the Office of Medical Services at (601) 359-6150.

ATTENTION: ALL PROVIDERS

03/14/2022 03:15 p.m.

The Division of Medicaid (DOM) is aware of the issues related to claims denying for denial Edit #0118. We are diligently working to resolve these issues. Providers will be notified if/when a Mass Adjustment will be completed to reprocess claims denied in error. Thank you for your patience during this process.

ATTENTION: NOTICE TO PHARMACY PROVIDERS ONLY

(DME or Pharmacy Disease Management Providers ARE NOT included)
03/10/2022 04:15 p.m.

There will be a point of sale (POS) system outage on Saturday, Mar 12th from 11:00PM CT until Sunday, Mar 13th 5:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 5:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

WHAT'S NEW?

ATTENTION: Pediatric Providers

03/03/2022 09:48 a.m.

In October 2021, the Centers for Disease Control and Prevention (CDC) decreased the Blood Lead Reference Value (BLRV) to ≥3.5µg/dL. With this decrease, CDC has provided state Lead Poisoning Prevention and Healthy Homes Programs with additional guidance for follow-up and case management of children based on initial screening Capillary and Confirmed Venous Blood Lead Levels (BLLs).

Effective **March 1, 2022**, the Mississippi State Department of Health will begin implementing the new BLRV and CDC recommendations for follow-up below.

Capillary Blood Lead Level*	Time to Confirm with Venous
≥3.5-9 µg/dL	Within 3 months
10-19 µg/dL	Within 1 month
20-44 µg/dL	Within 2 weeks
≥45 µg/dL	Within 48 hours

**Any child identified with a capillary lead level of ≥3.5µg/dL, must receive a confirmatory venous in the time frame shown above based on the blood lead level (BLL).*

Based on the confirmatory venous result, a follow-up venous BLL test should be done according to the time frame shown below based on the BLL.

Confirmatory Venous Blood Lead Level	Follow-up Venous Testing
≥3.5-9 µg/dL	3 months**
10-19 µg/dL	1-3 months**
20-44 µg/dL	2 weeks – 1 month
≥45 µg/dL	As soon as possible

***Some providers may choose to repeat blood lead tests on all new patients within a month to ensure the BLL is not rising more quickly than anticipated.*

WHAT'S NEW?

In addition to the confirmatory testing and follow-up guidelines, there is specific anticipatory guidance providers should follow based on the confirmed venous blood lead level.

3.5-19µg/dL	20-44µg/dL	≥45µg/dL
Report test to MS Lead Poisoning Prevention and Healthy Homes Program (LPPHHP) 6612.pdf (ms.gov) Perform routine assessment of physical and mental development per AAP guidelines and nutrition assessment Perform structured developmental screenings at child health maintenance visits (*Note: Lead's effect on development may manifest over years.*) Ensure iron sufficiency via testing and treatment per AAP guidelines Provide nutritional counseling related to calcium and iron intake Provide anticipatory guidance about common sources of environmental lead exposure Make referral for family support based on BLL: BLL ≥10 µg/dL refer to Early Intervention BLL ≥15 µg/dL refer for home visit and environmental assessment F/U BLL monitoring within timeline (*See chart above.*)	Report test to MS LPPHHP Follow recommendations for BLL 3.5-19 µg/dL and: • Complete history and physical exam assessing for signs and symptoms related to lead • Consider obtaining an abdominal X-ray to evaluate for lead-based paint chips and other foreign bodies • Contact UMMC Poison Control Center for guidance • F/U BLL monitoring within timeline (*See chart above.*) and continue routine assessment of physical and mental development, including structured developmental screenings at child health maintenance visits (*Note: Lead's effect on development may manifest over years.*), per AAP/Bright Futures guidelines, anticipatory guidance, and nutrition counseling	Report test to MS LPPHHP Follow recommendations for BLL 20-44 µg/dL and: • Complete history and physical exam including detailed neurological exam • Obtain abdominal X-ray to evaluate for lead-based paint chips and other foreign bodies and initiate bowel decontamination, if indicated • Contact UMMC Poison Control Center for guidance • F/U BLL monitoring within timeline (*See chart above.*) and continue routine assessment of physical and mental development, including structured developmental screenings at child health maintenance visits (*Note: Lead's effect on development may manifest over years.*), per AAP/Bright Futures guidelines, anticipatory guidance, and nutrition counseling

Please contact the MS State Department of Health Lead Poisoning Prevention and Healthy Homes Program at 601 -576-7447 if there are questions or concerns about the information shared above.

WHAT'S NEW?

ATTENTION: All Providers

02/24/2022 04:30 p.m.

The Division of Medicaid will reprocess Family Planning Waiver claims for dates of service January 01, 2018 through August 31, 2021 due to a change from Federal Fiscal Year to Calendar Year. The mass adjustment will appear on your remittance advice dated February 28, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION: Mississippi Youth Program Around the Clock (MYPAC) Providers

02/24/2022 11:53 a.m.

Effective July 1, 2021, HCPCS) code H0037 – Community Psychiatric Supportive Treatment Program will be reimbursed at a rate of $241.00.

This rate change is effective for dates of service on or after July 1, 2021. The Division of Medicaid will reprocess fee-for service (FFS) claims for H0037 for dates of service beginning July 1, 2021 to February 15, 2022. The mass adjustment will appear on your admittance at a future date. No further action on the part of the provider is needed. Providers will need to resubmit impacted FFS claims for dates of service on and after February 16, 2022.

The Coordinated Care Organizations (CCO) will be updating their claims system to reimburse at the rate of $241 retroactive to July 1, 2021, and will reprocess claims. For further information regarding the reprocessing of claims, please contact each CCO.

If you have questions, please contact Penelope Hall at Penelope.Hall@medicaid.ms.gov or Kimberly.Sartin-Holloway@medicaid.ms.gov or call the Office of Mental Health at 601-359-9545.

WHAT'S NEW?

ATTENTION: All Providers

02/18/2022 03:32 p.m.

UPDATED Physician Administered Drugs PA List

Certain Physician Administered Drugs will require Prior Authorization

Effective February 14, 2022, the Division of Medicaid (DOM) will require prior authorization (PA) of physician administered drugs (PADs). The chart below reflects the PADs that will require PA. Alliant Health Solutions is responsible for authorization requests for fee-for-service (FFS) Medicaid beneficiaries. Please refer to Alliant Health Solutions' provider portal at: https://ms.allianthealth.org/, or call Alliant directly at 1 -888-224-3067 for assistance. Providers are encouraged to register with Alliant as soon as possible to submit authorization requests via the Alliant web-portal https://ms.allianthealth.org/.

For billing issues, call Conduent Provider and Beneficiary Services at 800-884-3222.

Code	Drug Brand Name	Long Description	Generic Name	Min Age	Max Units	PA Required Effective Date
J9042	Adcetris	Injection, brentuximab vedotin, 1 mg	brentuximab vedotin	18	200	2/14/2022
J0172	Aduhelm	Injectin, aducanumab-avwa, 2 mg	aducanumab-avwa	18	795	2/14/2022
J1931	Aldurazyme	Injection, laronidase, 0.1 mg	laronidase	0	377	2/14/2022
J9305	Alimta	Injection, pemetrexed, not otherwise specified, 10 mg	pemetrexed	0	150	2/14/2022
J9035	Avastin	Injection, bevacizumab, 10 mg	bevacizumab	0	170	2/14/2022
J9023	Bavencio	Injection, avelumab, 10 mg	avelumab	18	140	2/14/2022
J0597	Berinert	Injection, c-1 esterase inhibitor (human), berinert, 10 units	c1 esterase inhibitor	0	250	2/14/2022
J9229	Besponsa	Injection, inotuzumab ozogamicin, 0.1 mg	inotuzumab ozogamicin	18	1	2/14/2022
J0585	Botox	Injection, onabotulinumtoxina, 1 unit	onabotulinumtoxina	2	600	2/14/2022
J1786	Cerezyme	Injection, imiglucerase, 10 units	imiglucerase	0	680	2/14/2022
J2786	Cinqair	Injection, reslizumab, 1 mg	reslizumab	18	500	2/14/2022
J0598	Cinryze	Injection, c-1 esterase inhibitor (human), cinryze, 10 units	c1 esterase inhibitor	0	100	2/14/2022

WHAT'S NEW?

UPDATED Physician Administered Drugs PA List (continued)...

Code	Drug Brand Name	Long Description	Generic Name	Min Age	Max Units	PA Required Effective Date
J9308	Cyramza	Injection, ramucirumab, 5 mg	ramucirumab	18	280	2/14/2022
J9145	Darzalex	Injection, daratumumab, 10 mg	daratumumab	18	240	2/14/2022
J9144	Darzalex Faspro	Injection, daratumumab, 10 mg and hyaluronidase-fihj	daratumumab-hyaluronidase-fihj	18	255	2/14/2022
J1743	Elaprase	Injection, idursulfase, 1 mg	idursulfase	0	66	2/14/2022
J9358	Enhertu	Injection, fam-trastuzumab deruxtecan-nxki, 1mg	fam-trastuzumab deruxtecan-nxki	18	1018	2/14/2022
J3380	Entyvio	Injection, vedolizumab, 1 mg	vedolizumab	18	300	2/14/2022
J1428	Exondys-51	Injection, eteplirsen, 10 mg	eteplirsen	0	450	10/1/2019
J0517	Fasenra	Injection, benralizumab, 1 mg	benralizumab	12	1	2/14/2022
J9307	Folotyn	Injection, pralatrexate, 1 mg	pralatrexate	0	60	2/14/2022
J9301	Gazyva	Injection, obinutuzumab, 10 mg	obinutuzumab	18	100	2/14/2022
J9173	Imfinzi	Injection, durvalumab, 10 mg	durvalumab	18	150	2/14/2022
J9043	Jevtana	Injection, cabazitaxel, 1 mg	cabazitaxel	0	60	2/14/2022
J9354	Kadcyla	Injection, ado-trastuzumab emtansine, 1 mg	ado-trastuzumab emtansine	18	600	2/14/2022
Q5117	Kanjinti	Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg	trastuzumab-anns	18	120	2/14/2022
J9271	Keytruda	Injection, pembrolizumab, 1 mg	pembrolizumab	18	400	2/14/2022
J2507	Krystexxa	Injection, pegloticase, 1 mg	pegloticase	8	8	2/14/2022

WHAT'S NEW?

UPDATED Physician Administered Drugs PA List (continued)...

Code	Drug Brand Name	Long Description	Generic Name	Min Age	Max Units	PA Required Effective Date
Q2042	Kymriah	Tisagenlecleucel , up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	tisagenlecleucel	0	1	10/1/2019
J0202	Lemtrada	Injection, alemtuzumab, 1 mg	alemtuzumab	18	12	2/14/2022
J9119	Libtayo	Injection, cemiplimab-rwlc, 1 mg	cemiplimab-rwlc	18	350	2/14/2022
J0221	Lumizyme	Injection, alglucosidase alfa, (lumizyme), 10 mg	alglucosidase alfa	8	250	2/14/2022
A9513	Lutathera	Lutetium lu 177, dotatate, therapeutic, 1 millicurie	lutetium lu 177, dotatate	18	200	2/14/2022
J3398	Luxturna	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes	voretigene neparvovec-rzyl	1	1	10/1/2019
J9349	Monjuvi	Injection, tafasitamab-cxix, 2 mg	tafasitamab-cxix	18	954	2/14/2022
J2562	Mozobil	Injection, plerixafor, 1 mg	plerixafor	0	48	2/14/2022
Q5107	Mvasi	Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg	bevacizumab-awwb	18	170	2/14/2022
J2506	Neulasta	Injection, pegfilgrastim, excludes biosimilar, 0.5 mg	pegfilgrastim	0	12	2/14/2022
J2182	Nucala	Injection, mepolizumab, 1 mg	mepolizumab	6	300	2/14/2022
J2350	Ocrevus	Injection, ocrelizumab, 1 mg	ocrelizumab	18	1	2/14/2022
J9266	Oncaspar	Injection, pegaspargase, per single dose vial	pegaspargase	0	2	2/14/2022
J9299	Opdivo	Injection, nivolumab, 1 mg	nivolumab	0	480	2/14/2022
J0129	Orencia	Injection, abatacept, 10 mg	abatacept	0	100	2/14/2022

WHAT'S NEW?

UPDATED Physician Administered Drugs PA List (continued)...

Code	Drug Brand Name	Long Description	Generic Name	Min Age	Max Units	PA Required Effective Date
J9306	Perjeta	Injection, pertuzumab, 1 mg	pertuzumab	18	840	2/14/2022
J9316	Phesgo	Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg	pertuzumab, trastuzumab, and hyaluronidase-zzxf	18	180	2/14/2022
J9204	Poteligeo	Injection, mogamulizumab-kpkc, 1 mg	mogamulizumab-kpkc	18	160	2/14/2022
J0897	Prolia; Xgeva	Injection, denosumab, 1 mg	denosumab	18	120	2/14/2022
J1745	Remicade	Injection, infliximab, excludes biosimilar, 10 mg	infliximab	0	150	2/14/2022
J9312	Rituxan	Injection, rituximab, 10 mg	rituximab	18	150	2/14/2022
J2353	Sandostatin LAR	Injection, octreotide, depot form for intramuscular injection, 1 mg	octreotide	0	60	2/14/2022
J1300	Soliris	Injection, eculizumab, 10 mg	eculizumab	0	120	2/14/2022
J1930	Somatuline Depot	Injection, lanreotide, 1 mg	lanreotide	0	120	2/14/2022
J2326	Spinraza	Injection, nusinersen, 0.1mg	nusinersen	0	1	10/1/2019
J3357	Stelara	Ustekinumab, for subcutaneous injection, 1 mg	ustekinumab sc	12	90	2/14/2022
J3358	Stelara	Ustekinumab, for intravenous injection, 1 mg	ustekinumab iv	18	520	2/14/2022
J9226	Supprelin LA	Histrelin Implant, (supprelin la), 50 mg	histrelin	2	1	2/14/2022
J9022	Tecentriq	Injection, atezolizumab, 10 mg	atezolizumab	18	168	2/14/2022
J3241	Tepezza	Injection, teprotumumab-trbw, 10 mg	teprotumumab-trbw	18	320	2/14/2022
J9317	Trodelvy	Injection, sacituzumab govitecan-hziy, 2.5 mg	sacituzumab govitecan-hziy	18	636	2/14/2022

WHAT'S NEW?

UPDATED Physician Administered Drugs PA List (continued)...

Code	Drug Brand Name	Long Description	Generic Name	Min Age	Max Units	PA Required Effective Date
J1746	Trogarzo	Injection, ibalizumab-uiyk, 10 mg	ibalizumab-uiyk	18	200	2/14/2022
J2323	Tysabri	Injection, natalizumab, 1 mg	natalizumab	0	300	2/14/2022
J1303	Ultomiris	Injection, ravulizumab-cwvz, 10 mg	ravulizumab-cwvz	18	1	2/14/2022
J1429	Vyondys-53	Injection, golodirsen, 10 mg	golodirsen	0	477	1/25/2021
J9153	Vyxeos	Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine	daunorubicin-cytarabine	18	1	2/14/2022
J2357	Xolair	Injection, omalizumab, 5 mg	omalizumab	6	90	2/14/2022
J9228	Yervoy	Injeciton, ipilimumab, 1 mg	ipilimumab	18	1100	2/14/2022
Q2041	Yescarta	Axicabtagene ciloleucel, up to 200 million autologous-anti-cd19 car positive viable t cells, including leukapheresis and dose preparation precedures, per therapeutic dose	axicabtagene ciloleucel	18	1	10/1/2019
J9223	Zepzelca	Injection, lurbinectedin, 0.1 mg	lurbinectedin	18	93	2/14/2022
J3399	Zolgensma	Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10^15 vector genomes	onasemnogene abeparvovec-xioi	0	1	10/1/2019

WHAT'S NEW?

ATTENTION: Hospice Providers

02/18/2022 03:32 p.m.

Effective January 1, 2022, the Mississippi Administrative Code Title 23: Medicaid Part 205: Hospice Services was updated to 1) add language clarifying the prior authorization and notice of election requirements, 2) add language that late documentation will result in the hospice effective date beginning on the date the completed documentation is received, and 3) add exceptions to the timely submission of documentation requirements. The Hospice Administrative Code can be viewed in its entirety at Administrative Code (ms.gov).

The Division of Medicaid (DOM) will be collaborating with Alliant Health Solutions to host virtual training opportunities for Medicaid Hospice providers to review the Administrative Code and other requirements. Alliant Health Solutions will be notifying Hospice providers about the upcoming virtual trainings and how to register.

Reminders Regarding Election and Discharge Procedures

Medicaid Only Beneficiaries:

DOM requires hospice providers to submit the election statement to the Utilization Management/Quality Improvement Organization (UM/QIO), currently Alliant Health Solutions, or designated entity within five (5) calendar days of a beneficiary's admission to hospice. Providers should file discharge notices within five (5) calendar days after the effective date of discharge.

Dual Eligible Beneficiaries:

DOM requires the hospice provider to notify DOM's Utilization Management/Quality Improvement Organization (UM/QIO), currently Alliant Health Solutions, or designated entity, within five (5) calendar days of the beneficiary's hospice election or discharge date. Please refer to Alliant Health Solutions' provider portal at: https://ms.allianthealth.org/, or call Alliant directly at 1-888-224-3067, for assistance from the UM/QIO.

Required Forms:

Medicaid Only Beneficiaries:

Election Notice Form (DOM 1165 A-B)
Physician Certification/Recertification of Terminal Illness (DOM 1165 C)
Hospice Discharge/Hospice Revocation Form (DOM 1166 A)

Dual Eligible Beneficiaries:

Notice of Hospice Election or Discharge for Dual Eligible Beneficiaries (DOM 1166 C)
Hospice Forms are located on DOM's website on the Hospice page at https://medicaid.ms.gov/programs/hospice/.

Questions concerning Hospice services, that are not covered by Mississippi CAN, should be directed to the Office of Medical Services at (601) 359-6150.

WHAT'S NEW?

ATTENTION: All Providers
Correction for CPT codes 86328, 86769, U0003, U0004, G2023, G2024

02/18/2022 09:12 a.m.

Attention All Providers:
The Division of Medicaid will reprocess claims with codes 86328, 86769, U0003, U0004, G2023, G2024 for dates of service 3/1/2020 through 10/12/2020. The mass adjustment will appear on your remittance advice dated February 21, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION: All Providers-Multiple Surgery Claims

02/18/2022 09:07 a.m.

The Mississippi Division of Medicaid will reprocess Multiple Surgery claims for dates of service January 01, 2018 through April 20, 2018. The mass adjustment will appear on your remittance advice dated February 21, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION: Pharmacy Providers

02/17/2022 04:35 p.m.

NOTICE TO PHARMACY PROVIDERS ONLY
(DME or Pharmacy Disease Management Providers ARE NOT included)

There will be a point of sale (POS) system outage on Saturday, Feb 19th from 11:00PM CT until Sunday, Feb 20th 5:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 5:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

WHAT'S NEW?

ATTENTION: Correction for CPT codes 71271, 78429,78430, 78431, 78432, 78433, 78434 and 78469

02/11/2022 08:25 a.m.

The Division of Medicaid will reprocess claims with codes 71271, 78429,78430, 78431, 78432, 78433, 78434 and 78469 for dates of service 1/1/2020 through 1/27/2021. The mass adjustment will appear on your remittance advice dated February 14, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION: All Providers

02/10/2022 04:17 p.m.

The Mississippi Division of Medicaid will reprocess claims for dates of service October 1, 2012 through June 1, 2017 where the Category of Eligibility (COE) was applied incorrectly to claims processed when there were multiple COEs for the Date of Service range. The mass adjustment will appear on your remittance advice dated February 14, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION: All Providers

02/08/2022 12:47 p.m.

Attention All Providers: The Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) used by Mississippi Division of Medicaid effective February 14, 2022 are available for reference at "CARC and RARC values used by Mississippi Division of Medicaid" document at Provider Resources page of https://www.ms-medicaid.com/msenvision/index.do. This document also available at "What's New" article located on the home page of the Envision Web portal.

ATTENTION: All Providers

01/26/2022 05:08 p.m.

Attention All Providers: The Division of Medicaid will reprocess claims that processed incorrectly with dates of service 1/1/2012 through 12/16/2020. The Mass Adjustment will appear on your remittance advice dated January 31, 2022. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

ATTENTION: All Providers

12/20/2021 03:35 p.m.

Certain Physician Administered Drugs will require Prior Authorization

Effective February 14, 2022, the Division of Medicaid (DOM) will require prior authorization (PA) of an additional 63 physician administered drugs (PADs). The chart below reflects the PADs that will require PA. Alliant Health Solutions is responsible for authorization requests for fee-for-service (FFS) Medicaid beneficiaries. Please refer to Alliant Health Solutions' provider portal at: https://ms.allianthealth.org/, or call Alliant directly at 1-888-224-3067 for assistance. Providers are encouraged to register with Alliant as soon as possible to submit authorization requests via the Alliant web-portal https://ms.allianthealth.org/.

For billing issues, call Conduent Provider and Beneficiary Services at 800-884-3222.

Code	Description	Drug Brand Name
J9042	Brentuximab Vedotin Inj, 1 Mg	Adcetris
J0172*	Inj, Aducanumab-Avwa, 2 Mg	Aduhelm
J1931	Laronidase Injection	Aldurazyme
J9305	Inj. Pemetrexed Nos 10 Mg	Alimta
J0841	Inj Crotalidae Im F(Ab')2 Eq	Anavip
J9035	Bevacizumab Injection	Avastin
J0597	C-1 Esterase, Berinert	Berinert
J9229	Inj Inotuzumab Ozogam 0.1 Mg	Besponsa
J0585	Injection,Onabotulinumtoxina 1 Unit	Botox
J1786	Imuglucerase Injection	Cerezyme
J2786	Reslizumab 1 Mg	Cinqair
J0598	C-1 Esterase, Cinryze	Cinryze
J9308	Inj Ramucirumab 5 Mg	Cyramza
J9145	Daratumumab 10 Mg	Darzalex
J9144	Daratumumab, Hyaluronidase	Darzalex Faspro
J1743	Idursulfase Injection 1 Mg	Elaprase
J9358	Inj Fam-Trastu Deru-Nxki 1Mg	Enhertu
J3380	Inj Vedolizumab 1 Mg	Entyvio
J9307	Pralatrexate Injection	Folotyn
J9301	Obinutuzumab Inj	Gazyva
J9173	Inj., Durvalumab, 10 Mg	Imfinzi
J9043	Cabazitaxel Inj, 1 Mg	Jevtana
J9354	Ado-Trastuzumab Emtansine, 1 Mg Injecti	Kadcyla
Q5117	Inj, Trastuzumab-Anns, Biosimilar	KANJINTI
J9271	Inj Pembrolizumab 1 Mg	Keytruda
J2507	Pegloticase Inj, 1 Mg	Krystexxa
J0202	Inj Alemtuzumab 1 Mg	Lemtrada
J9119	Inj., Cemiplimab-Rwlc, 1 M	Libtayo
J0221	Inj, Alglucosidase Alfa, , 10 Mg	Lumizyme
A9513	Lutetium Lu 177, Dotatate, Therap	Lutathera
J9349	Inj., Tafasitamab-Cxix, 2 Mg	Monjuvi
J2562	Plerixafor Inj 1 Mg	Mozobil

Code	Description	Drug Brand Name
J9023	Avelumab 10 Mg	Bavencio
Q5107	Inj, Bevacizumab, 10 Mg	Mvasi
J2505	Injection, Pegfilgrastim 6 Mg	Neulasta
J2182	Mepolizumab 1 Mg	Nucala
J2350	Ocrelizumab 1 Mg	Ocrevus
J9266	Pegaspargase Inj Sngl Dose Vial	Oncaspar
J9299	Injection, Nivolumab	Opdivo
J0129	Inj, Abatacept, 10 Mg	Orencia
J9306	Pertuzumab, 1 Mg Injection,	Perjeta
J9316	Pertuzu, Trastuzu, 10 Mg	Phesgo
J9204	Inj, Mogamulizumab-Kpkc, 1 Mg	Poteligeo
J1459	'Inj Ivig Privigen 500 Mg	Privigen
J0897	Denosumab Inj, 1 Mg	Prolia; Xgeva
J1745	Infiximab Excl Biosimilar 10 Mg	Remicade
J9312	Inj., Rituximab, 10 Mg	Rituxan
J2353	Octreotide Injection, Depot, 1 Mg	Sandostatin LAR
J1300	Eculizumab Injection 10 Mg	Soliris
J1930	Lanreotide Inj 1 Mg	Somatuline Depot
J3357	Ustekinumab Subq 1 Mg	Stelara
J3358	Ustekinumab Iv 1 Mg	Stelara
J9226	Histrelin Implant, 50 Mg	Supprelin LA
J9022	Inj, Atezolizumab 10 Mg	Tecentriq
J3241	Inj. Teprotumumab-Trbw 10 Mg	Tepezza
J9317	Inj, Sacituzumab Govitecan-Hziy, 2	Trodelvy
J1746	Inj., Ibalizumab-Uiyk, 10 Mg	Trogarzo
J2323	Natalizumab Injection 1 Mg	Tysabri
J1303	Inj., Ravulizumab-Cwvz 10 Mg	Ultomiris
J9153	Inj, Liposomal, 1 Mg Daunorubicin	Vyxeos
J2357	Omalizumab Injection, 5 Mg	Xolair
J9228	Ipilimumab Injection, 1 Mg	Yervoy
J9223	Inj. Lurbinectedin, 0.1 Mg	Zepzelca

*Code J0172 will be a valid code effective 1/1/22

WHAT'S NEW?

ATTENTION: Nursing Facilities, ICF-IIDs, PRTFs, and NFSD

12/13/2021 08:12 a.m.

2022 New Bed Values for Nursing Facilities, ICF-IIDs, PRTFs, and NFSD

The new bed values for FY 2022's Nursing Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IIDs), Psychiatric Residential Treatment Facilities (PRTFs) and Nursing Facility for the Severely Disabled (NFSD) have been determined by using the R.S. Means Historical Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care Facilities.

Facility Class	FY 2022 New Bed Value
Nursing Facilities	$107,220
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)	$128,664
Psychiatric Residential Treatment Facilities (PRTF)	$128,664
Nursing Facilities Severely Disabled (NFSD)	$187,635

WHAT'S NEW?

ATTENTION: Long-Term Care Facilities

12/13/2021 08:12 a.m.

2021 Owner Salary Limits for Long-Term Care Facilities

The maximum amounts that will be allowed on cost reports filed by Nursing Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities and Psychiatric Residential Treatment Facilities as owner's salaries for 2021 are based on 150% of the average salaries paid to non-owner/administrators that receive payment for services related to patient care. The limits apply to all salaries paid directly by the facility or by a related management company or home office.

Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2021 are as follows:

Small Nursing Facilities (1 to 60 Beds)	**$148,211**
Large Nursing Facilities (61 or more Beds)	**$179,685**
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)	**$135,071**
Psychiatric Residential Treatment Facilities (PRTF)	**$134,232**

WHAT'S NEW?

ATTENTION: Nursing Facilities, ICF-IID's and PRTF's

12/13/2021 08:12 a.m.

Allowable Board of Directors Fees for Nursing Facilities, ICF-IID's and PRTF's
2021 Cost Reports

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2021 cost reports filed by Nursing Facilities (NF's), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID's), and Psychiatric Residential Treatment Facilities (PRTF's) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price index for all Urban Consumers - All Items. The amounts listed below are the per meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2021 are as follows

Category	Maximum Allowable Cost for 2021
0 to 99 Beds	$4,571
100 to 199 Beds	$6,856
200 to 299 Beds	$9,142
300 to 499 Beds	$11,427
500 or More Beds	$13,713

WHAT'S NEW?

ATTENTION: Durable Medical Equipment (DME) Providers - System Update Completed for Incontinent Garments

12/6/2021 08:12 a.m.

The Division of Medicaid (DOM) completed the system update that was causing incorrect denials related to incontinent garments when a prior authorization (PA) was included for more than six (6) incontinent garments per day. As a reminder, DOM removed the prior authorization requirement for incontinent garments of six (6) or less per day, effective October 1, 2021. Providers will need to resubmit impacted claims for dates of service on and after October 1, 2021. If you have any questions, please call Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

ATTENTION: All Community and Private Mental Health Centers!

11/19/2021 10:30 a.m.

The new HCPCS code H0037 – Community Psychiatric Supportive Treatment Program, will be submitted for services rendered under the Mississippi Youth Program Around the Clock (MYPAC) program. Please review DOM Mental Health Services State Plan Amendment (SPA) 21-0028 located at Pages-from-MS-SPA-21-0028-Approval-Pages-1.pdf. Filing of corresponding Division of Medicaid Administrative Code for MYPAC services with the Secretary of State's Office is pending.

HCPCS H0037 – Community Psychiatric Supportive Treatment Program
Prior authorization will not be required for HCPCS code H0037
Required Modifiers:
- HW – State Mental Health Agency Funded
- HT – Multi Disciplinary Team

Allowed Provider Types:
- X00 – Community Mental Health Center
- X01 – Private Mental Health Center

DOM Fee Schedule Per Diem Rate $214.00
Effective Date – July 1, 2021
Providers must be certified by the Department of Mental Health to provide MYPAC.
This service is excluded from the Children's Health Insurance Program (CHIP).

This HCPCS code reimbursement is effective **July 1, 2021,** with corresponding certification for MYPAC services by the Department of Mental Health. Prior to submitting claims for this service, please verify with your Coordinated Care Organizations' Provider Representative to ensure corresponding claim system updates have been activated.

Please contact Kim Sartin Holloway at Kimberly.Sartin-Holloway@medicaid.ms.gov or 601-359-6630 if you have any questions.

ATTENTION: All Providers!

11/18/2021 04:00 p.m.

In accordance with the TPL Bipartisan Budget Act of 2018, the Division of Medicaid will reprocess claims for dates of service 07/01/2020 through 11/09/2020. The mass adjustment will appear on your remittance advice dated 11/22/2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

ATTENTION: All Providers

11/15/2021 03:30 p.m.

Temporary Telehealth Codes Ending November 20, 2021

The Division of Medicaid (DOM) is ending coverage of the Temporary Telehealth Procedure Codes effective Saturday, November 20, 2021, which aligns with the end of Mississippi's COVID-19 State of Emergency. Beginning with dates of service on and after November 21, 2021, Telehealth interactions must be live, interactive, and audiovisual. Providers should refer to the Mississippi Medicaid State Plan and Administrative Code Part-225 for DOM's regular Telehealth policy requirements.

Telehealth Security Requirements / HIPPA – To ensure continued access to telehealth services, DOM will continue to allow providers to operate under the enforcement discretion provided by the Office of Civil Rights (OCR) at the United States of Health and Human Services (HSS) on March 17, 2020, for the remainder of the federal public health emergency (PHE).

Temporary Telehealth Service Codes

Code	Code Description	Effective End Date
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service	11/20/2021
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an E&M service	11/20/2021
99441	Telephone E&M service by a physician or other qualified health care professional who may report E&M services provided 5-10 mins	11/20/2021
99442	Telephone E&M service by a physician or other qualified health care professional who may report E&M services provided for established patient 11-20 mins	11/20/2021
99443	Telephone E&M service by a physician or other qualified health care professional who may report E&M services provided for established patient 21-30 mins	11/20/2021

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

WHAT'S NEW?

ATTENTION: EPSDT Providers

11/15/2021 03:30 p.m.

All children enrolled in the Mississippi Medicaid program are required to receive blood lead screening tests at ages 12 months and 24 months. In addition, any child between 24 and 72 months with no record of a previous blood lead screening test must receive one. Completion of a risk assessment questionnaire does not meet the Medicaid requirement. The Medicaid requirement is met only when the two blood lead screening tests identified above (or a catch-up blood lead screening test) are conducted.

The Division of Medicaid (DOM) is aware that the ESA Leadcare recall is affecting providers across the state, however delaying blood lead testing due to the unavailability of LeadCare lead test kits, increases the risk for children exposed to lead to not be identified and receive necessary treatment and services. According to the Centers for Disease Control (CDC), providers should be conducting a capillary or venous test that is analyzed using higher complexity methods if LeadCare lead test kits are unavailable for children that use this point of care testing machine for lead.

The CDC uses a blood lead reference value of 3.5 micrograms per deciliter (µg/dL) to identify children with blood lead levels that are higher than most children's levels. This level is based on the 97.5th percentile of the blood lead values among U.S. of children ages 1-5 years from the 2015-2016 and 2017-2018 National Health and Nutrition Examination Survey (NHANES) cycles. Additional information regarding the new reference value can be found at Update of the Blood Lead Reference Value — United States, 2021 | MMWR (cdc.gov). If blood lead testing indicates blood lead levels are above the current CDC blood lead reference value, the health care provider should refer to CDC guidelines or state/local guidelines for appropriate follow-up action.

Medicaid providers must report all blood lead levels (those that are less than 3.5µg/dL and those that are above 3.5 µg/dL) to the Mississippi State Department of Health (MSDH), Lead Poisoning Prevention and Healthy Homes Program (LPPHHP). The Report of Lead Levels Form should be used for reporting all blood lead levels to the MSDH LPPHHP and can be obtained here: https://msdh.ms.gov/msdhsite/_static/resources/6612.pdf. This form must be completed in its entirety and faxed to the MSDH LPPHHP at 601-576-7498 on a weekly basis. If there are questions about the reporting requirement or form, please contact the MSDH LPPHHP at (601) 576-7447.

WHAT'S NEW?

ATTENTION: Hospice Providers

11/12/2021 09:12 a.m.

The Division of Medicaid will reprocess claims for dates of service 1/1/2016 through 06/30/2021 due to the incorrect application of the tier rate. The Mass Adjustment will appear on your remittance advice dated November 15, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

ATTENTION: Hospital Providers

10/28/2021 04:39 a.m.

The Medicaid Management Information System has been updated to properly process hospital inpatient claims modify post-HAC DRG assignment input to include procedures identified as "required to satisfy HAC criteria" effective October 1, 2018. A Mass Adjustment is being completed for all related Hospital inpatient claims with last dates of service on or after October 1, 2018, which were processed through December 28, 2020.

ATTENTION: All DME Providers

10/28/2021 08:00 a.m.

The Division of Medicaid (DOM) began a workgroup earlier in 2021 to review non-covered wheelchair codes for possible coverage. Due to DOM's upcoming transition to a new claims adjudication system, this code update must be placed on hold. As a temporary workaround, DOM is advising DME providers to begin utilizing the most appropriate Healthcare Common Procedure Coding System (HCPCS) code when submitting authorization requests and claims for wheelchairs or wheelchair accessories. The list of wheelchair K-codes is available on DOM's Provider Resources page under "Medical Services". This temporary workaround process will be **effective 12/1/2021**. Fee-for-service (FFS) claims will be handled through a manual paper claim process by DOM's Office of Medical Services.

The list of HCPCS wheelchair and wheelchair accessory K-codes may be used in addition to existing wheelchair/wheelchair accessory codes already open for coverage on DOM's DME Fee Schedule, which will continue to reflect these K-codes as non-covered until after post go-live of the implementation of the new claims adjudication system in 2022. Requests must be reviewed and approved for medical necessity by DOM's UM/QIO, Alliant Health Solutions. The list includes the rate at which DOM will reimburse each code. Those HCPCS codes with "MP" will be manually priced in accordance with the payment methodology outlined in the DOM State Plan, Attachment 4.19-B Exhibit A, VII. Durable Medical Equipment C.

DOM is directing the Coordinated Care Organizations (CCOs) to follow DOM's process by accepting authorization requests and claims using the attached list of K-codes and rates effective **12/1/2021**.

Pursuant to code of federal regulations (CFR) § 440.70 (b)(1)(v) Home Health Services, all state Medicaid agencies are prohibited from having any absolute exclusions of coverage on medical equipment supplies, equipment, or appliances.

Fee-for-service Medicaid paper claims should be mailed to:

Division of Medicaid
Attention: Office of Medical Services
550 High Street, Suite 1000
Jackson, MS 39201

Questions should be directed to the Office of Medical Services at 601-359-6150.

WHAT'S NEW?

ATTENTION: All Providers: EDI/Electronic Remittance Advice (ERA) Update

10/22/2021 03:00 p.m.

Effective October 25, 2021, the submission of a new EDI Trading Partner Agreement & Business Associate Agreement and EDI Enrollment Application to link a new trading partner will result in the removal of all previously linked trading partners.

If you have questions, please contact Conduent at 1-800-884-3222.

ATTENTION: HOSPITAL PROVIDERS

10/15/2021 09:15 a.m.

The Mississippi Division of Medicaid will reprocess inpatient claims with last dates of service on or after July 1,2021, which were processed between July 1, 2021 through July 26, 2021, to apply the update of the Medicaid Management Information system (MMIS) to allow the payment of inpatient APR-DRG claims with V.38 of the APR-DRG grouper and other payment parameters effective July 1, 2021. The Mass Adjustment will appear on your remittance advice dated October 18, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

ATTENTION: HOSPITAL PROVIDERS

10/11/2021 10:40 a.m.

The Mississippi Division of Medicaid will reprocess denied inpatient claims with first dates of service on or after October 1, 2012, which were processed between October 1, 2012 through January 4, 2016, to apply the update of the Medicaid Management Information system (MMIS) to allow the payment of inpatient APR-DRG payments when the category of eligibility (COE) changes to or from COE 029 during in an inpatient stay. The Mass Adjustment will appear on your remittance advice dated October 18, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION: HOSPITAL PROVIDERS

10/07/2021 4:30 p.m.

The Medicaid Management Information System has been updated to properly process hospital inpatient claims with the new POA exempt diagnosis codes effective January 1, 2021. A Mass Adjustment is being completed for all related Hospital inpatient denied claims with last dates of service on or after January 1, 2021, which were processed through July 2, 2021.

Attention Nursing Facility Providers: Types of Bill Clarification

10/06/2021 03:47 p.m.

Effective June 1, 2021, Types of Bill (TOB) 021X, 022X and 023X were made available to and should now be utilized by nursing facility providers. To allow providers and clearing houses the opportunity to transition to the use of TOB 021X, 022X and 023X, the Division of Medicaid (DOM) continued to permit the use of the TOB 089X between the period of June 1, 2021 through August 31, 2021. While TOB 089X was decommissioned for nursing facility providers effective August 31, 2021, any claim with a date of service prior to June 1, 2021, should still be billed using TOB 089X. After the transition period, effective September 1, 2021, all Long Term Care claims with dates of service on or after June 1, 2021 must be submitted with TOB 021X, 022X, and 023X. If you have any questions, please contact the Office of Long Term Care by emailing LaShunda.Woods@medicaid.ms.gov or calling 601-359-5251.

Attention ALL Providers: Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC)

10/01/2021 09:49 a.m.

The Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) used by Mississippi Division of Medicaid effective September 13, 2021 are available for reference at "CARC and RARC values used by Mississippi Division of Medicaid" document at Provider Resources page of https://www.ms-medicaid.com/msenvision/index.do. This document also available at "What's New" article located on the home page of the Envision Web portal.

LATE BREAKING NEWS ***2021***

WHAT'S NEW?

2021 MANAGED CARE PROVIDER WEBINARS

REGISTER TODAY!

Click the link above to be directed to registration site.

Designed to provide information and updates related to Medicaid and managed care programs, DOM encourages office directors & managers, coders, practitioners, and billing staff to attend. Topics will include:

- Provider Services
- Claims Processing
- Reconsideration & Appeals
- Contracting/Credentialing

Microsoft Teams Meeting

Join on your computer or mobile app

Click here to join the meeting

Or call in (audio only)

+1 769-230-0549,,811406046#

Phone Conference ID: 811 406 046#

*Log-in information is the same for **ALL** webinars.*

WEDNESDAY, NOVEMBER 3, 2021
1:00PM – 3:00PM

New Providers | Credentialing/Contracting | Authorizations | Claims Processing

THURSDAY, NOVEMBER 4, 2021
10:00AM – 12:00PM

Hospital Services | Inpatient & Outpatient Services | Newborn Services | Credentialing/Contracting

TUESDAY, NOVEMBER 16, 2021
1:00PM – 3:00PM

Dental | Vision | Durable Medical Equipment

THURSDAY, NOVEMBER 18, 2021
10:00AM – 12:00PM

Behavioral Health | Rural Health Clinic | Federal Qualified Health Centers | Credentialing/Contracting

MISSISSIPPI DIVISION OF MEDICAID

Responsibly providing access to quality health coverage for vulnerable Mississippians

Hosted by the Division of Medicaid, presenters include Conduent, Alliant (UM/QIO), and the MississippiCAN Managed Care Organizations – Magnolia Health, Molina Healthcare and UnitedHealthcare Community Plan

WHAT'S NEW?

Attention Providers: Advanced Imaging Prior Authorization Update - eQHealth Solutions News

09/03/2021 09:49 a.m.

eQHealth Solutions MS will implement a new DOM approved algorithm for procedure code 71271 (Computed Tomography, Thorax, Low Dose for Lung Cancer Screening, without Contrast Material(s)) during mid-September 2021. This addition will provide real-time certification decisions, 24 hours a day, seven days a week using a rules-based algorithm.
As a reminder, only valid MS Medicaid Providers (physicians, nurse practitioners, and physician assistants) with an active Medicaid Provider identification (ID) number can order advanced imaging procedures for MS Medicaid fee-for-service (FFS) beneficiaries. When using eQSuite to submit a request for advanced imaging procedures, please carefully choose the ordering practitioner's Medicaid ID number when the search function is used. Please note that group ID numbers and license numbers are not acceptable for the ordering practitioner's ID number.

Retrospective requests for advanced imaging procedures have strict timelines for submission to obtain authorization. Requests for urgent procedures done before authorization was obtained can be submitted up to three (3) business days after the procedure is completed. Retrospective requests for procedures completed prior to Medicaid eligibility can be submitted up to ninety (90) calendar days after eligibility is entered into the fiscal agent's eligibility system, also known as the "add date" for eligibility.

If there are questions, please contact eQHealth Solutions at 601-352-6353 or visit the eQSuite portal eQSuite Login (eqhs.org).

ATTENTION ALL PROVIDERS: NCCI 2nd Quarter 2020 Replacement Files

09/02/2021 04:54 p.m.

In accordance with Section 6507 of the Patient Protection and Affordable Care Act, the Division of Medicaid utilizes National Correct Coding Initiative (NCCI) methodologies in claims processing. CMS issued replacement files for the NCCI 2nd quarter 2020 Edit Files. The Mississippi Division of Medicaid will reprocess claims for dates of service April 1, 2020 through May 30, 2020. The mass adjustment will appear on your remittance advice dated September 6, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

Attention: Durable Medical Equipment Providers

09/02/2021 02:38 p.m.

Important Changes for Incontinent Garments

Effective October 1, 2021, the Division of Medicaid (DOM) will no longer require prior authorization (PA) for incontinent garments of six (6) or less per day. DOM will only require PA for more than six (6) incontinent garments per day. The revised Administrative Code was Propose Filed on August 6, 2021 and Final Filed on September 1, 2021, with the Secretary of State's office and can be accessed via this link Final Administrative Code Filings | Mississippi Division of Medicaid (ms.gov). Alliant Health Solutions will continue to review authorization requests for fee-for-service (FFS) Medicaid beneficiaries. Please refer to Alliant Health Solutions' provider portal at: https://ms.allianthealth.org/, or call Alliant directly at 1-888-224-3067. The chart below reflects the impacted codes.

Code	Description
A4554	Disposable underpads
T4521	Adult size brief/diaper sm
T4522	Adult size brief/diaper med
T4523	Adult size brief/diaper lg
T4524	Adult size brief/diaper xl
T4525	Adult size pull-on sm
T4526	Adult size pull-on med
T4527	Adult size pull-on lg
T4528	Adult size pull-on xl
T4529	Ped size brief/diaper sm/med
T4530	Ped size brief/diaper lg
T4531	Ped size pull-on sm/med
T4532	Ped size pull-on lg
T4533	Youth size brief/diaper
T4534	Youth size pull-on
T4543	Adult disp brief/diap abv xl
T4544	Adlt disp und/pull on abv xl

WHAT'S NEW?

Attention: All Vision Providers
08/12/2021 08:00 a.m.

Reminder to all Vision Providers

Polycarbonate and Hi-Index lenses are covered for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible beneficiaries only. A prior authorization (PA) along with a priced invoice are required for these services. DOM contracts with Alliant Health Solutions as the Utilization Management and Quality Improvement Organization (UM/QIO) vendor for fee-for-service (FFS) beneficiaries to review requests for medical necessity. Please refer to Alliant Health Solutions' provider portal at: https://ms.allianthealth.org/, or call Alliant directly at 1-888-224-3067. Providers should contact Magnolia Health, Molina Healthcare or United Healthcare Community Plan for specific prior authorization requirements for beneficiaries enrolled in Mississippi Coordinated Access Network (MSCAN).

The beneficiary cannot be billed for this covered service. When billing for polycarbonate or hi-index lenses the appropriate V-code must be used.

- Polycarbonate lenses should be billed using HCPCS code V2784.
- Hi-index lenses should be billed using HCPCS codes V2782 or V2783
- Polycarbonate and Hi-index lenses should not be billed using unspecified codes (V2199, V2299, V2399, V2499, V2599 or V2799)

These codes should not be billed in conjunction with other lens codes nor as add-ons to regular lens codes.

WHAT'S NEW?

Attention: All Providers: Provider Education Webinar
08/09/21/2021 08:00 a.m.

The Mississippi Division of Medicaid (DOM) and Conduent will conduct a Provider Enrollment virtual workshop on **August 26, 2021 at 10:00 a.m.**

Topics include the following:

- **Change of Ownership (CHOW)**
- **Provider Revalidation**
- **Electronic Funds Transfer (EFT) Requests**
- **Envision Web portal (Overview)**
- **Frequently Asked Questions**
- **Provider Enrollment**

Please submit your RSVP via the link provided below by **August 23, 2021**. If you have any questions, please contact your provider field rep or email Conduent at **msmedicaidlatebreakingnews@conduent.com.**

***If multiple individuals will be calling in/logging in from one facility, please use one line in order to allow other interested parties an opportunity to participate in the webinar. The webinar information will be provided by email prior to the session.**

Registration Link:

Provider Education Webinar Registration

WHAT'S NEW?

Attention: All Provider – Code updates

07/23/2021 09:50 a.m.

Effective for dates of service on and after 7/1/2021 through 7/22/2021, providers who received claim denials for procedure codes H0031, S9470, T1023, T2023 should resubmit claims for processing.

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

Attention: All Providers

07/21/2021 11:20 a.m.

Effective October 1, 2021, the Division of Medicaid (DOM) will require providers to include accurate CPT® Category II codes on physician, physician assistant, and nurse practitioner claims. CPT Category II Codes are supplemental tracking codes used for performance measurement and data collection related to quality and performance measurement, including Healthcare Effectiveness Data and Information Set (HEDIS®). Use of CPT Category II Codes will allow providers to report services and/or values based on nationally recognized, evidence-based performance guidelines for improving quality of patient care, which may decrease the need for chart abstractions.

CPT Category II codes are more specific than CPT I codes and describe components that are typically included in an evaluation and management (E&M) service or test results that are part of the laboratory test/procedure. Use of CPT Category II codes for services performed during office, lab, or facility visits will provide more accurate medical data and decrease requests for members' records for review. The more specific codes identify and close gaps in care more accurately and quickly – this drives HEDIS measures and quality improvement initiatives.

CPT Category II Codes are billed in the procedure code field, just as CPT Category I codes are billed. However, Category II Codes are not reimbursable. These CPT II codes are to be billed with a $0 charge amount and are not a substitute for CPT Category I codes.

The chart reflects the CPT Category II codes that DOM will require beginning October 1, 2021.

(Continued on next 2 pages)

LATE BREAKING NEWS ***2021***

WHAT'S NEW?

Measure	Description	Required Codes
Adult Follow-up Care		
Timeliness of Transition of Care	Measures the percentage of beneficiaries, 18 years and older, who completed a visit within 30 days of an inpatient stay. Includes medication reconciliation post-discharge.	Appropriate E/M and ICD-10 codes; **and** ICD-10 code for follow up exam (Z09); **and** CPT Category II: 1111F (medication reconciliation)
Annual Wellness Visits		
Wellness- Adults	Measures the percentage of beneficiaries age 18 or older who completed an Annual Wellness Visit. Documentation should include measurement of BMI, depression screening results, as well as nutrition and physical activity counseling when abnormal BMI is found.	Appropriate preventive medicine code; **and** CPT Category II code: 3008F (BMI recorded) **and** ICD-10 code: Z68.1 - Z68.45 (BMI level) Z71.3 (dietary counseling and surveillance) Z71.82 (exercise counseling) **and** CPT Category II code: 3351F (negative screen for depressive symptoms) or 3352F (no significant depressive symptom) or 3353F (mild to moderate depressive symptoms) or 3354F (clinically significant depressive symptoms)
Wellness- Child and Adolescent	Measures the percentage of child and adolescent beneficiaries who completed an Annual Wellness Visit. Includes measurement of BMI, nutritional assessment, physical activity counseling, and depression screening for members age 12 and above,	Appropriate preventive medicine code; **and** ICD-10 code: Z68.51 (BMI, < 5th percentile for age) or Z68.52 (BMI, 5th percentile to < 85th percentile for age) or Z68.53 (BMI, 85th percentile to < 95th percentile for age) or Z68.54 (BMI, > /= to 95th percentile for age) **and** Z71.3 (dietary counseling and surveillance) **and** Z71.82 (exercise counseling) **and** CPT Category II code: 3008F (BMI recorded) 3351F (negative screen for depressive symptoms) or 3352F (no significant depressive symptoms) or 3353F (mild to moderate depressive symptoms) or 3354F (clinically significant depressive symptoms)

LATE BREAKING NEWS ***2021***

WHAT'S NEW?

Cardiovascular		
Controlling High Blood Pressure	Measures the blood pressure control of beneficiaries age 18 or older with a diagnosis of hypertension (HTN)	Appropriate E/M code; **and** ICD-10 code for high blood pressure (I10-I16); **and** CPT Category II code: 3074F (Systolic < 130 mm HG) or 3075F (Systolic 130-139 mm HG) or 3077F (Systolic >/= to 140 mm HG) or **and** 3078F (Diastolic < 80 mm HG) or 3079F (Diastolic 80-89 mm HG) or 3080F (Diastolic >/= to 90 mm HG)
Cholesterolemia		
Controlling High Cholesterol	Measures low-density lipoprotein control in beneficiaries age 18 years or older with a diagnosis of elevated cholesterol.	Appropriate E/M code; **and** ICD-10 code for high cholesterol (E78.0-E78.9); **and** CPT Category II code: 3048F (LDL-C was < 100 mg/dL) or 3049F (LDL-C was 100-129 mg/dL) or 3050F (LDL-C >/= to 130 mg/dL)
Comprehensive Diabetes Care (CDC)		
Controlling Hemoglobin A1c (HbA1c)	Measures blood sugar control of beneficiaries 18-75 years of age with a diagnosis of diabetes (type 1 and type 2).	Appropriate E/M code; **and** ICD-10 code for diabetes (E08-E13); **and** CPT Category II code: 3044F (HbA1c control <7.0%) or 3051F (HbA1c control >/= 7 and < 8) or 3052F (HbA1c >/= to 8 and </= to 9) or 3046F (HbA1c poor control >9.0%)
Perinatal		
Timeliness of Prenatal Care	Measures the percentage of deliveries in which women had a prenatal care visit in the first 16 weeks of gestation and timing of subsequent visits.	Appropriate E/M and ICD-10 codes; **and** Z3A weeks of gestation of pregnancy (Z3A.01-Z3A.49); **and** CPT Category II code: 0500F (initial prenatal care visit) or 0501F (prenatal flow sheet) or 0502F (subsequent prenatal care)
Timeliness of Postpartum Care	Measures the percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery.	Appropriate E/M code; **and** ICD-10 code: Z39.1 (care of a lactating mother) or Z39.2 (routine postpartum follow up) **and** CPT Category II code: 0503F (postpartum care visit)

WHAT'S NEW?

Attention: All Providers

07/20/2021 01:30 p.m.

As a reminder, Medicaid providers are able to submit electronic claims through the EDI Online portal for dual eligible for beneficiaries. The Division of Medicaid and Conduent has resources to assist with this process. Please refer to the following for assistance:

Medicare Advantage Crossover Training Presentation
(https://www.ms-medicaid.com/trainingMaterials/Electronic%20Medicare%20Part-C%20Secondary%20Claims%20Submission.pdf)

The Companion Guide
(https://edisolutionsmmis.portal.conduent.com/gcro/ms-guides)

Beginning October 1, 2021, EOMB's can be uploaded to electronically submitted claims.

If using a clearinghouse to submit claims, please be sure they are following the guidelines provided in these resources to ensure proper processing of Medicare Advantage Claims. Additionally, providers can still submit Medicare Advantage claims via the state-specific paper claim forms or via the MS Envision Web Portal.

If you have any questions, please contact your Provider Field Representative or the Conduent Provider & Beneficiary Services Call center at 1-800-884-3222 for additional assistance.

WHAT'S NEW?

Attention: All Providers

07/16/2021 12:53 p.m.

Policy Quick Reference Guide

Purpose: The purpose of this quick reference guide is to inform providers about Division of Medicaid (DOM) standards for the submission of requests to reconsider payment or policy outcomes relative to the adjudication of claims and policy matters.

Prior Authorizations: DOM requires prior authorization (PA) of certain services for fee-for-service (FFS) beneficiaries. An approved PA does not guarantee payment for services or the amount of payment. Eligibility for and payment of Medicaid services are subject to all terms, conditions, and limitations of the Medicaid program. PA related questions and considerations must be sent to:

Alliant Health Solutions is responsible for the prior authorization process and provider education opportunities for FFS beneficiaries, with the exception of Advanced Imaging.
Website: https://ms.allianthealth.org/
Phone: (888) 224-3067
Email: mspaportal@allianthealth.org

eQHealth Solutions is responsible for the prior authorization process and provider education opportunities of *Advanced Imaging* services only for FFS beneficiaries.
Website: https://ms.eqhs.com/Advanced-Imaging.
Phone: 866.740.2221

MississippiCAN Coordinated Care Organizations (CCOs) are responsible for prior authorizations for beneficiaries enrolled in MississippiCAN.

Reconsideration of payment for a denied claim: Reconsideration for payment of a claim that has denied, for a reason other than "the claim requires prior authorization" should be sent to:

Conduent Medical Review
P. O. Box 23080
Jackson, MS 39225

Please be sure to include supporting documentation/justification for reconsideration with your denied claim.

For more information go to: https://medicaid.ms.gov/wp-content/uploads/2014/04/ClaimCheck_Reconsideration_Form.pdf
Only Mississippi Division of Medicaid covered services will be reconsidered for payment. Services that are not covered or services rendered to ineligible beneficiaries or providers will not be considered for payment under this subject area.

Timely Filing: Where do I obtain information on timely filing: https://medicaid.ms.gov/wp-content/uploads/2014/11/1.12-Timely-Filing.pdf

Where do I send a request for timely filing review when a claim denies for timely filing requirements?

Division of Medicaid
Attention: Office of Provider Solutions
550 High Street
Suite 1000
Phone: 601-359-6050 Fax: 601-359-9153

WHAT'S NEW?

Attention: All RHC and FQHC Providers

07/01/2021 04:22 a.m.

The Division of Medicaid will reprocess claims with dates of service November 1, 2013, through June 3, 2019 for CPT codes 99050, 99051, and Q3014. The mass adjustment will appear on your remittance advice dated July 5, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

Attention: All Providers – Telehealth Updates

07/01/2021 10:12 a.m.

Effective for dates of service on and after July 1, 2021, providers should refer to the Medicaid State Plan for DOM's coverage of Telehealth Services, except for the Temporary Telehealth Codes below. Coverage of these Temporary Telehealth Codes will continue through the end of the Mississippi State of Emergency.

Telehealth Security Requirements / HIPPA – To ensure continued access to telehealth services, DOM will continue to allow providers to operate under the enforcement discretion provided by the Office of Civil Rights (OCR) at the United States of Health and Human Services (HSS) on March 17, 2020, for the remainder of the federal public health emergency (PHE).

Temporary Telehealth Service Codes	
Code	**Code Description**
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an E&M service
99441	Telephone E&M service by a physician or other qualified health care professional who may report E&M services provided 5-10 mins
99442	Telephone E&M service by a physician or other qualified health care professional who may report E&M services provided for established patient 11-20 mins
99443	Telephone E&M service by a physician or other qualified health care professional who may report E&M services provided for established patient 21-30 mins

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

WHAT'S NEW?

Attention: All Providers – Medicaid Updates effective July 1, 2021

06/30/2021 03:15 p.m.

The Mississippi Division of Medicaid (DOM) is making updates in fee-for-service and MississippiCAN systems to comply with Senate Bill (SB) 2799 that was enacted into law on April 20, 2021. In accordance with Mississippi Code Section 43-13-117 (D), as amended by SB2799 during the 2021 Legislative Session, DOM will freeze all provider reimbursement rates at the levels in effect on July 1st of this year. This rate-freeze will remain in effect until the legislature authorizes rate adjustments.

SB2799 makes numerous changes to Medicaid provider reimbursement, medical management practices, and procedures. Updates include discontinuation of the five percent (5%) reduction and numerous revisions to the Mississippi Medicaid Administrative Code and State Plan. Additional information is found at the links below.

Administrative Code - Changes to DOM's can be viewed at the following: Administrative Code | Mississippi Division of Medicaid (ms.gov)

State Plan - DOM's Office of Policy will be sending email notifications as State Plan Amendments are posted on DOM's public website. Changes can be viewed at the following: Mississippi Medicaid State Plan | Mississippi Division of Medicaid (ms.gov)

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

Attention All Pharmacy Providers

06/30/2021 09:54 a.m.

In accordance with Mississippi Code Section 43-13-117 (D), as amended by Senate Bill 2799 during the 2021 Legislative Session, the Division of Medicaid is freezing all provider reimbursement rates at the levels in effect on July 1st of this year. This rate-freeze will remain in effect until the legislature authorizes rate adjustments.

Attention All Providers:
Interactive and Downloadable Fee Schedules 5% Reduction Removal

06/28/2021 04:02 p.m.

Please disregard the "REDUCED PRICE" column/information on the interactive and downloadable fee schedules. The 5% reduction is no longer applicable for all providers for dates of service on/or after July 1, 2021 and does not affect claims adjudication. The Division of Medicaid is working to remove this information from the interactive and downloadable fee schedules.

WHAT'S NEW?

Attention: PPEC Center Providers

06/28/2021 10:41 a.m.

Beginning with dates of service on and after July 1, 2021, Prescribed Pediatric Extended Care (PPEC) Center Providers will be required to use procedure code T2002 for authorization requests and claims reimbursement of PPEC transportation services. Use of the UC modifier appended to procedure codes T1025 and T1026 will be ending for dates of services on and before 6/30/2021. Please see the updated PPEC fee schedule found on DOM's website Fee Schedules and Rates | Mississippi Division of Medicaid (ms.gov).

If you have any questions, please contact the Office of Medical Services at 601-359-6150 or at OMS@medicaid.ms.gov.

Attention All Obstetric Providers

06/17/2021 03:38 p.m.

Attention All Obstetric Providers: The Mississippi Division of Medicaid will reprocess claims for the immunization administration for the Tdap vaccine for dates of service January 01, 2020 through December 18, 2020. The Mass Adjustment will appear on your remittance advice dated June 21, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Nursing Facility Providers:

05/20/2021 01:15 p.m.

Effective June 1, 2021, Maximus/Ascend will resume face-to-face Level II screenings within nursing facilities. You will receive more detailed communication within the upcoming days from Maximus/Ascend that will explain what can be expected as assessors return to in-person screenings within your facility. If you have any questions, please contact the Office of Long Term Care by emailing *LaShunda.Woods@medicaid.ms.gov* or calling 601-359-5251.

Attention All Hospital Providers: APR-DRG Update

05/13/2021 04:26 p.m.

The Mississippi Division of Medicaid will reprocess Hospital claims for dates of service April 01, 2020 through July 29, 2020. The mass adjustment will appear on your remittance advice dated May 17, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

Attention All Providers:
Conduent Extended Maintenance Announcement

05/5/2021 09:03 a.m.

Beginning **Saturday, May 8, 2021 at 7:00 PM CDT**, Conduent will be performing a system migration which will extend our usual weekend downtime for maintenance. This outage is expected to conclude at or before **2:30 PM CDT on Sunday, May 9, 2021**. The following systems will be unavailable during the below times:

May 8th (Saturday)

7:00 PM CDT	Conduent EDI Shutdown*
	Mississippi Envision Web Portal Shutdown
11:00 PM CDT	Pharmacy: POS (Point of Sale) Smart Router Shutdown**
	MMIS and PBM internal processing Shutdown

May 9th (Sunday)

11:00 AM CDT – 2:30 PM CDT	MMIS and PBM internal processing Startup
	Mississippi Envision Web Portal Startup
	Conduent EDI Startup*
	Pharmacy: POS (Point of Sale) Smart Router Startup**

* For this week only, 835s (Electronic Remittance Advice transactions) will be made available around noon on Saturday 05/08/2021 instead of the regular scheduled day Monday 5/10/2021. All EDI batch and real time transactions processing will experience timeouts during this extended maintenance window.

** During this time, pharmacies will receive a reject code 92, meaning '*processing host did not accept transaction/did not respond within time out period* '. This is the same message received during the normal weekend maintenance downtime.

Attention All Pharmacies:

05/5/2021 09:03 a.m.

There will be a point of sale (POS) system outage on Saturday, May 8th from 11:00PM CT until Sunday, May 9th 2:30PM CT, to accommodate system migration. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 2:30PM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

WHAT'S NEW?

Attention All Providers:

05/5/2021 10:28 a.m.

****** Attention Qualified Providers who need to attest/re-attest to receive increased primary care services payments ******

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers at 100 percent (100%) of the Medicare Physician Fee Schedule for certain primary care Evaluation and Management (E&M) and Vaccine Administration codes. Qualified providers who attest to a specialty designation in family medicine, general internal medicine, obstetric/gynecologic medicine, pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), the American Congress of Obstetricians and Gynecologists (ACOG), and the American Osteopathic Association (AOA) may be eligible for increased payment of certain primary care E&M and Vaccine Administration codes.

To receive the increased payment for certain primary care and vaccine administration services provided for dates of service (DOS) beginning 7/1/2021, eligible providers must send a completed and signed 7/1/2021 – 6/30/2024 Self-Attestation Statement form to Conduent Provider Enrollment by **6/30/2021** through one of the following means:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: P. O. Box 23078, Jackson, MS 39225

Providers must notify Conduent of any change(s) to their completed 7/1/2021 – 6/30/2024 Self-Attestation Statement form. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at https://www.ms-medicaid.com/msenvision/.

Additional information can be found on the DOM website (www.medicaid.ms.gov), including the PCP Self-Attestation General Instructions and the 7/1/2021 – 6/30/2024 Self-Attestation Statement form. Providers may also find this information on the Envision Web Portal (www.ms-medicaid.com/msenvision/) or it can be requested by calling the Conduent Call Center toll-free at 800-884-3222.

WHAT'S NEW?

Attention All Providers:
05/4/2021 09:03 a.m.

To request an Administrative Review in accordance with Part 200, Rule 1.7(F), a provider must submit a letter requesting an Administrative Review that specifically states why the provider disagrees with the Mass Adjustment within 90 days with all appropriate attachments. Attachments should include but are not limited to, a newly submitted claim, a copy of the Remittance Advice that contains the Mass adjustment, and all other evidence that supports the provider's position.

Attention All Providers:
04/22/2021 04:34 p.m.

The Mississippi Division of Medicaid will update all Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) effective May 24, 2021. These codes are available for review at "CARC and RARC values used by Mississippi Division of Medicaid" document at Provider Resources page of https://www.ms-medicaid.com/msenvision/index.do.

WHAT'S NEW?

Attention Pharmacy Providers:

04/21/2021 09:11 a.m.

Some pharmacy claims for Long Term Care beneficiaries with DOS of March 1, 2020 through October 4, 2020 on which a $3.00 copay was credited also adjusted the dispensing fees. These claims have been corrected to reimburse the original dispensing fees that were negatively impacted.

Attention Hospital Providers
Intensive Outpatient Psychiatric (IOP) and Chemical Dependency Services

04/20/2021 02:27 p.m.

Intensive outpatient psychiatric service is considered a covered Mental Health service when provided in an outpatient department of a general hospital or freestanding psychiatric facility. Effective May 1, 2021, HCPCS code S9480 will only be applicable to Intensive Outpatient Psychiatric programs operated in the outpatient programs in General Hospitals and Freestanding Psychiatric Hospitals.

Effective **May 1, 2021**, the following revenue codes are to be opened for Outpatient Prospective Payment System (OPPS) billing:

0905 – IOP Psychiatric Services
0906 – IOP Chemical Dependency

Effective **May 1, 2021** physicians, NPs and PAs are to bill for their professional services separately from the IOP per diem rate. All other non-physician practitioner services, such as LCSW, LPC, psychologists, will be included in the per diem rate.

IOP – Psychiatric Services

Effective **May 1, 2021**, HCPCS Code S9480 IOP Psychiatric Service billed with revenue code **0905 - IOP Psychiatric Services** will be reimbursed for facility services at a rate of $122.54 (Factor Code O1) when billed in the Outpatient Hospital.

IOP – Chemical Dependency Services

Effective **May 1, 2021**, HCPCS Code H0015 - IOP Chemical Dependency (SUD) Service will be reimbursed at a rate of $122.54 (Factor Code O1) when billed with revenue code **0906 - IOP Chemical Dependency** in the Outpatient Hospital.

Please contact Kimberly Evans or Charlene Craft at 601-359-9545 or Kimberly.Evans@medicaid.ms.gov or Charlene.Craft@medicaid.ms.gov if you have questions.

WHAT'S NEW?

Attention Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) ICF/IID Claims Submissions

04/20/2021 02:27 p.m.

The Division of Medicaid (DOM), in accordance with Federal Regulations § 455.440 National Provider Identifier and § 456.360 Certification and recertification of need for inpatient care, requires Ordering, Referring or Prescribing (ORP) providers to be identified on ICF/IID facility claims. Claims submitted by ICF/IID providers will be denied unless the ORP Provider is actively enrolled in Medicaid and the National Provider Identifier (NPI) number is included on the claim submitted to Medicaid by the billing provider.

Please contact Kim Sartin-Holloway at 601-359-6630 or Kimberly.Sartin-Holloway@medicaid.ms.gov if you have questions.

Attention Opioid Treatment Providers

Medication Assisted Treatment (MAT) including Opioid Treatment Fee Schedule Updates

04/20/2021 02:27 p.m.

Effective April 1, 2021, the Division of Medicaid (DOM) will be utilizing bundled codes for MAT for Opioid Treatment services. Please refer to the Medication Assisted Treatment fee schedule located at Fee Schedules and Rates | Mississippi Division of Medicaid (ms.gov).
These bundled services include 1). Opioid Treatment Programs (OTPs) certified by the Mississippi Department of Mental Health that provide methadone treatment and 2). Physicians, non-physician practitioners and clinics operating within their scope of practice that are appropriately licensed and certified to prescribe MAT drugs excluding methadone.
Please contact Kim Sartin-Holloway at 601-359-6630 or Kimberly.Sartin-Holloway@medicaid.ms.gov if you have questions.

Attention all Providers

04/09/2021 02:01 p.m.

The Division of Medicaid will reprocess traditional Medicare & Medicare Part C claims for dates of service January 1, 2017 through April 13, 2020. These claims were paid incorrectly when there was no Medicare eligibility on file for the recipient. The mass adjustment will appear on your remittance advice dated: 4/19/2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention all Providers

04/08/2021 04:28 p.m.

Claims were adjusted for physician administered drug billed with J, Q, S or C procedure codes purchased at 340B pricing. If 'UD' modifier is present for the claim line's last date of service, validation was done to verify 340B status. These adjustments will appear on RA dated '04/12/2021".

WHAT'S NEW?

Attention: Therapy Providers - Prior Authorization Changes
03/29/2021 08:45 a.m.

Therapy Providers - Prior Authorization Changes

The Mississippi Division of Medicaid (DOM) revised prior authorization (PA) requirements for evaluation and re-evaluation procedure codes for outpatient Occupational, Physical and Speech therapy services, as outlined in Administrative Code Part 213: Therapy Services Administrative Code (ms.gov). Beginning April 1, 2021 prior authorization is no longer required for evaluation and re-evaluation procedure codes for fee-for-service (FFS) beneficiaries. DOM contracts with Alliant Health Solutions as the Utilization Management/Quality Improvement Organization (UM/QIO) vendor. Alliant is responsible for determining medical necessity for fee-for-service (FFS) beneficiaries. Please refer to Alliant Health Solutions' provider portal at https://ms.allianthealth.org/, or call Alliant directly at 1-888-224-3067.

Therapy Evaluation Codes	
Procedure Code	**Procedure Code Description**
92521	Evaluation of Speech Fluency
92523	Evaluation Speech Sound Production with Language Comprehension/Expression
92524	Behavioral and Qualitative Analysis of Voice and Resonance
97165	OT Evaluation LOW complexity 30 MIN
97166	OT Evaluation MOD complexity 45 MIN
97167	OT Evaluation HIGH complexity 60 MIN
97168	OT RE-Evaluation EST PLAN CARE
97161	PT Evaluation LOW complexity 20 MIN
97162	PT Evaluation MOD complexity 30 MIN
97163	PT Evaluation HIGH complexity 45 MIN
97164	PT RE-Evaluation EST PLAN CARE

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

WHAT'S NEW?

Attention: Nursing Facility Providers

03/26/2021 11:30 a.m.

Effective June 1, 2021, Types of Bill (TOB) 021X, 022X and 023X will be available and should be used by nursing facility providers. While TOB 089X will still be available after June 1, to allow a transition period for providers; this TOB will be decommissioned for nursing facility providers on August 31, 2021. If you have any questions, please contact the Office of Long Term Care by emailing *LaShunda.Woods@medicaid.ms.gov* or calling 601-359-5251.

Attention: Long-Term Care Facilities

03/25/2021 02:28 p.m.

2020 Owner Salary Limits for Long-Term Care Facilities

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities as owner's salaries for 2020 are based on 150% of the average salaries paid to non-owner/administrators that receive payment for services related to patient care. The limits apply to all salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2020 are as follows:

Small Nursing Facilities (1 - 60 Beds)	$147,264
Large Nursing Facilities (61+ Beds)	$167,813
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	$134,117
Psychiatric Residential Treatment Facilities (PRTF)	$91,070

WHAT'S NEW?

Attention: Ambulatory Surgical Center Providers

03/22/2021 07:40 a.m.

Effective April 1, 2021, the Division of Medicaid (DOM) will update the reimbursement rate for current procedural terminology (CPT) code 41899 to $490.65. The ASC fee schedule can be viewed on DOM's Fee Schedule webpage. Fees are subject to the rules and requirements of DOM, Federal and State law. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: All Providers – COVID Vaccine Administration Updates

03/18/2021 01:30 p.m.

The Division of Medicaid (DOM) has submitted a Disaster Relief State Plan Amendment (SPA) 21-0001 to the Centers for Medicare and Medicaid Services (CMS) to allow reimbursement to all Mississippi Medicaid pharmacies, physicians, and non-physician practitioners at 100% of the Medicare rate for the administration of an FDA-approved COVID-19 vaccine during the public health emergency (PHE). Additionally, on March 15, 2021, CMS released updated Medicare rates for all FDA-approved COVID-19 vaccine administration procedure codes effective for dates of service on and after March 15, 2021 and can be viewed on DOM's Coronavirus Updates page Coronavirus Updates | Mississippi Division of Medicaid (ms.gov).

The Medicaid Management Information System (MMIS) is currently able to reimburse Mississippi Medicaid pharmacies and physicians 100% of the Medicare rate for the administration of COVID-19 vaccine. However, for non-physician practitioners a workaround is required once the claim has been submitted. DOM will perform the workaround which will consist of a quarterly review of all fee-for-service (FFS) claims for COVID vaccine administration codes to calculate a financial transaction to reconcile the reimbursement rate to 100% of Medicare. There will be no action required on the part of non-physician practitioners to process the quarterly financial transactions.

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

WHAT'S NEW?

ATTENTION: ALL PROVIDERS-Change of Ownership Q&A

03/12/2021 11:00 a.m.

This article supports the Mississippi Division of Medicaid's (DOM's) policy related to Changes of Ownership for entities enrolled in the Mississippi Medicaid Program and the requirement to report such a change within 35 days.

Any Medicaid entity submitting a Change of Ownership (CHOW) application to the Mississippi Division of Medicaid must adhere to specific policy guidelines. The Question and Answer section below provides general guidance to the provider community related to CHOWs. Please refer to the complete Change of Ownership policy located on the Mississippi Division of Medicaid's website.

Why is the DOM's CHOW policy important?

Failure to report changes to the Mississippi Division of Medicaid may result in revocation and/or result in recoupment of funds for paid claims.

What steps should be followed when a Change of Ownership occurs?

Notify the Division of Medicaid within thirty-five (35) days after any Change of Ownership by submitting the following:

1. Completed Provider Enrollment Application
2. Proof of Change of Ownership documents such as the Medicare Tie-in Notice, Bill of Sale, etc.

Comply with all applicable Mississippi Department of Health requirements.

How does DOM define a Change of Ownership?

A Change of Ownership of an entity as defined by the Division of Medicaid includes, but is not limited to inter vivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions or other comparable arrangements whenever the person or entity acquires or controls a majority interest of the facility or service.

What are some examples of a Change of Ownership?

Changes in type of organization (ex. Partnership to limited liability company, or single proprietorship to organization),

Mergers, when a new organization is formed and the merging companies are non-surviving,

Consolidation of two or more corporations resulting in a new corporate entity,

Changes in partnership, including the removal, addition, or substitution of one or more individuals as partners (under Mississippi law, these actions result in dissolution of an older partnership and creation of a new one),

Transfers between different levels of government, such as city to county, state to county, etc., and

Transfer (sale, gift, exchange of stock) that results in a person or entity acquiring or controlling a majority interest of the facility or service.

What responsibility does a new owner assume when taking over ownership of the entity?

The new ownership agreement shall be subject to any restrictions, conditions, penalties, sanctions, or other remedial actions taken by the Division of Medicaid, the state agency, or the federal agency against the prior owner of the facility.

How long should beneficiary records be maintained after a change of ownership?

Six (6) years unless otherwise approved by DOM.

Continued…

WHAT'S NEW?

Is a provider agreement required for organizations or providers who furnish services under the Mississippi Medicaid State Plan?

Yes

Will the Division of Medicaid make payment to any provider or organization prior to the date of a valid Medicaid provider Agreement?

No

If I acquire an entity through the CHOW process that provides Medicaid services, is a screening required?

Yes. Screenings must be conducted by DOM or use of the screening results performed by a Medicare contractor, another state's Medicaid or the Children's Health Insurance Program (CHIP) agency. (Screenings conducted outside the State of Mississippi are accepted subject to verification by DOM.)

Where may I find the Division of Medicaid's CHOW policy?

Please refer to the Mississippi Division of Medicaid's Administrative Code, Part 200, Chapter 4, Rule 4.3, for the complete CHOW policy. https://medicaid.ms.gov/providers/administrative-code/

What steps should I take if I have changes in business information, but I review the policy and it is not a Change of Ownership?

Providers who have changes which are not considered a CHOW should review the following:

Change of Information found in Part 200, Chapter 4, Rule 4.8(7)
Change of Tax ID found in Part 200, Chapter 4, Rule 4.7

ATTENTION: ALL PROVIDERS -*1099 Forms*

03/12/2021 07:50 a.m.

Conduent mailed 1099 forms in January of this year. Some 1099 of forms have been returned to Conduent due to invalid mailing addresses. Any provider that has not received their 2020 1099 form should take the following steps:

1. Call the Conduent Provider and Beneficiary Services Call center at 1-800-884-3222,
2. Verify the 1099 mailing address on file,
3. Complete and submit a change of address form to Conduent specifically to update the 1099 mailing address if appropriate,
4. Request that the 1099 be mailed again after the 1099 mailing address has been updated.

Change of address forms can be submitted by fax to 1-888-495-8169 or mailed to P.O. Box 23078, Jackson Mississippi 39225. Change of address forms can be downloaded from the Mississippi Envision Web Portal at: https://www.medicaid.ms.gov/wp-content/uploads/2014/06/ProviderChangeofAddressForm.pdf.

WHAT'S NEW?

ATTENTION ALL PROVIDERS
CPT Code 87661 Procedure/Gender Conflict
03/11/2021 02:23 p.m.

The Mississippi Division of Medicaid will reprocess claims billed with CPT code 87661 for dates of service January 1, 2018 through January 9, 2019. The mass adjustment will appear on your remittance advice dated March 15, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION ALL PROVIDERS
Update CLIA Certification List
03/11/2021 02:07 p.m.

The Mississippi Division of Medicaid will reprocess claims for dates of service October 1, 2017 through November 11, 2019. The mass adjustment will appear on your remittance advice dated March 15, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION: ALL PROVIDERS
03/04/2021 03:48 p.m.

The Division of Medicaid will reprocess claims reimbursed for targeted case management services that were billed more than once a month for the PHRM/ISS and EI programs for dates of service July 1, 2018 through July 20, 2020. The mass adjustment will appear on the remittance advice dated March 8, 2021. No further action on the part of the provider is needed. If you have any question, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

ATTENTION: ALL PROVIDERS

03/01/2021 07:12 p.m.

Electronic Fund Transfers (EFT)

The Division of Medicaid (DOM) is improving security measures around the EFT change process. Providers submitting EFT change requests through either the provider web portal or via the paper form will be contacted by a provider enrollment specialist. Validation steps include:

1. Contact the authorized official or owner on file
2. Validate account and organizational information

As a reminder, ALL form submissions should be filled out completely according to instructions provided with the form. Failure to fill out the form completely will result in denial of the request. Additionally, providers should ensure that all contact information on file with DOM is up to date as failure to make contact for verification purposes will result in the denial of the request. Thank you for your patience while we adjust this process and strengthen our information security protocols to better serve the needs of our provider community.

ATTENTION: ALL PROVIDERS

02/25/2021 04:46 p.m.

HCPCS Code G2066 is Open for Coverage Effective 1/1/2020. The Mississippi Division of Medicaid will reprocess claims for dates of service January 1, 2020 through May 20, 2020. The mass adjustment will appear on your remittance advice dated March 1, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

ATTENTION: DURABLE MEDICAL EQUIPMENT PROVIDERS

02/25/2021 01:03 p.m.

Clarification regarding use of HCPCS code B9998 for Enteral Supplies

The Division of Medicaid (DOM) requires Durable Medical Equipment (DME) providers to use the most specific code available within the enteral feeding supplies and equipment Healthcare Common Procedure Code System (HCPCS) code range B4034-B4088, when billing for enteral feeding supplies, as listed on the Medical Supply Fee Schedule. Correct coding requires the use of a specific HCPCS code for an item when a specific code exists. Use of a Not Otherwise Classified (NOC) code in place of specific code represents incorrect coding. Use of HCPCS code B9998 (NOC for enteral supplies) should be reserved for instances when a specific code does not exist, and documentation must clearly identify the item for which the NOC code is being used. This applies to all claims, including Fee-for-Service (FFS) and MississippiCAN (MSCAN). Use of the specific HCPCS code will help reduce the possibility of denials or other claims issues.

Code	Description
B4034	ENTERAL FEEDING SUPPLY KIT; SYRINGE FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE
B4035	ENTERAL FEEDING SUPPLY KIT; PUMP FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE
B4036	ENTERAL FEEDING SUPPLY KIT; GRAVITY FED, PER DAY, INCLUDES BUT NOT LIMITED TO FEEDING/FLUSHING SYRINGE, ADMINISTRATION SET TUBING, DRESSINGS, TAPE
B4081	NASOGASTRIC TUBING WITH STYLET
B4082	NASOGASTRIC TUBING WITHOUT STYLET
B4083	STOMACH TUBE - LEVINE TYPE
B4087	GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD, ANY MATERIAL, ANY TYPE, EACH
B4088	GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PROFILE, ANY MATERIAL, ANY TYPE, EACH
B4220	PARENTERAL NUTRITION SUPPLY KIT; PREMIX, PER DAY
B4222	PARENTERAL NUTRITION SUPPLY KIT; HOME MIX, PER DAY
B4224	PARENTERAL NUTRITION ADMINISTRATION KIT, PER DAY
B9998	NOC FOR ENTERNAL SUPPLIES
B9999	NOC FOR PARENTERAL SUPPLIES

*MississippiCAN claims that have been denied due to the use of code **B9998** for a Gastrostomy/jejunostomy tube, low -profile, any material, any type, each and submitted prior to the date of this released clarification, will be reprocessed accordingly if all supporting documentation has been provided. Providers are strongly encouraged to use HCPCS code range B4034-B4088 as described above to help reduce the possibility of denials or other claims issues.*

LATE BREAKING NEWS ***2021***

WHAT'S NEW?

Attention All Pharmacy Providers

02/18/2021 02:39 p.m.

Please be aware that pharmacy claims calls to the HelpDesk may not go through due to inclement weather and power outages. This is impacting both the primary and alternate sites. Refer to https://medicaid.ms.gov/providers/pharmacy/ for assistance in answering claims questions. Thank you for your patience.

Attention All Hospital Providers

02/11/2021 04:42p.m.

The Division of Medicaid will reprocess impacted claims that were processed incorrectly for the 3-day window for dates of service October 1, 2012 through February 11, 2020. The mass adjustment will appear on your remittance advice dated 02/15/2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2021***

WHAT'S NEW?

Attention Prescribed Pediatric Extended Care (PPEC) Providers

02/11/2021 04:11 p.m.

Rate Change for T1026 effective 01/01/2020

The Division of Medicaid will reprocess impacted claims with CDT code T1026 for dates of service on and after January 1, 2020. The mass adjustment will appear on your remittance advice dated February 15, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: All Dental Providers!

02/11/2021 04:10 p.m.

The Mississippi Division of Medicaid will reprocess claims for Dental Claims with dates of service July 1, 2018 through June 30, 2019. The mass adjustment will appear on your remittance advice dated February 15, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: All Providers!

02/09/2021 03:00 p.m.

Correction of Fee for CPT codes 78431, 78432, 78433

The Division of Medicaid will reprocess claims with codes 78431, 78432, and 78433 with dates of service 1/1/2020 through 6/24/2020. The mass adjustment will appear on your remittance advice dated February 15, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers!!!

02/09/2021 11:00 a.m.

The COVID-19 vaccine administration fees for pharmacy claims billed for DOS December 28, 2020 – January 13, 2021 were adjusted on 02/08/21 to pay at a 100% of the Medicare rate.

WHAT'S NEW?

Attention Hospice Providers

02/05/2021 03:51 p.m.

In an effort to streamline the Hospice election process and reduce beneficiary and provider burden, the Division of Medicaid is making updates to the requirements for the election of the hospice benefit. Please see the specifics listed below of both the updated requirement of dually eligible beneficiaries along with changes and updates to hospice forms. These updates will be effective **March 1, 2021**.

Update to the Administrative Code Update: Part 205, Chapter 1, Rule 1.10 - For dual eligible beneficiaries, the Division of Medicaid requires the hospice provider to notify the Division of Medicaid's Utilization Management/Quality Improvement Organization (UM/QIO), Alliant Health Solutions, within five (5) calendar days of the beneficiary's hospice election or discharge date. Please refer to Alliant Health Solutions' provider portal at: https://ms.allianthealth.org/, or call Alliant directly at 1-888-224-3067, for assistance from the UM/QIO.

Updates to the following Hospice Forms are located on the Hospice website at https://medicaid.ms.gov/programs/hospice/. These forms must be used effective March 1, 2021.

New Notice of Hospice Election or Discharge for Dual Eligible Beneficiaries - This new form is required to notify DOM of a hospice election for dual eligible beneficiaries. The following forms will no longer be required for dual eligible beneficiaries:

Election Notice Form (1165 A-B),
Hospice Discharge/Hospice Revocation Form (1166 A)
Physician Certification/Recertification of Terminal Illness (1165 C)

Update to the Hospice Discharge/Hospice Revocation Form – This updated form should be used for Medicaid Only beneficiaries. This form now only requires the beneficiary's signature on the hospice revocation statement. A hospice discharge does not require the beneficiary's signature.

Updates to the Election Notice Form – This updated form should be used for Medicaid Only beneficiaries. Updates include the following:

Removed the "to-from" election period date and now requires only the election date.
Added the county where hospice services will be provided.
Clarified the choice of having or not having an attending physician to oversee a beneficiary's hospice care.

Please contact the Office of Long Term Care at (601) 359-6141, if you have any questions regarding these changes. Thank you for all you do to serve this vulnerable Medicaid population.

WHAT'S NEW?

Attention All Providers-*NCCI Updates*

02/05/2021 10:58 a.m.

The Division of Medicaid will reprocess claims for dates of service April 01, 2019 through May 2, 2019 due to CMS NCCI updates. The mass adjustment will appear on your remittance advice dated February 8, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers-*NCCI 3rd Quarter 2020 Replacement*

02/05/2021 10:58 a.m.

In accordance with Section 6507 of the Patient Protection and Affordable Care Act, the Division of Medicaid utilizes National Correct Coding Initiative (NCCI) methodologies in claims processing. CMS issued replacement files for the NCCI 3rd quarter 2020 Edit Files. The Mississippi Division of Medicaid will reprocess claims for dates of service July 1, 2020 through September 14, 2020. The mass adjustment will appear on your remittance advice dated February 8, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary services at 800-884-3222.

WHAT'S NEW?

Attention: OUTPATIENT Hospital Providers-*Q5107 Fee Update*

02/05/2021 10:14 a.m.

The Division of Medicaid will reprocess claims for dates of service January 1, 2020 through May 13, 2020 due to a fee change for HCPCS code Q5107. The mass adjustment will appear on your remittance advice dated February 8, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: All Providers!

02/05/2021 09:58 a.m.

Correction of Fee for CPT codes 78431, 78432, 78433

The Division of Medicaid will reprocess claims with codes 78431, 78432, and 78433 with dates of service 1/1/2020 through 6/24/2020. The mass adjustment will appear on your remittance advice dated 2/8/2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: Ambulance Providers!

02/03/2021 01:47 a.m.

Effective March 1, 2021, the Division of Medicaid (DOM) will begin utilizing certain procedure codes for the purpose of tracking Ambulance Provider trip data. Ambulance Providers will use A0888 per mile to document the first twenty-five (25) miles per trip. Additionally, DOM will use the existing fee on file of $404.26 for HCPCS A0427-Advanced Life Support Level 1 (ALS1) to establish a rate for codes A0433-Advanced Life Support Level 2 (ALS2) and A0434-Specialty Care Transport (SCT). Providers should use the procedure code that is appropriate for the type of transport.

Procedure Code	Description	Rate	Max Units	Begin Date
A0888	Ambulance mileage per mile (first 25)	$0.00	25	3/1/2021
A0427	Advanced Life Support Level 1 (ALS1)	$404.26	2	7/1/2020
A0433	Advanced Life Support Level 2 (ALS2)	$404.26	1	3/1/2021
A0434	Specialty Care Transport (SCT)	$404.26	2	3/1/2021

Please refer to the Mississippi Administrative Code Part 201: Transportation Services https://medicaid.ms.gov/wp-content/uploads/2015/07/Admin-Code-Part-225.pdf, for additional information. Questions can be directed to the Office of Medical Services mailbox at OMS@medicaid.ms.gov.

WHAT'S NEW?

Attention: Durable Medical Equipment Providers!

02/02/2021 11:41 a.m.

Effective January 1, 2021, the Medical Supply fee schedule was updated and posted to the Mississippi Division of Medicaid (DOM) website. Additional updates have been made to certain codes. The updates will be reflected in red and will be in the 'Max Units' and/or 'Per Time Frame' columns. All updates will be retroactively effective to January 1, 2021. Providers are advised to void and resubmit claims. The Medical Supply fee schedule can be viewed on DOM's website at Fee Schedules and Rates | Mississippi Division of Medicaid (ms.gov).

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

Attention All Providers!

01/29/2021 11:56 a.m.

Rate Change 99441, 99442, 99443

The Division of Medicaid will reprocess claims with codes for Telephone Evaluation and Managements Services for dates of 3/1/2020 through 5/12/2020. The mass adjustment will appear on your remittance advice dated February 1, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Pharmacies

01/28/2021 01:02 p.m.

All pharmacy claims with DOS March 1, 2020 through October 4, 2020 on which a $3.00 copay was applied were adjusted by Conduent reflecting a $3.00 credit on remittance advice statements dated 01/11/2021. Pharmacy providers are required to refund $3.00 copayments to beneficiaries who have already paid $3.00 copayments.

WHAT'S NEW?

Attention All Providers!

01/22/2021 08:20 a.m.

EVALUATION AND MANAGEMENT (E&M) CODE CHANGES EFFECTIVE 1/1/2021

To remain compliant with HIPAA code set standards, the Division of Medicaid (DOM) is required to make necessary code changes (additions/deletions/etc.) as outlined by the American Medical Association (AMA). The new code set effective January 1, 2021 has been updated in DOM's claim adjudication system.

It is the responsibility of the provider to maintain sufficient documentation in the medical records to support the service rendered. The Envision interactive fee schedule located at Mississippi Envision (ms-medicaid.com) is a helpful tool to determine coverage of specific procedure codes based on a date of service.

Additional helpful resources are:

Code and Guideline Changes | AMA (ama-assn.org)
CPT E/M Office Revisions | AMA (ama-assn.org)

MM12071 (cms.gov)

Attention All Providers!

01/21/2021 5:01 p.m.

Allow Coverage for CPT Code 87426

The Division of Medicaid will reprocess claims for dates of service June 25, 2020 through September 9, 2020 due to changes in coverage for CPT code 87426. The mass adjustment will appear on your remittance advice dated **January 25, 2021**. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Max Unit Changes on HCPCS Codes J0585, J0587, J0588. Minimum Age changed to 2 on HCPCS Code J0585.

The Division of Medicaid will reprocess claims for dates of service January 01, 2020 through July 8, 2020 due to changes in max units and age restrictions for HCPCS Codes J0585, J0587, and J0588. The mass adjustment will appear on your remittance advice dated January 25, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2021***

WHAT'S NEW?

Attention All Providers!

01/21/2021 5:01 p.m.

Code Corrections on HCPCS Codes K0900, L5976, J0857 and CPT 90707 and 76390.

The Division of Medicaid will reprocess claims for dates of service November 01, 2015 through August 7, 2017 due to code corrections. The mass adjustment will appear on your remittance advice dated January 25, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Multiple and Bilateral Surgery Codes

The Division of Medicaid will reprocess claims for dates of service January 1, 2017 through March 9, 2017 due to changes in multiple and bilateral codes. The mass adjustment will appear on your remittance advice dated January 25, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Update of Modifiers

The Division of Medicaid will reprocess claims with dates of service January 1, 2020 through March 31, 2020. The mass adjustment will appear on your remittance advice dated January 25, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

NCCI 1ST Quarter 2020 Replacement

In accordance with Section 6507 of the Patient Protection and Affordable Care Act, the Division of Medicaid utilizes National Correct Coding Initiative (NCCI) methodologies in claims processing. CMS issued replacement files for the NCCI 1st quarter 2020 Edit Files. The Mississippi Division of Medicaid will reprocess claims for dates of service January 1, 2020 through March 1, 2020. The mass adjustment will appear on your remittance advice dated January 25, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary services at 800-884-3222.

Attention OUTPATIENT Hospital Providers!

01/21/2021 5:01 p.m.

SFY19 OPPS Fee Correction

The Division of Medicaid will reprocess claims for dates of service July 1, 2018 through September 4, 2018 due to fee changes for HCPCS code J9145 and certain dental codes. The mass adjustment will appear on your remittance advice dated January 25, 2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

Attention All Providers!

01/14/2021 4:46 p.m.

Correction of Fee for CPT codes 90460, 90471, 90472, 90473, 90474.
The Division of Medicaid will reprocess claims with codes 90460, 90471, 90472, 90473, 90474 for dates of service 7/1/2020 through 8/10/2020. The mass adjustment will appear on your remittance advice dated 01/18/2021. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers!

01/13/2021 8:29 a.m.

Due to changes to the 2020 IRS 1099-MISC, the Division of Medicaid will be using Box 6 of the updated form to report payments made to providers. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Long Term Care Facilities:

Allowable Board of Directors Fees for Long-Term Care Facilities

01/08/21 11:25 a.m.

2020 Cost Reports

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2020 cost reports filed by nursing facilities (NFs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and psychiatric residential treatment facilities (PRTFs) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for all Urban Consumers - All Items. The amounts listed below are the per-meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2020 are as follows:

Category	Maximum Allowable Cost for 2020
0 – 99 Beds	$ 4,337
100 – 199 Beds	$ 6,506
200 – 299 Beds	$ 8,674
300 – 499 Beds	$10,843
500 Beds or More	$13,011

WHAT'S NEW?

Attention Pharmacy Providers:

Billing directions for COVID-19 vaccines via NCPDP D.0 pharmacy claims

12/30/20 10:01 a.m.

Background

Doses of COVID-19 vaccines are now available in Mississippi, and the Mississippi State Department of Health has developed a plan on how Mississippians will be prioritized to receive the vaccine. Find more information at Vaccination Against COVID-19 - Mississippi State Department of Health (ms.gov)

Effective Dec. 11, 2020, the Mississippi Division of Medicaid (DOM) will reimburse Medicaid-enrolled pharmacy providers for COVID-19 vaccine claims billed on NCPDP D.0 pharmacy claims. Currently, the vaccine itself is being provided at no cost to providers and patients by the federal government, but DOM will still require submission of the vaccine NDC#s on claims to ensure the appropriate administration fees are being billed for the vaccines given.

COVID-19 is not included in the Vaccines for Children (VFC) program, and therefore pharmacy providers do not have to be enrolled as VFC providers in order to administer COVID-19 vaccines to beneficiaries younger than 19 years of age.

DOM is following guidance found in the following documents:

CMS' State Medicaid Plans Toolkit entitled, "Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration, and Cost Sharing under Medicaid, the Children's Health Insurance Program, and Basic Health Program," update Dec. 17, 2020.

Link: Coverage and Reimbursement of COVID-19 Vaccines, Vaccine Administration and Cost Sharing under Medicaid, CHIP, and Basic Health Program

NCPDP Emergency Preparedness Guidance – COVID-19 Vaccines

Link**:** NCPDP-Emergency-Preparedness-Guidance-COVID-19-Vaccines.pdf

CDC COVID-19 Vaccination Program Provider Agreement

Link: COVID-19 Vaccination Provider Requirements and Support | CDC

Medicaid Pharmacy Provider Requirements

Qualified pharmacists must comply with any applicable requirements (or conditions of use) as set forth in the CDC COVID-19 vaccination provider agreement and any other federal requirements that apply to the administration of COVID-19 vaccines. Please review full details under Section V: Other Federal Requirements and Considerations on pages 24-30 of the CMS State Medicaid Plans Toolkit.
Pharmacists should also refer to the Mississippi State Board of Pharmacy requirements at: HHS and Board Recs .pdf (ms.gov)

WHAT'S NEW?

Long term care residents with full Medicaid benefits

The first phase of vaccine distribution has begun to hospitals and health facilities for administration to those involved in COVID-19 patient care. Long term care facility residents and staff are also considered as first priority for vaccination.

Pharmacy providers going onsite to long term care facilities to administer vaccines are considered "outside providers," and therefore they allowed to bill Medicaid directly to administer vaccines for residents who have full Medicaid benefits. The long term care facility cannot claim the cost on the Medicaid cost report. Please refer to Mississippi Administrative Code, Part 224, Rule 1.4.B.

Pharmacy providers cannot bill COVID-19 vaccines administered to Medicaid beneficiaries who are dually eligible for Medicare and Medicaid. Medicare must be billed.

NCPDP D.0 Claim Billing Requirements for COVID-19 Vaccines

Quantity Dispensed – Submit the total milliliters (**ml**) administered in field **442-E7**

Days Supply – Submit a value of '**1**' in field **405-D5** whether administering a single-dose or a two-dose vaccine.

Prescriber ID Field – Pharmacist prescriptive authority applies to COVID-19 vaccines, therefore, the pharmacy provider's NPI # may be entered in the Prescriber ID Field, if the vaccine is being administered without a prescription or without a physician collaborative agreement.

Field #	NCPDP Field Name	Value	Payer Situation	Payer Usage
419-DJ	PRESCRIPTION ORIGIN CODE	5=Pharmacy	For vaccine administration where the pharmacist is also the prescriber, please send value '5 – Pharmacy'. This must be included with 42Ø-DK Submission Clarification Code '42 – Prescriber ID is valid and prescribing requirements have been validated' to prevent claim from denying with NCPDP reject 42.	RW
42Ø-DK	SUBMISSION CLARIFICATION CODE	42= Prescriber ID	For vaccine administration where the pharmacist is also the prescriber, please send value '42 – Prescriber ID is valid and prescribing requirements have been validated'. This must be included with 419-DJ Prescription Origin Code value '5 – Pharmacy', to prevent claim from denying with NCPDP reject 42.	RW

WHAT'S NEW?

Vaccine Ingredient and Administration Fee Billing Fields				
42Ø-DK	SUBMISSION CLARIFICATION CODE	2= 'Other Override" submit '2' for the first dose 6= 'Starter Dose'- indicates that the previous dose was a starter dose and now additional vaccine is needed to continue treatment	Used for two- dose COVID vaccines to indicate which dose is being administered allowing for applicable edits to be invoked and determine proper reimbursement. Send a value of '2' for the first dose Submit a value of '6' for the second dose (Note-this field is NOT required for single-dose vaccines)	RW
4Ø9-D9	INGREDIENT COST SUBMITTED		A value of $0.00 should be submitted for vaccines provided free of charge by the federal government	R
412-DC	DISPENSING FEE SUBMITTED	N/A	A Dispensing Fee *should not be submitted. Vaccines are not classified as covered outpatient drugs and dispensing fees are not reimbursable*	N/A
438-E3	INCENTIVE AMOUNT SUBMITTED	**First Dose- Allowed Administration Fee = $15.25** **Second Dose-Allowable Administration Fee = $25.55**	Required when submitting claims for vaccine administration.	RW
440-ES	PROFESSIONAL SERVICE CODE	MA-Medication Administration	Required for reimbursement of vaccine administration fees	RW

Pharmacy providers are urged to check their software systems to ensure that these fields are accessible and configured for billing before the COVID-19 vaccines become more widely available to most pharmacies.

WHAT'S NEW?

####

12/29/2019

Please forward this message to colleagues who might be interested. If you wish to be removed from this list or know of a colleague to add, send an email message to: matt.westerfield@medicaid.ms.gov.

About Mississippi Division of Medicaid
Medicaid is a state and federal program created by the Social Security Amendments of 1965, authorized by Title XIX of the Social Security Act, to provide health coverage for eligible, low income populations. In 1969, Medicaid was enacted by the Mississippi Legislature. All 50 states, five territories of the United States and District of Columbia participate in this voluntary matching program. The mission of the Mississippi Division of Medicaid is to responsibly provide access to quality health coverage for vulnerable Mississippians, by conducting operations with accountability, consistency and respect.

WHAT'S NEW?

Attention All Medical Providers!

COVID-19 Vaccine Billing Guidance for Medical Claims

12/28/20 3:51 p.m.

The Division of Medicaid (DOM) will cover the administration of COVID-19 Vaccines as shown in the chart below. The Centers for Medicare & Medicaid Services (CMS) indicates that the initial supply of COVID-19 vaccines will be federally purchased. CMS states that providers should not bill the vaccine product code since it is being supplied at no cost to providers. DOM's COVID vaccine and treatment information is found in the chart below.

Please monitor DOM's Coronavirus Updates | Mississippi Division of Medicaid (ms.gov) page as updates may be made frequently. Directions for billing pharmacy claims will be forthcoming.

Coronavirus Vaccines and Treatment
Billing Information for Medical Claims

Code	Code Description	Z1 Rate	O1 OUTPT HSP Rate	Effective Begin Date	Minimum Age	Maximum Age
0001A (Pfizer)	IMMUNIZATION ADMINISTRATION BY INTRAMUSCULAR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE [COVID-19]) VACCINE, MRNA-LNP, SPIKE PROTEIN, PRESERVATIVE FREE, 30 MCG/0.3ML DOSAGE, DILUENT RECONSTITUTED; FIRST DOSE	$15.25	$15.25	12/11/2020	16	999
0002A (Pfizer)	IMMUNIZATION ADMINISTRATION BY INTRAMUSCULAR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE [COVID-19]) VACCINE, MRNA-LNP, SPIKE PROTEIN, PRESERVATIVE FREE, 30 MCG/0.3ML DOSAGE, DILUENT RECONSTITUTED; SECOND DOSE	$25.55	$25.55	12/11/2020	16	999

WHAT'S NEW?

Coronavirus Vaccines and Treatment
Billing Information for Medical Claims

Code	Code Description	Z1 Rate	O1 OUTPT HSP Rate	Effective Begin Date	Minimum Age	Maximum Age
0011A (Moderna)	IMMUNIZATION ADMINISTRATION BY INTRAMUSCULAR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE [COVID-19]) VACCINE, MRNA-LNP, SPIKE PROTEIN, PRESERVATIVE FREE, 100 MCG/0.5ML DOSAGE; FIRST DOSE	$15.25	$15.25	12/18/2020	18	999
0012A (Moderna)	IMMUNIZATION ADMINISTRATION BY INTRAMUSCULAR INJECTION OF SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE [COVID-19]) VACCINE, MRNA-LNP, SPIKE PROTEIN, PRESERVATIVE FREE, 100 MCG/0.5ML DOSAGE; SECOND DOSE	$25.55	$25.55	12/18/2020	18	999
M0243	INTRAVENOUS INFUSION, CASIRIVIMAB AND IMDEVIMAB INCLUDES INFUSION AND POST ADMINISTRATION MONITORING	$278.64	$278.64	11/21/2020	12	999
M0239	INTRAVENOUS INFUSION, BAMLANIVIMAB-XXXX, INCLUDES INFUSION AND POST ADMINISTRATION MONITORING	$278.64	$278.64	11/10/2020	12	999

WHAT'S NEW?

Reminder: Medical providers must place the copayment exception code "V" immediately after the beneficiary ID number to waive the copayment deduction from the claim's total payment amount on all COVID-19 related treatments and services until the end of the public health emergency.

Since we anticipate that providers, initially, will not incur a cost for the product, CMS will update the payment allowance at a later date. Providers should not bill for the product if they received it for free.

Code	Code Description	Medicaid Rate
91300	SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE [COVID-19]) VACCINE, MRNA-LNP, SPIKE PROTEIN, PRESERVATIVE FREE, 30 MCG/0.3ML DOSAGE, DILUENT RECONSTITUTED, FOR INTRAMUSCULAR USE	$0.00
91301	SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2) (CORONAVIRUS DISEASE [COVID-19]) VACCINE, MRNA-LNP, SPIKE PROTEIN, PRESERVATIVE FREE, 100 MCG/0.5ML DOSAGE, FOR INTRAMUSCULAR USE	$0.00
Q0239	INJECTION, BAMLANIVIMAB-XXXX, 700 MG	$0.00
Q0243	INJECTION, CASIRIVIMAB AND IMDEVIMAB, 2400 MG	$0.00

WHAT'S NEW?

Attention Adult Daycare Providers!

12/23/2020 9:54 a.m.

All Adult Daycare Providers must notify DOM within 24 hours for any reason of facility closure. DOM must be notified again when facility reopens. Failure to notify DOM of facility closures may result in your provider number being terminated.

Send all notice of closures to HCBSProviders@Medicaid.MS.Gov

Attention All Medical Providers!

12/21/2020 8:50 a.m.

To be compliant with the HIPAA Administrative Simplification Requirements, effective December 21, 2020, Claims Adjustment Reason Code (CARC) 50 has been replaced with CARC 45 or CARC 94 depending on the provider type on the claim.

- SUBMITTED CHARGES < ALLOWED CHARGES - Change to populate CARC 94 instead of 50.
- SUBMITTED CHARGES > ALLOWED CHARGES - Change to populate CARC 45 instead of 50.

Additional changes to Claims Adjustment Reason Code (CARCs) and Remittance Advice Remark Codes (RARCs) will be made in January 2021. A link will be provided that will reveal a listing of all medical exception code numbers, descriptions, CARCs, and RARCs. You will be advised when the link is available.

Should you have any questions, please contact Conduent Provider Relations at 800-884-3222.

WHAT'S NEW?

Attention Providers!

11/24/20 3:35pm

Effective February 9, 2018 section 53102(a)(1) of the Bipartisan Budget Act of 2018 amended section 1902(a)(25)(E) of the Act to require a state to cost avoid all prenatal services. Previously only labor and delivery and postpartum claims were cost avoided. All claims, associated with prenatal services, will be returned to the provider noting the third party that DOM believes to be legally responsible for the payment. Changes to adhere to this requirement were implemented on November 9, 2020.

Attention Mental Health/Substance Use Disorder Providers!

11/12/20 3:50pm

Effective October 1, 2020, modifier HF is required on professional claims (CMS 1500) for substance use disorder (SUD) services. The HF modifier does not apply to Department of Mental Health certified Opioid Treatment Program Providers. Please refer to DOM's public website https://medicaid.ms.gov/providers/fee-schedules-and-rates/ to view current fee schedules and any additional modifiers required to be placed on the claim.

Annual service limits for SUD services will be combined with annual Mental Health limits.

Should you have any questions, please contact the Office of Mental Health at 601-359-9545.

NOTICE TO PHARMACY PROVIDERS ONLY

(DME or Pharmacy Disease Management Providers ARE NOT included)

11/12/20 3:45pm

There will be a point of sale (POS) system outage on Saturday, Nov 14th from 11:00PM CT until Sunday, Nov 15th 8:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

WHAT'S NEW?

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(DME or Pharmacy Disease Management Providers ARE NOT included)

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WHAT'S NEW?

Opioid Treatment Program (OTP) 10/05/20 4:45pm

To be compliant with the SUPPORT ACT, and contingent upon approval from the Centers for Medicare and Medicaid services, the proposed State Plan Amendment (SPA) 20-0023 Medication Assisted Treatment provided by Opioid Treatment Programs will be effective October 1, 2020.

OTP providers may begin submitting applications to become a MS Medicaid provider. Providers should enroll as a Private Mental Health Center (X01). OTP providers must be certified by the MS Department of Mental Health (DMH) as an Opioid Treatment Provider and include their DMH certification and SAMHSA certification with their application. Any servicing provider must be enrolled independently with the Division of Medicaid.

The Envision website lists application instructions, documentation and forms required to enroll. Providers may start the enrollment process by completing the Mississippi Medicaid Provider Enrollment Application located at https://www.ms-medicaid.com/msenvision/index.do. If you have any questions regarding the enrollment application or process, contact a Conduent provider enrollment specialist toll-free at 800-884-3222.

The Opioid Treatment Programs fee schedule can be located at https://medicaid.ms.gov/providers/fee-schedules-and-rates/ and are for dates of service on or after October 1, 2020. Refer to the fee schedule for the codes and modifiers covered.

If you have any program questions, please contact the Office of Mental Health by emailing Kimberly.Sartin-Holloway@medicaid.ms.gov or calling 601-359-9545.

WHAT'S NEW?

ATTENTION: Speech Therapists – Prior Authorization Requirements 09/30/20 9:24am

The Mississippi Division of Medicaid (DOM) requires prior authorization (PA) of outpatient speech therapy services, evaluation, and re-evaluations, for fee-for-service (FFS) beneficiaries. DOM contracts with Alliant Health Solutions as the Utilization Management/Quality Improvement Organization (UM/QIO) vendor. Alliant is responsible for determining medical necessity for fee-for-service (FFS) beneficiaries. Please refer to Alliant Health Solutions' provider portal at https://ms.allianthealth.org/, or call Alliant directly at 1-888-224-3067. Additionally, providers may submit requests to change information on a PA, as outlined in the Alliant Provider Medical Review Portal User Manual. Please refer to section 2.5 "Submit/View PA Change Request" in the Alliant Provider Medical Review Portal User Manual. In general, change requests are permitted for all pending/not referred and approved PAs and must be submitted within thirty (30) calendar days of the PA request date, or date of service, whichever is greater. Only three (3) change requests per PA may be submitted.

Speech Therapy Evaluation Codes			
Procedure Code	Procedure Code Description	PA Required in Outpatient Hospital	PA Required in Clinic or Office
92521	Evaluation of Speech Fluency	Yes	Not currently
92523	Evaluation Speech Sound Production with Language Comprehension/Expression	Yes	Yes
92524	Behavioral and Qualitative Analysis of Voice and Resonance	Yes	Yes

Please refer to the Mississippi Administrative Code Part 213: Therapy Services, Chapter 3: Speech Therapy: Rule 3.5 Prior Authorization/Pre-certification for additional information https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-213.pdf.

WHAT'S NEW?

Attention: Cost-Sharing Waived for COVID-19 Related Services

09/29/20 4:11 pm

Medical Fee-For-Service (FFS) Providers:

In the MS Medicaid Provider Bulletin COVID-19, Special Edition, Volume 26, issue 1, DOM notified medical providers that collection of a copayment from beneficiaries was prohibited beginning March 1, 2020. A mass adjustment has been completed to return copayments deducted from provider claims for the DOS March 1, 2020 through June 29, 2020. DOM did not deduct any copayments from claims beginning June 30, 2020 to October 3, 2020. Medical providers must refund ***any*** copayments to beneficiaries who paid a copayment during this timeframe.

Effective October 4, 2020, DOM will resume deduction of copayments from all claims. However, medical providers are prohibited from collecting copayment from a Medicaid beneficiary for COVID-19 related treatments and services.

Copayment Exception Code "V"

Medical providers must place the copayment exception code "V" immediately after the beneficiary ID number in order to waive the copayment deduction from the claim's total payment amount on all COVID-19 related treatments and services until the end of the public health emergency.

Pharmacy Fee for Service Claims (NCPDP D.0) 09/29/20 4:20pm

In the Provider Notice, disseminated by DOM on May 8, 2020, and per the MS Medicaid Provider Bulletin, COVID-19, Special Edition, Volume 26, Issue 1 pharmacy providers were directed to cease collecting copayments until the claims system update allowing COVID-related prescriptions to be identified by entry of the copay exception code "V" as a suffix to the beneficiary's Medicaid ID number.

Claim Timeline and actions required by pharmacy providers:

Claim Date of Service	Action Required
March 1, 2020 through April 8, 2020	None- Conduent has already adjusted all pharmacy claims and credited back copays. Pharmacy providers were previously instructed to refund these copayments to beneficiaries
April 9, 2020 through October 3, 2020	Conduent will adjust all claims and credit back copayments to pharmacy providers
October 4, 2020 and forward through the end date of the COVID-19 emergency	Providers must identify COVID-19 related claims by entering a "V" immediately after the beneficiary ID number in order to waive the $3.00 copay*

*The prescriber has indicated a diagnosis of COVID-19 on the prescription, or
*The prescriber notates the beneficiary may have COVID-19 illness on the prescription, or
*The beneficiary states that they may have COVID-19 or are being treated for COVID-19.

LATE BREAKING NEWS **2020**

WHAT'S NEW?

Attention Dental Providers! 09/02/20 12:15pm

Effective October 1, 2020, dental providers must submit a dental scoring tool for dental services provided in an outpatient hospital setting or Ambulatory Surgical Center (ASC), for fee-for-service (FFS) Medicaid beneficiaries, when requesting a prior authorization (PA) from DOM's Utilization Management and Quality Improvement Organization UM/QIO, Alliant Health Solutions

The dental scoring tool can be accessed at the following link:
http://prod-mspa2019.allianthealth.org/docs/help/Dental%20in%20OR%20and%20ASC.pdf

Should you have any questions, please contact Alliant Health Solutions at 888-224-3067.

Attention: All Providers - Copayment Refunds 09/25/20 3:57pm

DOM will mass adjust medical fee-for-service (FFS) claims for dates service March 1 , 2020 through June 29, 2020, reversing the copay deduction from the claim's payment amount. Medical providers are required to refund copayments to beneficiaries who have paid a copayment from March 1 , 2020, through June 29, 2020.

Attention Dental Providers 09/17/20 4:00pm

Effective October 1, 2020, dental providers must submit a dental scoring tool for dental services provided in an outpatient hospital setting or Ambulatory Surgical Center (ASC), for fee-for-service (FFS) Medicaid beneficiaries, when requesting a prior authorization (PA) from DOM's Utilization Management and Quality Improvement Organization UM/QIO, Alliant Health Solutions
The dental scoring tool can be accessed at the following link:

https://ms.allianthealth.org/docs/help/Dental in OR and ASC.pdf

Should you have any questions, please contact Alliant Health Solutions at 888-224-3067.

WHAT'S NEW?

Important Notice to Community Mental Health Service Providers

09/01/20 1:30 pm

On August 28, 2020, the Division of Medicaid (DOM) submitted the proposed State Plan Amendment (SPA) 20-0022 Mental Health Coverage and Reimbursement. Contingent upon approval from the Centers for Medicare and Medicaid Services, this SPA will be effective September 1, 2020.

This SPA includes several enhancements which include, but are not limited to, the following: a) Allowing a more innovative approach to providing Intensive Outpatient Psychiatric services, b) Allowing providers of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) community mental health services to provide services to non-EPSDT beneficiaries, c) Adding coverage and reimbursement of Acute Partial Hospitalization in the outpatient hospital setting or free standing psychiatric unit, a private psychiatric clinic or other provider certified by the Department of Mental Health or other appropriate entity as determined by the Division of Medicaid, d) Adding language to ensure that community mental health services are covered for beneficiaries with a substance use disorder, e) Removing annual service limits for Crisis Response Services and Medication Administration, and f) Increasing the rate for Mental Health Assessments by a non-physician to 90% of the Medicaid physician rate for Psychiatric Diagnostic Evaluations.

Providers are encouraged to review these changes at the following link: https://medicaid.ms.gov/wp-content/uploads/2020/08/MS-SPA-20-0022-Mental-Health-Services-and-Reimbursement-Public-Notice.pdf.

If you have any program questions, please contact the Office of Mental Health at 601-359-9545.

Attention: Dental Providers 09/01/20 1:30 pm

Effective February 1, 2018, the Mississippi Division of Medicaid (DOM) opened Current Dental Terminology (CDT) code D0120-Periodic Oral Evaluation. This oral evaluation is allowed twice per fiscal year (July 1-June 30) for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible beneficiaries and must be at least five (5) months apart.

Additionally, DOM limits use of CDT code D0150-Comprehensive Oral Evaluation to once every three (3) years per beneficiary, per provider or per provider group. This applies to new patients; established patients who have had a significant change in health conditions or other unusual circumstances, by report, or established patients who have been absent from active treatment for three (3) or more years.

Please contact Provider Services at Conduent at 1-800-884-3222 for additional information.

WHAT'S NEW?

Attention Providers: Texas, Louisiana Residents displaced by Hurricane Laura 08/27/20 4:51 pm

Please be aware that many Texas and Louisiana residents may have evacuated to Mississippi because of Hurricane Laura and may remain displaced for the near future. If a patient presents a Texas or Louisiana Medicaid card, and you have questions concerning beneficiary eligibility and/or claim submission, please reach out to the specific state's Medicaid program.

Texas Medicaid: 1-800-925-9126
Louisiana Medicaid: 1-888-342-6207

ATTENTION HOSPITAL PROVIDERS: Inpatient Hospital Authorization Process 07/31/20 4:30pm

Effective September 1, 2020, hospital providers will be required to adhere to the outlined timeframes for requesting authorizations from the Division of Medicaid (DOM) Utilization Management and Quality Improvement Organization (UM/QIO), Alliant Health Solutions. **Failure to adhere to these timeframes for authorization requests will result in a denial.** Nothing in this notification will supersede DOM authorization process for Maternity related services or Newborns. Providers must request the following: ***Elective or Non-Emergency Inpatient Admission***-Prior authorization must be obtained at least one (1) to three (3) business days before admission. ***Emergency Inpatient Admission***-The provider must request authorization for an Emergency Inpatient Admission within one (1) business day of admission.
Continued Stay Review-Provider must request a continued stay review within 2 business days prior to the expiration of the authorization but no later than 1 business day after the expiration of the authorization. ***Retrospective Review***-Requests for post service reviews will be considered when prior authorization was not obtained due to extenuating circumstances. (i.e., beneficiary was unconscious upon arrival, acts of nature impairing the provider's ability to verify the beneficiary coverage/eligibility status, services authorized by another payer who subsequently determined member was not eligible at the time of service, etc.)

More information regarding DOM policy can be found at https://medicaid.ms.gov/.

For assistance with authorization requests, please visit Alliant Health Solutions website at https://ms.allianthealth.org/.

WHAT'S NEW?

Attention All Elderly and Disabled (E&D) Waiver Case Management Providers—*RATE CHANGE!* 07/24/20 3:20 pm

For dates of service on or after July 1, 2020, the rate for Case Management (T2022) has been changed to $195.14 per month. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.

Attention All Providers: Autism Spectrum Disorder (ASD)

07/10/20 4:45 pm

The Division of Medicaid will reprocess claims with codes for Autism Spectrum Disorder (ASD) for dates of service July 1, 2019 through January 24, 2020. The mass adjustment will appear on your remittance advice dated July 13, 2020. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: Durable Medical Equipment Providers – Clarification for Wheelchair Code E1220 07/07/20 5:00 pm

Durable Medical Equipment (DME) providers are reminded that Healthcare Common Procedure Coding System (HCPCS) code E1220 can only be billed when there is no HCPCS code or combination of HCPCS codes which adequately describes the components and/or accessories of a specially sized or constructed (Custom) wheelchair. Code E1220 is a bundled code which only includes those components and/or accessories with no HCPCS code or combination of HCPCS codes assigned that adequately describe(s) these items for a specially sized or constructed wheelchair. Components and/or accessories used to construct the wheelchair that have an assigned HCPCS code with a fee on file, must be billed separately by the HCPCS code.

E1220 is specific to one chair type and should not be used in combination with other wheelchair codes. Wheelchairs other than E1220 that require additional items which have no codes or combination of codes that adequately describe the items required for that chair would utilize code E1399 - Durable Medical Equipment Miscellaneous.

WHAT'S NEW?

Attention: Private Duty Nursing Providers 06/26/20 1:08 pm

The Division of Medicaid (DOM) final filed the Administrative Code for Private Duty Nursing (PDN) and Personal Care Service (PCS) providers that will be effective July 1, 2020 and can be viewed on DOM's Final Administrative Code Filings page. PDN and PCS are for early and periodic screening, diagnosis and treatment (EPSDT) eligible beneficiaries, when medically necessary and prior authorized by the Utilization Management and Quality Improvement Organization (UM/QIO). Failure to obtain prior authorization will result in denial of payment. DOM is contracted with Alliant Health Solutions as the UM/QIO vendor, responsible for determining medical necessity for fee-for-service (FFS) beneficiaries. Please refer to Alliant Health Solutions' provider portal https://ms.allianthealth.org/ or call Alliant directly at 1-888-224-3067.

Procedure Code	Description of Service	Reimbursement Rate per Unit	Required Modifier
S9122	Certified Nurse Assistant (CNA), Providing Care In The Home	$17.26	N/A
S9123	Nursing Care, in the Home; by a Registered Nurse (RN), Per Hour	$32.41	EP
S9123	Nursing Care, in the Home; by a Registered Nurse (RN), Per Hour	$51.00	TG- Home Ventilator Dependent
S9124	Nursing Care, in the Home; by a Licensed Practical Nurse (LPN), Per Hour	$26.00	EP

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

WHAT'S NEW?

Attention: All Telehealth Providers 05/29/20 1:00 pm

Use of GT Modifier and Place of Service 02

The Division of Medicaid (DOM) reminds Telehealth providers that professional claims (CMS 1500) for audio -visual Telehealth services should be billed with a GT modifier and place of service 02. The temporary audio only codes 99441-99443 and G2012 should be billed with place of service 02. Lastly, Telehealth services billed on the UB-04 claim form should include the GT modifier. Providers are encouraged to visit DOM's website to monitor updates to the Emergency Telehealth Policy. Services rendered through Telehealth must be medically appropriate and in accordance with the qualified healthcare professional's scope-of-practice, license, medical certification or Mississippi Department of Mental Health (MDMH) certification and in accordance with state and federal guidelines, including but not limited to, authorization of prescription medications at both the originating and distant site. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

2020 New Bed Values for Nursing Facilities, ICF-IIDs, PRTFs, and NFSD

05/22/20 6:30pm

The new bed values for 2020 for nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs), psychiatric residential treatment facilities (PRTFs) and Nursing Facility for the Severely Disabled (NFSD) have been determined by using the R.S. Means Historical Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

Facility Class	2020 New Bed Value
Nursing Facility	$102,927
ICF-IID	$123,512
PRTF	$123,512
NFSD	$180,122

2019 Owner Salary Limits for Long-Term Care Facilities 05/22/20 6:31 pm

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities as owner's salaries for 2019 are based on 150% of the average salaries paid to non-owner/administrators that receive payment for services related to patient care. The limits apply to all salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2019 are as follows:

Small Nursing Facilities (1 - 60 Beds)	$143,645
Large Nursing Facilities (61+ Beds)	$165,975
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	$161,622
Psychiatric Residential Treatment Facilities (PRTF)	$164,540

WHAT'S NEW?

NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included)

05/16/20 3:30 pm

There will be a point of sale (POS) system outage on Saturday, May 16th from 11:00PM CT until Sunday, May 17th 5:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 5:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

Attention: NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included) 04/17/2020 6:03 pm

There will be a point of sale (POS) system outage on Saturday, Apr 18th from 11:00PM CT until Sunday, Apr 19th 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

Attention: Hospital Providers 04/17/2020 12:48 pm

Due to the COVID-19 Pandemic, the Division of Medicaid (DOM) will be postponing the **Inpatient Hospital Authorization Process** until further notice . The original Late Breaking News (LBN) notification was published on February 19, 2020 and was scheduled to be effective May 1, 2020.
For assistance with authorization requests, please refer to DOM's Utilization Management and Quality Improvement Organization (UM/QIO), Alliant Health Solutions at https://ms.allianthealth.org/.

WHAT'S NEW?

Attention: Hospital Providers - Newborn Enrollment Process and Maternity Related Authorizations 04/17/2020 12:48 pm

Newborn Enrollment
Hospitals must notify the Division of Medicaid (DOM) within five (5) calendar days of a newborn's birth via the Newborn Enrollment Form located on DOM's website. Hospitals must obtain a Treatment Authorization Number (TAN) for sick newborns requiring hospitalization whose length of stay is six (6) days or more. A sick newborn whose length of stay exceeds nineteen (19) days requires a concurrent review by DOM's Utilization Management and Quality Improvement Organization (UM/QIO), Alliant Health Solutions. For assistance with authorizations, please refer to Alliant's website https://ms.allianthealth.org/.

Maternity-Related Services
Alliant accepts the Newborn Enrollment Form, which is submitted to DOM, to authorize Maternity admissions up to nineteen (19) days. Maternity admissions exceeding nineteen (19) days require a continued stay request, in accordance with the policies and procedures provided by Alliant .

Attention: Telemedicine Providers 03/25/20 4:30 pm

Effective April 1, 2020, the Division of Medicaid (DOM) will reimburse an enhanced daily monitoring rate for remote patient monitoring (RPM) when medication adherence management services are included. RPM with medication adherence management services will be reimbursed using Healthcare Common Procedure Coding System (HCPCS) code S9110 with a U9 modifier.

Providers must obtain authorization, for fee-for-service (FFS) beneficiaries, from DOM's Utilization Management and Quality Improvement Organization (UM/QIO), Alliant Health Solutions. Please refer to Alliant Health Solutions' provider portal at: https://ms.allianthealth.org/, or call Alliant directly at 1-888-224-3067.

Providers should contact Magnolia Health, Molina Healthcare or United Healthcare Community Plan, for beneficiaries enrolled in Mississippi Coordinated Access Network (MSCAN), for specific authorization and

WHAT'S NEW?

Attention: Durable Medical Equipment Providers 02/27/20 11:20 am

In response to public comments for State Plan Amendment (SPA) 20-0001 Durable Medical Equipment (DME) and Medical Supply Reimbursement, the codes below will be removed from the proposed DME fee schedule. Effective March 1, 2020, DOM will continue to reimburse these codes through manual pricing. Please refer to the initial public notice and proposed fee schedule for this SPA on DOM's website DME and Medical Supply Reimbursement SPA and Public Notice.

Code	Description
A7520	Tracheostomy/Laryngectomy Tube, Non-Cuffed
A7521	Tracheostomy/Laryngectomy Tube, Cuffed
B4088	Gastrostomy/Jejunostomy Tube, Low profile

Attention: Hospital Providers - Inpatient Authorization Process 02/19/20 1:33 pm

Effective May 1, 2020, hospital providers will be required to adhere to the outlined timeframes for requesting authorizations from the Division of Medicaid (DOM) Utilization Management and Quality Improvement Organization (UM/QIO), Alliant Health Solutions. **Failure to adhere to these timeframes for authorization requests will result in a denial.** Nothing in this notification will supersede DOM authorization process for Maternity related services or Newborns.

Elective or Non-Emergency Inpatient Admission

- The provider shall request authorization for Elective or Non-Emergency Inpatient Admission from Alliant. Prior authorization must be obtained at least one (1) to three (3) business days before admission.

Emergency Inpatient Admission

- The provider must request authorization for an Emergency Inpatient Admission within one (1) business day of admission.

Continued Stay Review

- Provider must request a continued stay review within 2 business days prior to the expiration of the authorization but no later than 1 business day after the expiration of the authorization.

Retrospective Review

- Requests for post service reviews will be considered when prior authorization was not obtained due to extenuating circumstances. (i.e., beneficiary was unconscious upon arrival, acts of nature impairing the provider's ability to verify the beneficiary coverage/eligibility status, services authorized by another payer who subsequently determined member was not eligible at the time of service, etc.)

More information regarding DOM policy can be found at https://medicaid.ms.gov/.

For assistance with authorization requests, please visit Alliant Health Solutions website at https://ms.allianthealth.org/.

WHAT'S NEW?

Attention: RHC & FQHC Providers 02/19/20 1:37 pm

Effective February 1, 2020, the Mississippi Division of Medicaid (DOM) will no longer allow Rural Health Clinics (RHCs) and Federal Qualified Health Centers (FQHCs) to receive a separate encounter for HCPCS codes H0023, H1002, S9127, S9445, T1017 or T1023. These services will be covered in the encounter rate for the core service. There will be no recoupment of any payments from RHCs and FQHCs for services billed using HCPCS codes H0023, H1002, S9127, S9445, T1017 or T1023 for dates of service prior to February 1, 2020. Please contact the Mississippi Division of Medicaid at 601-359-6150 if you have any questions.

Attention Nursing Home Providers 02/14/20 1:16 pm

Effective October 1, 2020, the Optional State Assessment (OSA) will be required to complete all Minimum Data Set (MDS) resident assessment instruments. As the Division of Medicaid continues to move forward with fully implementing the Patient Driven Payment Model (PDPM), we will keep the provider community abreast of upcoming changes.

Attention Providers!!! 1099 Forms 02/14/20 9:46 am

Conduent mailed 1099 forms in late January of this year. A larger than normal volume of 1099 forms have been returned to Conduent due to invalid mailing addresses. While many providers completed and submitted a change of address form in 2019, only the servicing and or billing addresses were requested to be updated on the 2019 form. The 1099 mailing address remained unchanged if the change of address form did not indicate a change to the 1099 mailing address was needed. If a provider has not received their 1099, providers should take the following actions, 1) Call the Conduent Provider and Beneficiary Call Center at 1-800-884-3222, 2) verify the 1099 mailing address on file, 3) complete and submit a change of address form to Conduent specifically to update the 1099 mailing address if appropriate, 4) request the 1099 be mailed again after the 1099 mailing address has been updated. Change of address forms can be downloaded from the Mississippi Envision Web Portal at https://www.medicaid.ms.gov/wp-content/uploads/2014/06/ProviderChangeofAddressForm.pdf. Change of address forms can be submitted by fax to 1-888-495-8169 or mailed to P.O. Box 23078, Jackson Mississippi 39225. Providers can email the Change of Address form to providerenrollment@conduent.com.

WHAT'S NEW?

NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included)

02/14/20 9:24 am

There will be a point of sale (POS) system outage on Saturday, Feb 15th from 11:00PM CT until Sunday, Feb 16th 5:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/ POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 5:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

Attention All Outpatient Hospital Providers! 02/07/20 9:30 am

The Division of Medicaid will reprocess claims for dates of service October 30, 2019 through November 7, 2019 due to an issue with E&M claims denying for no prior authorization. A mass adjustment for affected claims has been requested and is forthcoming. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Providers! 02/07/20 11:38 am

The Division of Medicaid will reprocess claims for dates of service January 1, 2011 through October 19, 2017, which denied for affiliation, CLIA, and vaccine errors related to CPT codes 90460, 90461, 90473, 90474, 90644, 90647, 90648, 90655, 90657, 90662, and 90673. The mass adjustment will appear on your remittance advice dated 02/10/2020. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

Attention: Durable Medical Equipment Providers 01/27/20 2:33 pm

Notice concerning use of unlisted, custom or miscellaneous Durable Medical Equipment (DME) Healthcare Common Procedure Coding System (HCPCS) Codes

The Mississippi Division of Medicaid (DOM) reimburses for certain unlisted, custom and miscellaneous Healthcare Common Procedure Coding System (HCPCS) Codes when medically necessary, and for certain codes, with prior authorization. DOM is contracted with Alliant Health Solutions as the Utilization Management/Quality Improvement Organization (UM/QIO) vendor, responsible for determining medical necessity for fee-for-service (FFS) beneficiaries. DOM expects that use of HCPCS code E1220 is limited to items where there is truly no listed code or combination of codes that adequately describes the item provided.

Beginning March 1, 2020, requests submitted to Alliant Health Solutions for HCPCS code E1220 will be unbundled and priced based on DOM's DME fee schedule, if determined that an appropriate procedure or service code is available. This will also apply to items that are bundled with a mixture of manually priced items and items that have an associated fee. Items submitted for reimbursement must also list each individual HCPCS code when applicable.

The Office of Program Integrity will closely monitor DME claims submitted by providers relative to this issue. Any improper/fraudulent billing will be addressed and appropriate action will be taken.

Allowable Board of Directors Fees for Long-Term Care Facilities 2019 Cost Reports 01/10/20 4:59 pm

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2019 cost reports filed by nursing facilities (NFs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and psychiatric residential treatment facilities (PRTFs) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for all Urban Consumers - All Items. The amounts listed below are the per-meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2019 are as follows:

Category	Maximum Allowable Cost for 2019
0 – 99 Beds	$ 4,309
100 – 199 Beds	$ 6,464
200 – 299 Beds	$ 8,618
300 – 499 Beds	$10,773
500 Beds or More	$12,928

WHAT'S NEW?

Attention Providers!! 2019 New Bed Values for Nursing Facilities, ICF-IIDs, PRTFs, and NFSD 01/10/20 4:54pm

The new bed values for 2020 for nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs), psychiatric residential treatment facilities (PRTFs) and Nursing Facility for the Severely Disabled (NFSD) have been determined by using the R.S. Means Historical Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

Facility Class	2020 New Bed Value
Nursing Facility	$102,927
ICF-IID	$123,512
PRTF	$123,512
NFSD	$180.122

Attention Providers!! 2019 Owner Salary Limits for Long-Term Care Facilities 01/10/20 4:56 pm

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities as owner's salaries for 2019 are based on 150% of the average salaries paid to non-owner/administrators that receive payment for services related to patient care. The limits apply to all salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2019 are as follows:

Small Nursing Facilities (1 - 60 Beds)	$134,193
Large Nursing Facilities (61+ Beds)	$165,975
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	$151,292
Psychiatric Residential Treatment Facilities (PRTF)	$143,432

WHAT'S NEW?

NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included)

01/10/20 4:34 pm

There will be a point of sale (POS) system outage on Saturday, Jan 11th from 11:00PM CT until Sunday, Jan 12th 5:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 5:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

ATTENTION PROVIDERS!! *12/23/2019 10:59 am*

The Division of Medicaid will reprocess claims for dates of service January 1, 2011 through October 19, 2017, which denied for affiliation, CLIA, and vaccine errors related to CPT codes 90460, 90461, 90473, 90474, 90644, 90647, 90648, 90655, 90657, 90662, and 90673. The mass adjustment will appear on your remittance advice dated 12/23/2019 . No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: Durable Medical Equipment Providers

Effective March 1, 2020, all fee-for service (FFS) requests for incontinence items (diapers, pull-ups, blue pads and ointments) must be submitted with the Mississippi Division of Medicaid (DOM) Certificate of Medical Necessity (CMN) form. As a reminder, DOM covers incontinence items in accordance with the Mississippi Administrative Code Title 23, Part 209: Durable Medical Equipment. DOM covers up to six (6) units of incontinence garments per day, for a maximum of thirty-one (31) days per month, for beneficiaries aged three (3) and above, only when certified as medically necessary and prior authorized by the Division of Medicaid or designee. One (1) unit is equal to one (1) diaper or one (1) pull-on or one (1) underpad. The six (6) units can consist of any combination of diapers, pull-ons and/or underpads. Failure to obtain prior authorization will result in denial of payment.

The DOM CMN form will be the only CMN form accepted for FFS beneficiaries requesting incontinence items beginning March 1, 2020; all other CMNs used for incontinence items will be rejected.

The CMN can be found on DOM's website at https://medicaid.ms.gov/wp-content/uploads/2019/11/CMN-Incontinence-Supplies.pdf

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

WHAT'S NEW?

ATTENTION OCCUPATIONAL THERAPISTS – Prior Authorization requirements *12/02/2019 3:12 pm*

The Mississippi Division of Medicaid (DOM) requires prior authorization (PA) of outpatient occupational therapy services, evaluations and re-evaluations, for fee-for-service (FFS) beneficiaries. DOM is contracted with Alliant Health Solutions as the Utilization Management/Quality Improvement Organization (UM/QIO) vendor. Alliant is responsible for determining medical necessity for fee-for-service (FFS) beneficiaries. Please refer to Alliant Health Solutions' provider portal at: https://ms.allianthealth.org/, or call Alliant directly at 1-888-224-3067 to obtain a prior authorization. Additionally, providers may submit requests to change information on a PA, as outlined in the Alliant Provider Medical Review Portal User Manual. Please refer to section 2.5 "Submit/View PA Change Request" in the Alliant Provider Medical Review Portal User Manual. In general, change requests are permitted for all pending/not referred and approved PAs, and must be submitted within 30 calendar days of the PA request date, or date of service, whichever is greater. Only three (3) change requests per PA may be submitted.

Occupational Therapy Evaluation Codes	
Procedure Code	Procedure Code Description
97165	OT EVAL LOW COMPLEX 30 MIN
97166	OT EVAL MOD COMPLEX 45 MIN
97167	OT EVAL HIGH COMPLEX 60 MIN
97168	OT **RE-EVAL** EST PLAN CARE

Please refer to the Mississippi Administrative Code Part 213: Therapy Services, Chapter 2: Occupational Therapy for additional information https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-213.pdf.

Part 213: Therapy Services, Chapter 2: Occupational Therapy

Rule 2.5: Prior Authorization/ Precertification

A. The UM/QIO will determine medical necessity, the types of therapy services, and the number of units reasonably necessary to treat the beneficiary's condition. The frequency of visits provided by the therapist must match the Plan of Care signed by the prescribing provider.

WHAT'S NEW?

ATTENTION PHYSICAL THERAPISTS – Prior Authorization Requirements 12/02/2019 3:03 pm

The Mississippi Division of Medicaid (DOM) requires prior authorization (PA) of outpatient physical therapy services, evaluations and re-evaluations, for fee-for-service (FFS) beneficiaries. DOM is contracted with Alliant Health Solutions as the Utilization Management/Quality Improvement Organization (UM/QIO) vendor. Alliant is responsible for determining medical necessity for fee-for-service (FFS) beneficiaries. Please refer to Alliant Health Solutions' provider portal at: https://ms.allianthealth.org/, or call Alliant directly at 1-888-224-3067. Additionally, providers may submit requests to change information on a PA, as outlined in the Alliant Provider Medical Review Portal User Manual. Please refer to section 2.5 "Submit/View PA Change Request" in the Alliant Provider Medical Review Portal User Manual. In general, change requests are permitted for all pending/not referred and approved PAs, and must be submitted within 30 calendar days of the PA request date, or date of service, whichever is greater. Only three (3) change requests per PA may be submitted.

Physical Therapy Evaluation Codes	
Procedure Code	Procedure Code Description
97161	PT EVAL LOW COMPLEX 20 MIN
97162	PT EVAL MOD COMPLEX 30 MIN
97163	PT EVAL HIGH COMPLEX 45 MIN
97164	PT **RE-EVAL** EST PLAN CARE

Please refer to the Mississippi Administrative Code Part 213: Therapy Services, Chapter 1: Physical Therapy for additional information https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-213.pdf.

Part 213: Therapy Services, Chapter 1: Physical Therapy

Rule 1.6: Prior Authorization/Precertification

A. Medicaid requires prior authorization/precertification for certain outpatient therapy services.

1. Prior authorization/precertification for therapy services is conducted through the Utilization Management and Quality Improvement Organization (UM/QIO).
2. Failure to obtain prior authorization/precertification will result in denial of payment to the providers billing for services.
3. The UM/QIO must determine medical necessity for the types of therapy services and the number of units reasonably necessary to treat the beneficiary's condition. The frequency of visits provided by the therapist must match the Plan of Care signed by the physician.

WHAT'S NEW?

Attention: RHC & FQHC Providers 11/15/2019 3:13 pm

Effective December 1, 2019, the Mississippi Division of Medicaid (DOM) will no longer allow Rural Health Clinics (RHCs) and Federal Qualified Health Centers (FQHCs) to bill CPT code 99211 for services rendered. There will be no recoupment of any payments from RHCs and FQHCs for services billed using CPT code 99211 for dates of service prior to December 1, 2019. Please contact the Mississippi Division of Medicaid at 601-359-6150 if you have any questions.

ATTENTION: Durable Medical Equipment (DME) Providers - Reminder regarding coverage of gloves and disposable wipes 10/11/2019

Gloves

The Mississippi Division of Medicaid (DOM) does not cover gloves provided solely for the convenience of the beneficiary or family, or the convenience of any health care provider; as outlined in Mississippi Administrative Code Title 23: Medicaid Part 200, Rule 5.1: Medically Necessary. DOM reimburses for gloves in accordance with Mississippi Administrative Code Title 23: Medicaid Part 209 Durable Medical Equipment and Medical Supplies, when they are medically necessary and considered standard care for the treatment of a beneficiary's medical condition and dispensed in quantities that meet a beneficiary's medical needs without excessive utilization.

Providers should refer to the following DME Administrative Code sections, regarding inclusion of gloves:

Title 23: Medicaid Part 209 Durable Medical Equipment and Medical Supplies

- D. Dressing (Bandaging) Supplies (page 76)
- F. Enteral Feeding (page 76)
- J. Insulin Pump Supplies (page 78)
- L. IV Supplies (page 78)
- S. Suction Pump Supplies -Respiratory and Gastric (page 80)
- T. Drug Infusion Catheter (page 81)
- U. External Drug Infusion Pump (page 82)
- X. Tracheostomy Supplies (page 82)
- Y. Urinary Catheters (page 83)

Disposable Wipes and Washcloths

Incontinence wipes/washcloths do not meet the definition of a medically necessary medical supply and therefore are not reimbursable by the Division of Medicaid

Please contact the Mississippi Division of Medicaid at 601-359-6150, if there are questions.

WHAT'S NEW?

Attention All Providers! 10/09/2019 11:55 pm

Effective October 1, 2019, the Mississippi Division of Medicaid (DOM) will require prior authorization (PA) of certain Physician Administered Drugs (PADs) billed through the Medical Benefit. DOM covers PADs in accordance with Mississippi Administrative Code Title 23, Part 203, Chapter 2, found on DOM's public website. https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-203.pdf

HCPCS Code	Physician Administered Drug
J1428	Exondys 51 (eteplirsen)
Q2042	Kymriah (tisagenlecleucel)
J3398	Luxturna (voretigene neparvovec-rzyl)
J2326	Spinraza (nusinersen)
Q2041	Yescarta (axicabtagene ciloleucel)
J3590*	Zolgensma (onasemnogene abeparvovec-xioi)

** Zolgensma does not have an established HCPCS code*

Failure to obtain authorization will result in denial of payment. The National Drug Code (NDC) number of the drug being administered should be submitted along with its corresponding Healthcare Common Procedure Coding System (HCPCS) Code. Please refer to the PAD fee schedule located on DOM's public website for PADs requiring a PA https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

Providers must obtain authorization, for fee-for-service (FFS) beneficiaries, from DOM's Utilization Management and Quality Improvement Organization (UM/QIO). DOM contracts with Alliant Health Solutions, as the UM/QIO vendor. Please refer to Alliant Health Solutions' provider portal at: https://ms.allianthealth.org/, or call Alliant directly at 1-888-224-3067.

Providers should contact Magnolia Health, Molina Healthcare or United Healthcare Community Plan, for beneficiaries enrolled in Mississippi Coordinated Access Network (MSCAN), for specific authorization and documentation requirements.

WHAT'S NEW?

Attention All Providers - Medically Unlikely Edits (MUE) Changes 04/01/2018-07/01/2018 09/30/2019 10:01 a.m.

The Division of Medicaid will reprocess claims for dates of service April 1, 2018 through July 1, 2018 due to changes in NCCI's Medically Unlikely Edits (MUE) for CPT codes 88291, 20936, 97169, 97170, 97171, and 97172. The mass adjustment will appear on your remittance advice dated September 30, 2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Dental Providers - Rate Changes for D7260, D7285, D7286, D7350, D7411, D7520, D7911, D7912 effective 03/01/2019 09/30/2019 10:06 a.m.

The Division of Medicaid will reprocess claims with CDT codes D7260, D7285, D7286, D7350, D7411, D7520, D7911, D7912 for dates of service March 1, 2019 through June 3, 2019. The mass adjustment will appear on your remittance advice dated September 30, 2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

Medicaid to implement new CHIP contracts, effective Nov. 1, 2019

08/23/19 5:15pm

On Nov. 1, the Mississippi Division of Medicaid (DOM) will implement new three-year contracts for the Children's Health Insurance Program (CHIP).

Although DOM's coordinated care program, MississippiCAN, includes three coordinated care organizations (CCOs), CHIP will continue to be administered by two vendors because it has a smaller number of members. A little over 46,000 Mississippi children are currently enrolled in CHIP. However, providers should be aware that there is one important change: Molina Healthcare will replace Magnolia Health as one of the two CCOs. UnitedHealthcare Community Plan will continue to serve as the other CHIP vendor. This only applies to CHIP; all three plans will continue to participate in MississippiCAN.

The new CHIP contracts with Molina Healthcare and UnitedHealthcare Community Plan will become operational on Nov. 1, 2019. CHIP beneficiaries currently enrolled with the outgoing CHIP CCO, Magnolia Health Plan, will receive a letter giving them the opportunity to choose between Molina Healthcare and UnitedHealthcare Community Plan. If a CHIP beneficiary does not respond, they will be assigned to Molina Healthcare.

All CHIP beneficiaries can select which plan they want during annual open enrollment which will be held in October through December with an effective date of Jan. 1, 2020.
As always, DOM encourages providers to enroll in all Mississippi Medicaid programs and wants providers to be aware that Molina Healthcare will be providing CHIP services come Nov. 1, 2019. For more information about CHIP, visit our website at https://medicaid.ms.gov/programs/childrens-health-insurance-program-chip/.

NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included)

08/23/19 5:15pm

There will be a point of sale (POS) system outage on Saturday, Aug 24th from 11:00PM CT until Sunday, Aug 25th 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/ POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

LATE BREAKING NEWS ***2019***

WHAT'S NEW?

Attention All Providers! 08/20/19 3:03 pm

Effective July 1, 2019, all claims not paid by June 30, 2019, are subject to Miss. Admin. Code Part 200 Rule 1.6: Timely Filing, Rule 1.7: Timely Processing of Claims, and Rule 1.8: Administrative Review of Claims. These new rules can be viewed at https://medicaid.ms.gov/wp-content/uploads/2019/08/00024160b.pdf

Attention Nursing Facilities! 08/20/19 3:05 pn

Effective October 1, 2019, CMS will retire the Medicare Prospective Payment Systems (PPS) 14-day, 30-day, 60-day, 90-day, and Medicare PPS unscheduled assessments. The Mississippi Division of Medicaid (DOM) will not require the submission of the Optional State Assessment (OSA) October 1, 2019.

Attention DME Providers – DOM Coverage of Incontinence Garments - UPDATE 08/20/2019 3:17 pm

Effective August 1, 2019, Mississippi Division of Medicaid (DOM) coverage of incontinence garments will include the following updates:

- HCPCS code T4525 - age range updated to 0 - 999
- HCPCS code T4544 - for all eligible beneficiaries and should be utilized for billing beginning with dates of service on or after 8/1/2019.
- HCPCS code T4543 - reimbursement will change from 'priced by prior authorization' to a reimbursement rate of $1.00 per unit.

Failure to obtain prior authorization of all incontinence garments will result in denial of payment. The updated Medical Supply fee schedule will be available on 8/1/2019 at: https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

As a reminder, DOM covers up to six (6) units of incontinence garments per day, for a maximum of thirty-one (31) days per month, for beneficiaries aged three (3) and above only when certified as medically necessary and prior authorized by the Division of Medicaid or designee. Failure to obtain prior authorization will result in denial of payment. One (1) unit is equal to one (1) diaper or one (1) pull-on or one (1) underpad. The six (6) units can consist of any combination of diapers, pull-ons and/or underpads.

Beneficiaries eligible for certain Home and Community Based Services (HCBS) waivers may receive additional units through those benefits, if medically necessary and prior approved. If applicable, DME providers would receive authorization to provide those additional units from waiver case managers.

WHAT'S NEW?

NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included)

08/09/19 2:26pm

There will be a point of sale (POS) system outage on Saturday, Aug 10th from 11:00PM CT until Sunday, Aug 11th 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/ POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

ATTENTION: Maternity Providers 08/02/19 1:14 pm

The Division of Medicaid will reprocess claims for dates of service October 1, 2015 through March 12, 2018 which denied due to edit 0750- -FPL-BENEFICIARY HAS PRIMARY INSURANCE C VERAGE RESUBMIT WITH TPL EOB. This mass adjustment will appear on you remittance a is dated August 5,2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers - 97760 Max Unit Change 08/02/19 1:19 pm

The Division of Medicaid will reprocess claims for dates of service July 1, 2015 through September 6, 2017 due to changes in max units on CPT code 97760. The mass adjustment will appear on your remittance advice dated August 5, 2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION ALL PROVIDERS - Autism Spectrum Disorder Fee Update

08/02/19 1:24 pm

The Mississippi Division of Medicaid will reprocess claims billed for dates of service 07/01/2018 through July 18, 2018. The mass adjustment will appear on your remittance advice dated August 5, 2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included)

07/26/19 10:48 am

There will be a point of sale (POS) system outage on Saturday, Jul 27th from 11:00PM CT until Sunday, Jul 28th 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

ATTENTION ALL PROVIDERS- System changes to allow vaccine codes to be billed with 90471 07/19/19 9:37 am

The Division of Medicaid will reprocess claims with exception code 6558 to allow certain vaccine codes to be billed with CPT code 90471 for dates of service January 1, 2018 through January 1, 2019. The mass adjustment will appear on your remittance advice dated 7/22/2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included)

07/19/19 9:37 am

There will be a point of sale (POS) system outage on Saturday, Jul 20th from 11:00PM CT until Sunday, Jul 21st 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included) 07/12/19 2:09 pm

There will be a point of sale (POS) system outage on Saturday, Jul 13th from 11:00PM CT until Sunday, Jul 14th 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

WHAT'S NEW?

Attention All DME Providers – DOM Coverage of Incontinence Garments 07/01/2019 9:53 am

Effective July 1, 2019, the Mississippi Division of Medicaid (DOM) will reimburse certain HCPCS codes for pull-on incontinence garments for all eligible beneficiaries. DOM covers up to six (6) units of incontinence garments per day, for a maximum of thirty-one (31) days per month, for beneficiaries aged three (3) and above only when certified as medically necessary and prior authorized by the Division of Medicaid or designee. Failure to obtain prior authorization will result in denial of payment. One (1) unit is equal to one (1) diaper or one (1) pull-on or one (1) underpad. The six (6) units can consist of any combination of diapers, pull-ons and/or underpads. The new procedure codes should be utilized for billing beginning with dates of service on or after 7/1/2019.

HCPCS Code	Fee Effective July 1, 2019
T4526	$0.70
T4527	$0.95
T4528	$0.95
T4531	$0.60
T4532	$0.60
T4534	$0.65

Providers can find the complete Administrative Code Filing for Part 209: Durable Medical Equipment (DME) on the Administrative Code final file page. The Medical Supply fee schedule will be available on 7/1/2019 at: https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

Beneficiaries eligible for certain Home and Community Based Services (HCBS) waivers may receive additional units through those benefits if medically necessary and prior approved. If applicable, DME providers would receive authorization to provide those additional units from waiver case managers.

Attention Providers: Accepting Medicare Advantage Part C Secondary Claims Electronically Effective July 1, 2019 - Register for webinar now!!

06/26/19 4:12 pm

Effective July 1, 2019, Medicaid providers will be able to submit electronic claims for dual eligible beneficiaries with Medicare Advantage Part C coverage. The Division of Medicaid and Conduent expect this change to be very beneficial for Medicaid providers. Please review the "What's New" article located on the home page of the Envision Web portal for more details. **A webinar will be offered on Tuesday, July 2, 2019 and slots are limited.** If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

Alliant Health Solutions to replace eQHealth Solutions as Medicaid UM/QIO vendor 06/19/19 10:30 am

Beginning Aug. 1, 2019, Alliant Health Solutions will begin performing prior authorization reviews as the Mississippi Division of Medicaid (DOM) transitions to a new Utilization Management/Quality Improvement Organization (UM/QIO) vendor. Alliant was awarded the new UM/QIO contract earlier this year, and will replace the current vendor, eQHealth Solutions, to review and process prior authorizations for fee-for-service Medicaid.

Alliant has already begun reaching out to providers with important enrollment information, and DOM urges providers to read these communications carefully. Both DOM and Alliant will provide more information and updates as they become available. Additionally, instructions and educational materials will be developed and shared through a variety of communications avenues to ensure no provider lacks access to necessary resources.

Prior authorizations for beneficiaries enrolled in MississippiCAN will continue to be handled by the respective coordinated care organizations.

All prior authorization reviews in process before Aug. 1 will be completed by eQHealth as part of the transition to Alliant. Therefore any requests submitted on or before July 31 will be handled by eQHealth and providers will submit related inquiries, requested information and documentation to eQHealth during the month of August. This UM/QIO transition applies to all prior authorization services currently reviewed by eQHealth with the exception of advanced imaging services, which will continue to be handled by eQHealth.

For information on service authorization processes and provider education opportunities, please visit Alliant's Mississippi Medicaid portal at https://ms.allianthealth.org.

If you have questions about the UM/QIO transition, please contact Alliant through one of the following:
Website: Alliant Health Solutions Mississippi portal https://ms.allianthealth.org/

- Phone : (888) 224-3067 Email: mspaportal@allianthealth.org

NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included) 06/19/19 10:28 am

There will be a point of sale (POS) system outages on Saturday, Jun 22nd from 11:00PM CT until Sunday, Jun 23rd 4:00AM CT, and also on Saturday, Jun 29th from 11:00PM CT until Sunday, Jun 30th 4:00AM CT to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

WHAT'S NEW?

NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included) 05/31/19 11:28 am

There will be a point of sale (POS) system outage on Saturday, Jun 1st from 11:00PM CT until Sunday, Jun 2nd 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

Attention: Nursing Facilities 05/24/19 8:54 am

Effective June 1, 2019, pursuant to its authority under Attachment 4.19-D to the State Plan, Sections 1-7, Subsection B, paragraphs 17 and 18, the Division of Medicaid will assess and impose a sanction against any nursing facility that submits untimely, inaccurate or false information related to resident assessments in order to increase reimbursement above what is allowed under the State Plan. You may read more about this policy on our website at the following link: https://medicaid.ms.gov/wp-content/uploads/2019/05/Case-Mix-Sanction-Policy-for-Inaccurate-Assessments.pdf. Any questions regarding this policy may be directed to the Office of Program Integrity at 601-576-4162.

Attention Family Planning Waiver Providers 05/24/19 8:56 am

Effective April 1, 2019, the Division of Medicaid (DOM) no longer reimburses for CPT code 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care profession. Usually the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services) under the Family Planning Waiver (FPW). All FPW visits should include at a minimal, an evaluation of the participant's contraceptive program, renewal or change of the contraceptive prescription or supplies, and counseling and education.

FPW participants are allowed four (4) visits a year for family planning and family planning related services, which includes one annual/initial visit and three (3) subsequent visits. Participants cannot exceed a total of four (4) visits per calendar year (Jan. 1 – Dec. 31). FPW initial/annual visits should be billed with the appropriate preventive medicine code (99384, 99385, 99386, 99394, 99395, or 99396) and follow-up visits should be billed with the appropriate evaluation and management code (99201-99205 or 99213-99215).

If you have any questions, please contact the Office of Medical Services at (601) 359-6150.

WHAT'S NEW?

Attention All DME Providers 05/09/19 11:06 a.m.

The Mississippi Division of Medicaid (DOM) does not currently cover pull-ups for non-EPSDT eligible beneficiaries. DOM is in the process of revising this policy to include coverage of pull ups effective July 1, 2019. In the interim, coverage of incontinence garments for non-EPSDT eligible beneficiaries is limited to diapers and under pads only. Durable medical equipment (DME) suppliers providing pull-ups and billing DOM for diapers must cease and desist immediately. DME suppliers must follow all rules, regulations, and appropriate billing practices for the provision of DME, including incontinence garments.

HOSPITAL INPATIENT APR-DRG ALERT – July 1, 2019 Updates 05/03/19 1:19pm

The Mississippi Division of Medicaid (DOM) is proposing the following changes to the hospital inpatient APR-DRG payment methodology effective for the payment of hospital inpatient claims for discharges on and after July 1, 2019:

The following APR-DRG parameters will be updated:

- Base Payment – will change from $6,585 to $6,731
- Neonate policy adjustor – will change from 1.40 to 1.25
- Pediatric mental health policy adjustor – will change from 2.00 to 1.85
- Adult mental health policy adjustor – will change from 1.60 to 1.50
- DRG Cost Outlier Threshold – will change from $45,000 to $48,500
- DRG Day Outlier per diem – will change from $450 to $675

DOM estimates the overall impact of the above changes will be a savings of $26,282 in state and federal funds.

Due to significant changes in the clinical logic and relative weights from version 35 to version 36 of the 3M APR-DRG grouper, DOM will not update to version 36 on July 1, 2019. The changes to the logic and weights in version 36 would have a substantial impact on hospital reimbursement; as a result DOM has decided to remain on version 35 of the APR-DRG grouper and weights for an extra year in order to study how best to adapt to the new logic and weights. DOM will begin educating hospitals on the potential impacts on reimbursement resulting from version 36 during the APR-DRG training sessions for the July 1, 2019 updates. Additional claims analysis will then be performed using the version 37 grouper when it becomes available, to determine changes in APR-DRG parameters that will be necessary for the July 1, 2020 APR-DRG updates.

Please keep in mind that 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 and after July 1, 2019.

Training will be scheduled with dates to be provided. Hospitals will be notified via e-mail and the DOM website www.medicaid.ms.gov.

LATE BREAKING NEWS ***2019***

WHAT'S NEW?

Attention: DME Providers 05/03/19 12:57pm

The Division of Medicaid will reprocess DME claims with dates of receipt between January 28, 2019 and February 3, 2019. The mass adjustment will appear on your remittance advice dated May 06, 2019. Providers must correct and resubmit such claims to comply with the required inclusion of NPI/Prov ID for Ordering physicians. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

NOTICE TO PHARMACY PROVIDERS ONLY 05/03/19 12:57 pm *(DME or Pharmacy Disease Management Providers ARE NOT included)*

There will be a point of sale (POS) system outage on Saturday, May 18th from 11:00PM CT until Sunday, May 19th 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/ POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

ATTENTION ALL PROVIDERS– 2018 CPT Code Update Rate Corrections!!!

03/08/19 1:12 pm

The Mississippi Division of Medicaid will reprocess claims for dates of service January 1, 2018 through January 25, 2018. The mass adjustment will appear on your remittance advice dated March 11, 2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION ALL PROVIDERS!!!!

01/18/19 11:32 am

Change in rate for 4/01/2018 for HCPCS code J7307, Etonogestrel (contraceptive) implant system, including implant and supplies.

The Mississippi Division of Medicaid will reprocess claims for dates of service April 1, 2018 through July 13, 2018. The mass adjustment will appear on your remittance advice dated January 21, 2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

WHAT'S NEW?

ATTENTION OUTPATIENT HOSPITAL PROVIDERS!!!!!

01/16/19 7:40 pm

Under some circumstances, it is necessary to perform dental procedures in an outpatient hospital setting. The Division of Medicaid (DOM) covers medically necessary dental treatment in the outpatient hospital setting when all the following are met:

1. Quality, safe, and effective treatment cannot be provided in an office setting,
2. Is not medically necessary for inpatient hospitalization, and
3. Prior authorized by the Division of Medicaid or designee.

DOM will implement a billing policy change effective March 2019 for all dental services rendered in an outpatient hospital setting and billed on a UB-04 claim which:

1. Requires prior authorization to be obtained by the dentist (Failure to obtain prior authorization will result in denial of payment),
2. Each unit must be billed on a separate line, and
3. Multiple discounting will apply.

ATTENTION DENTAL PROVIDERS!!!!! 01/16/19 7:39 pm

Certain dental services do not require prior authorization in the office setting; please refer to the dental provider fee schedule located at medicaid.ms.gov/providers/fee-schedules-and-rates/#. Under some circumstances, it is necessary to perform dental procedures in an outpatient hospital setting. The Division of Medicaid (DOM) covers medically necessary dental treatment in the outpatient hospital setting when all the following are met:

1. Quality, safe, and effective treatment cannot be provided in an office setting,
2. Is not medically necessary for inpatient hospitalization, and
3. Prior authorized by the Division of Medicaid or designee.

DOM will implement a billing policy change effective March 2019 for all dental services rendered in an outpatient hospital setting which requires:

1. The dentist to obtain a prior authorization from the Division of Medicaid or designee for dental services rendered in an outpatient hospital setting, and
2. The treatment authorization number (TAN) and Place of Treatment on the American Dental Association (ADA) Claim form.

WHAT'S NEW?

2019 Code Changes for Mental Health Providers

01/07/19 4:38 pm

The 2019 CPT code changes include discontinued codes for Autism Spectrum Disorder (ASD) services and Psychological, Neuropsychological, and Developmental Testing. The new procedure codes should be utilized for billing beginning with dates of service on or after 01/01/2019.

Autism Spectrum Disorder (ASD)			Psychological, Neuropsychological and Developmental Testing	
Discontinued Code	Replacement Code		Discontinued Code	Replacement Code
0359T	97151		96101	96130/96131
0360T/0361T	97152		96111	96112/96113
0363T	0362T		96118	96132/96133
0364T/0365T	97153			
0366T/0367T	97154			
0368T/0369T	97155			
0370T	97156			
0371T	97157			
0372T	97158			
0374T	0373T			

New fee schedules for mental health program areas are posted under the provider tab on the DOM website and accessible through the following link:

https://medicaid.ms.gov/providers/fee-schedules-and-rates/#

If you have any questions, please contact the Office of Mental Health at 601-359-9545.

Attention All Providers!!! 12/28/18 4:08pm

The Division of Medicaid will reprocess claims for dates of service January 1, 2018 through January 8, 2018 due to changes on the NCCI 2018 151 quarter update. The mass adjustment will appear on your remittance advice dated December **31**, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Attention Outpatient Hospital Providers!!! 12/28/18 4:07pm

The Division of Medicaid will reprocess claims for dates of service January 1, 2015 through January 03, 2018. The mass adjustment will appear on your remittance advice dated December **31**, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers!!! 12/28/18 4:06pm

The Division of Medicaid will reprocess claims for dates of service October 1, 2017 through January 2, 2018 due to changes for the October 2017 Physician Administered Drug Fee Update. The mass adjustment will appear on your remittance advice dated December **31**, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers!!! 12/28/18 4:04pm

Influenza Vaccine 90674 added to Edit 6558 to allow payment.

The Division of Medicaid will reprocess claims for dates of service January 1, 2017 through March 5, 2018. The mass adjustment will appear on your remittance advice dated December **31**, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Outpatient Hospital Providers!!! 12/28/18 4:02pm

The Division of Medicaid (DOM) has completed system changes for the new fee updates for SFY19 Outpatient Prospective Payment System (OPPS) and the removal of 5% reimbursement reduction. DOM will reprocess outpatient hospital claims with dates of service July 1, 2018, through October 22, 2018, for these system changes. The mass adjustment will appear on your December **31**, 2018 Remittance Advice. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Providers 12/28/18 4:00pm

The Division of Medicaid will reprocess claims for dates of service January 1, 2011 through October 19, 2017. The mass adjustment will appear on your remittance advice dated December 31, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

CPT Codes 90460, 90461, 90473, 90474, 90644, 90647, 90648, 90655, 90657, 90662 and 90673.

WHAT'S NEW?

Attention All Fee-for-Service Home Health Providers: Discontinuation of Home Health Type of Bill 33X

12/28/18 10:51 am

The Mississippi Division of Medicaid will deny claims submitted with Type of Bill (TOB) 033X for home health services rendered on or after January 28, 2019. Please refer to the current Uniform Billing Editor for guidance regarding TOB codes used for home health claims.

Attention All Providers!!! 12/21/18 4:04pm

OCTOBER 2017 PHYSICIAN ADMINISTERED DRUG FEE UPDATE

The Division of Medicaid will reprocess claims for dates of service October 1, 2017 through January 2, 2018 due to changes for the October 2017 Physician Administered Drug Fee Update. The mass adjustment will appear on your remittance advice dated December 24, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers!!! 12/21/18 4:02pm

NCCI 2018 1st QUARTER UPDATE

The Division of Medicaid will reprocess claims for dates of service January 1, 2018 through January 8, 2018 due to changes on the NCCI 2018 151 quarter update. The mass adjustment will appear on your remittance advice dated December 24, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Providers 12/21/18 4:00pm

S9470 Nutritional Counseling, Dietitian Visit Max age changed from 20 to 55

The Division of Medicaid will reprocess claims for dates of service January 1, 2015 through January 03, 2018. The mass adjustment will appear on your remittance advice dated December 24, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Attention All Providers!!! 11/02/18 10:00am

Fee-For-Service, MississippiCAN & CHIP

2018 Fall Workshops are coming your way!!!

The Division of Medicaid, in conjunction with its contractors Conduent, eQHealth and the MSCAN plans – Magnolia Health, Molina Healthcare and UnitedHealthcare Community Plan, will conduct Provider Workshops November 27, 2018 through December 12, 2018, at varied location across the state. The purpose of these two-day Workshops is to provide updates and changes related to Medicaid and MSCAN. Office directors, office managers, coders and billing staff are encouraged to attend.

HELP US HELP YOU!

Please bring copies of claims and any issues your facility is experiencing to the Workshops. There will be a "Help Desk" available.

The following topics will be covered:

MississippiCAN & CHIP Upcoming Changes
Prior Authorization
Retro Review
Claims Review
Dental
Vision
Non- Emergency Transportation
Home Health & Wavier Services
Durable Medical Equipment
Hospital Services
Newborn Services
Third Party Liability
Special Investigation Unit & Program Integrity
HIPAA

See additional information on following page

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Dates	***Location***
Tuesday November 27, 2018	Natchez Convention Center 211 Main Street Natchez, MS 39120
Wednesday November 28, 2018	
Monday December 3, 2018	**Embassy Suites by Hilton** 200 Township Avenue Ridgeland, MS 39157
Tuesday December 4, 2018	
Thursday December 6, 2018	**Landers Center** 4560 Venture Drive Southaven, MS 38671
Friday December 7, 2018	
Tuesday December 11, 2018	**Northeast Conference Center** 111 US Hwy 11 and 80 Meridian, MS 39301
Wednesday December 12, 2018	

RSVP SPACE IS LIMITED!

Complete your RSVP information below

Date Attending Workshop(s):	
Facility Name and Provider ID:	
Number of Attendees from Facility:	
Email and Contact Telephone Number:	

Please forward all RSVP replies to:

DOM Office Provider and Beneficiary Relations

Email: ProviderWkspReply@medicaid.ms.gov

Fax: 601-359-4185

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

New Billing Requirements Regarding Medicare Advantage Plan/ Traditional Medicare EOBs 10/19/18 1:40 pm

The MS Division of Medicaid and Conduent State Healthcare have completed a recent review of Medicare claims submitted by paper or through the Envision web portal and discovered that there is a vast inconsistency in the information presented as Medicare reimbursement data on the Explanations of Benefits (EOB). Many of the presented EOBs fail to provide adequate and correct information. Therefore, effective **01/01/2019**, the Mississippi Division of Medicaid will require that the EOB for Medicare and Medicare Part C services billed to Medicaid must include the following fields:

- Medicaid Beneficiary Name
- Medicare ID or HIC
- Payer name *(i.e., Novitas, Wellcare, United Healthcare, etc.)*
- Paid Date (*date Medicare or Medicare Advantage plan paid*)
- Paid Amount (*payment received from Medicare or Medicare Advantage plan paid*)
- Allowed or Approved Amount- *(amount the insurer allows for the service)*
- Co-insurance *(as specified by Medicare of applicable Health plan)*
- Co-Pay *(as specified by Part C Health plan)*
- Deductible *(a specified amount of money that the insured must pay before an insurance company will pay a claim)*
- Blood deductible *(if indicated – is in addition to any other applicable deductible and coinsurance amounts for which the patient is responsible)*
- Sequestration (*amounts are not covered by Medicaid and are not considered patient's responsibility)*
- Contractual Adjustment (*Optional – the amount agreed upon between the provider and the carrier)*
- Service Level Information – *(line level claims specific information)*

Failure to adhere to the above guidelines may result in denial or delays to claims payment. For additional questions and assistance, contact Conduent Provider Services Call Center at 1-800-884-3222.

Attention: Outpatient Hospital Providers 10/05/18 2:20 pm

The Division of Medicaid (DOM) has updated the new fees for SFY19 Outpatient Prospective Payment System (OPPS) fee schedule, effective July 1, 2018. The OPPS fee schedule can be found at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.

Additionally, Senate Bill 2836 excluded outpatient hospital services from the 5% reimbursement reduction effective July 1, 2018. DOM's Fiscal Agent is working to successfully update the MMIS claims processing system for the removal of the 5% reduction. DOM anticipates the 5% reduction change in MMIS claims processing system to be completed by October 22, 2018.

Once the 5% reduction system changes are complete, a Mass Adjustment for all outpatient hospital claims, previously submitted for dates of service on or after July 1, 2018, will be completed for the SFY19 OPPS fee updates and the removal of the 5% reduction. No further action on the part of the provider is needed. Please watch Late Breaking News for information on the date these corrected claims will appear on your remittance advice. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

DOM appreciates your patience during this process.

WHAT'S NEW?

Mandatory Billing Policy Change for 340B Purchased Drugs Takes Effect November 1, 2018 10/10/18 4:47 pm

Effective November 1, 2018, the Division of Medicaid (DOM) is implementing a mandatory billing policy whereby providers must identify 340B purchased drugs on claims. This billing policy is in response to the Centers for Medicare and Medicaid Services (CMS) requirement that DOM define its policies and oversight activities related to 340B purchased drugs as outlined in CMS State Release No. 161, dated Oct. 26, 2012. Providers can find the complete Administrative Code Filing on the Administrative Code final file page.

NOTE: This represents a mandatory change to DOM billing policy only and will not impact 340B reimbursement.

The 340B program is a Drug Pricing Program established by the Veterans Health Care Act of 1992, which limits the cost of covered outpatient drugs to certain federal grantees including, but not limited to federally -qualified health center look-alikes, and qualified hospitals. These providers are allowed to purchase, dispense and/or administer pharmaceuticals at significantly discounted prices. The significant discount applied to the cost of these drugs makes them ineligible for the Medicaid drug rebate. State Medicaid programs are mandated to ensure that rebates are not claimed on these drugs thereby preventing duplicate discounts for these drugs.

In early 2017, DOM mailed attestation packets to covered entities, requiring that they opt-in (bill 340B purchased drugs to Medicaid) or opt-out (not bill Medicaid for any 340B purchased drugs). Providers who opt-in must bill the appropriate codes on a claim billed with a 340B purchased drug.

Billing Guidelines for 340B covered entities who have opted in:

- **Medical claims:** On CMS 1500 Health Insurance Claim Form or Uniform Billing (UB04) Form, a "UD" modifier is required to identify a 340B purchased drug in addition to the corresponding Healthcare Common Procedure Coding System (HCPCS) and National Drug Code (NDC).
- **Pharmacy point of sale claims billed electronically in the D.0 format:** The ingredient cost must be billed to DOM at the actual acquisition cost (AAC). This AAC is defined as the price at which the covered entity has paid the wholesaler or manufacturer for the covered outpatient drug.
    - The AAC must be submitted in field #4Ø9-D9, field name "ingredient cost submitted". The professional dispensing fee must be submitted in field # 412-DC, field name "dispensing fee submitted".
    - Enter "08" in field 423-DN, the Basis of Cost Determination field, and "20" in field 420-DK, the Submission Clarification Code.

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Attention Providers 09/13/18 11:54 pm

Effective for dates of service (DOS) on and after October 1, 2018, the Division of Medicaid will reimburse seventy percent (70%) of the Medicare fee schedule for chiropractic services as required by the Mississippi State Plan.

Attention All Elderly and Disabled (E&D) Waiver Adult Day Care Providers 09/07/18 4:08pm

Please see the below reminders regarding adult day care services billed under the S5100 procedure code for Elderly & Disabled Waiver participants.

For dates of service on or after November 1, 2017, the rate for Adult Day Care was changed to $3.88 per 15 minute unit for the duration of time the services were provided. Services will be reimbursed by DOM the lessor of the total amount of the 15 minute increment units billed or the maximum daily rate of $62.08. Providers should bill the number of actual units provided for each day. The system will pay the claims appropriately, but if the total unit rate exceeds the daily maximum, the line will be automatically adjusted to the daily maximum and a change reason code of 'LC - LTC Provider Cutback Amount' will be posted.

Services for the month cannot be billed until the first (1st) day of the month following the month in which services were rendered (i.e. April services cannot be billed until May 1). Claims will receive the following denial edit if this requirement is not met: Edit 0158 – BILLING DATE BEFORE LDOS

All services for the month must be billed on a single claim with individual lines for each date of service to accurately capture units provided each day. Claims for dates of service after September 4, 2018 will receive the following denial edit if this requirement is not met: Edit 1328 - LTC CAP LIMIT SPAN DOS

The duration of the service time should begin upon the person's entry in the facility and end upon their departure, and does not include transportation time.

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

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Attention Family Planning Waiver Providers 09/07/18 3:54 pm

Effective January 1, 2018, the Division of Medicaid (DOM) required Family Planning Waiver (FPW) initial and annual visits to be billed with the appropriate preventive medicine CPT codes 99384, 99385, 99386, 99394, 99395, or 99396. DOM will reprocess FPW claims which denied incorrectly due to edit 3196 (annual physical assessment/exam to be performed by EPSDT Provider) for dates of service on or after January 1, 2018 for preventive medicine CPT codes 99384, 99385, 99394 and 99395. Providers should continue to bill the appropriate preventive medicine CPT codes for FPW services. The mass adjustment will appear on a future remittance advice and no further action on the part of the provider is needed. If you have any questions, please contact the Office of Medical Services at 601-359-6150.

Stimulant Prescriptions and Prescribing-Guideline Requirements 08/08/2018 8:37 am

Effective October 1, 2018 and in accordance with recommendations from the Drug Utilization Board, the Mississippi Division of Medicaid (DOM) will implement prescribing-guideline clinical edits for stimulant drugs most commonly used to treat attention deficit hyperactivity disorder (ADHD)/ attention deficit disorder (ADD) in children and adults. The electronic edit requires the presence of at least one (1) Food and Drug Administration (FDA)-approved indication or compendia-supported indication for each stimulant product prescribed. A list of FDA-approved or compendia-supported indications covered by DOM, along with corresponding ICD-10 codes, can be found on the DOM's Pharmacy Resource website page located at: https://medicaid.ms.gov/wp-content/uploads/2018/07/Stimulant-Approved-Indications-Coverage.pdf.

In order for a prescription claim to be electronically approved, the diagnosis must be:

•present in the patient's medical paid claims history within the past 24 months of the prescription fill,

OR

•written on the prescription by the prescriber and submitted by the pharmacist on the prescription claim.

Providers should be aware the new clinical edit is being implemented and taking effect Oct. 1, 2018, so that they may plan appropriately for uninterrupted care of their patients. For questions or more information, please contact the Office of Pharmacy at 601-359-5253, Option 4.

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Updated Provider Enrollment Application

07/11/18 3:00 pm

On May 7, 2018, the Division of Medicaid (DOM) rolled out its Updated Mississippi Medicaid Provider Enrollment Application that has been revised to collect additional information required for enrollments.

Effective July 29, 2018, Conduent will return any applications that are not completed on the revised Mississippi Medicaid Enrollment Application. The provider will be required to complete and resubmit the updated application packet located at https://www.ms-medicaid.com/msenvision/downloadenrollPackage.do.

Providers with questions or needing additional information about the updated enrollment application should contact Provider Enrollment at (800) 884-3222.

ATTENTION ALL PHYSICIANS

07/09/18 12:41 pm

Effective July 1, 2018, the Mississippi Division of Medicaid (DOM) will reimburse professional claim lines billed with Place of Service Code 19 (Outpatient Hospital-Off Campus) at 90% of the Medicare Physician Fee Schedule Site of Service Payment Differential as currently reimbursed with Place of Service codes 21 (Inpatient Hospital), 22 (Outpatient Hospital-On Campus), and 23 (Emergency Room-Hospital). If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Providers

06/29/18 12:07 pm

In accordance with Section 6507 of the Patient Protection and Affordable Care Act, the Mississippi Division of Medicaid utilizes National Correct Coding Initiative (NCCI) methodologies in claims processing. Providers must report services in accordance with Medicaid NCCI guidance. Effective, July 1, 2018, the maximum units for certain Current Dental Terminology codes (CDT) will be updated for the Dental Fees – Outpatient Hospital fee schedule located at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Attention All Providers!!! MississippiCAN & CHIP

06/28/18 8:51 am

2018 Workshops are coming your way!!!

The Division of Medicaid, in conjunction with its contractors – Conduent, eQHealth and the MSCAN plans – Magnolia Health, Molina Healthcare and UnitedHealthcare Community Plan, will conduct Provider Workshops July 25, 2018 through September 12, 2018, at varied location across the state. The purpose of these two-day Workshops is to provide updates and changes related to Medicaid and MSCAN. Office directors, office managers, coders and billing staff are encouraged to attend.

HELP US HELP YOU!

Please bring copies of claims and any issues your facility is experiencing to the Workshops. There will be a "Help Desk" available.

The following topics will be covered:

- MississippiCAN & CHIP Upcoming Changes
- Prior Authorization
- Retro Review
- Claims Review
- Dental
- Vision
- Non- Emergency Transportation
- Home Health & Wavier Services
- Durable Medical Equipment
- Hospital Services
- Newborn Services
- Third Party Liability
- Special Investigation Unit & Program Integrity
- HIPAA

Continued on next page

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Dates	***Location***
Wednesday July 25, 2018	Eagle Ridge Conference Center 1500 Raymond Lake Rd. **Raymond**, MS 39154
Thursday July 26, 2018	
Tuesday July 31, 2018	Bancorp South Arena 375 Main Street **Tupelo**, MS 38804
Wednesday August 1, 2018	
Tuesday August 14, 2018	Greenville Higher Education Center 1134 Archer Range Road **Greenville**, MS 38701
Wednesday August 15, 2018	
Tuesday August 28, 2018	Courtyard Gulfport Beachfront Marriot 1600 East Beach Boulevard **Gulfport**, MS 39501
Wednesday August 29, 2018	
Tuesday September 11, 2018	Lake Terrace Convention Center 1 Convention Center Plaza, **Hattiesburg**, MS 39401
Wednesday September 12, 2018	

RSVP SPACE IS LIMITED!

Complete your RSVP information below

Date Attending Workshop(s):	
Facility Name and Provider ID:	
Number of Attendees from Facility:	
Email and Contact Telephone Number:	

Please forward all RSVP replies to:
Division of Medicaid Provider and Beneficiary Relations
Email: ProviderWkspReply@medicaid.ms.gov
Fax: 601-359-4185

Continued on next page

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Workshop Agenda

Day 1

Time		***Discussion Topics***
9:00 a.m.	9:30 a.m.	**Welcome & Introductions**
9:30 a.m.	10:30 a.m.	**Medicaid & CCO Overview** Upcoming Changes, Provider Enrollment Credentialing
10:30 a.m.	12:30 p.m.	**Prior Authorizations** **Retro Reviews** **Claims Review**
12:30 p.m.	1:30 p.m.	***LUNCH BREAK***
1:30 p.m.	2:30 p.m.	**Dental Services** **Vision Services** **Non-Emergency Transportation**
2:30 p.m.	3:30 p.m.	**Home Health & Wavier Services** **Durable Medical Equipment**

Day 2

Time		***Discussion Topics***
9:00 a.m.	9:30 a.m.	**Welcome & Introductions**
9:30 a.m.	10:30 a.m.	**Medicaid & CCO Overview** Upcoming Changes, Provider Enrollment Credentialing
10:30 a.m.	12:30 p.m. -	**Prior Authorizations** **Retro Reviews** **Claims Review**
12:30 p.m.	1:30 p.m.	***LUNCH BREAK***
1:30 p.m.	2:30 p.m.	**Hospital Services** **Newborn Services**
2:30 p.m.	3:30 p.m.	**Third Party Liability** **Program Integrity** **Special Investigation Unit**

WHAT'S NEW?

Attention Durable Medical Equipment (DME) and Medical Supply Providers

06/26/18 4:38 pm

On November 8, 2017 the Mississippi Division of Medicaid (DOM) released public notice of Medicaid State Plan (SPA) 17-0015 Durable Medical Equipment (DME) and Medical Supply Reimbursement. The Centers for Medicare and Medicaid Services (CMS) approved SPA 17-0015 on December 14, 2017 with an effective date of November 9, 2017.

SPA 17-0015 states that "[w]hen it is determined by DOM, based on documentation, that the DMEPOS fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, then a fee will be calculated using market research from the area." As a result, DOM will modify rates for Healthcare Common Procedure Coding System (HCPCS) codes A4221, A4222, A4253, A4256, A4258 and A4259 to reflect market research from the area. DOM will reprocess claims for dates of service on or after November 9, 2017 which were billed using the aforementioned codes. No further action on the part of the provider is needed. If you have any questions, please contact the Office of Medical Services at 601-359-6150.

HCPCS Code	Fee Effective November 9, 2017
A4221	$20.33
A4222	$35.36
A4253	$24.14
A4256	$7.44
A4258	$13.85
A4259	$8.17

WHAT'S NEW?

HOSPITAL INPATIENT APR-DRG ALERT – July 1, 2018 Updates

05/04/18 2:21 pm

The Mississippi Division of Medicaid (DOM) is proposing the following changes to the hospital inpatient APR-DRG payment methodology effective for the payment of hospital inpatient claims for discharges on and after July 1, 2018:

1) DOM will adopt V.35 of the 3M Health Information Systems APR-DRG Grouper and Hospital-Specific Relative Value (HSRV) weights.

DOM will update the existing methodology used to assign pediatric and adult policy adjustors which is based on principal diagnosis codes and the age of the beneficiary. The new methodology will use the APR-DRG assigned to the stay and the age of the beneficiary to assign a pediatric or adult Medicaid Care Category (as established by DOM.) The Medicaid Care Category will be used to assign a policy adjustor to the inpatient stay.

Charge cap: If the sum of the APR-DRG base payment including effects of policy adjustors, APR-DRG cost outlier payment, APR-DRG day outlier payment, and transfer and/or prorated adjustments, if applicable, is more than the total billed charges on the claim, the total APR-DRG payment amount, net of medical education payments, will be limited to the total billed charges.

The following APR-DRG parameters will be updated:

Base Payment – will change from $6,415 to $6,585
Neonate policy adjustor – will change from 1.45 to 1.40
DRG Cost Outlier Threshold – will change from $50,000 to $45,000
DRG Cost Outlier Marginal Cost Percentage – will change from 50% to 60%

DOM estimates the overall impact of the above changes will be a savings of $165,620 in state and federal funds.

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 and after July 1, 2018.

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Attention Qualified Providers who need to attest/ re-attest to receive increased primary care services payments. Updated 05/07/18 12:26pm

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers at 100% of the Medicare Physician Fee Schedule for certain primary care Evaluation and Management (E&M) and Vaccine Administration codes. Qualified providers who attest to a specialty designation in family medicine, general internal medicine, obstetric/gynecologic medicine, pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), the American Congress of Obstetricians and Gynecologists (ACOG), and the American Osteopathic Association (AOA) may be eligible for increased payment of certain primary care E&M and Vaccine Administration codes.

Effective July 1, 2018, reimbursement of certain primary care services provided by eligible providers will be at 100% of the Medicare Physician Fee Schedule, which is updated July 1 of each year and takes effect January 1. To receive the increased payment for dates of service beginning 7/1/2018, eligible providers must send a completed and signed 7/1/2018 – 6/30/2021 Self-Attestation Statement form to Conduent Provider Enrollment by **6/30/2018** through one of the following means:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: P. O. Box 23078, Jackson, MS 39225

Providers must notify Conduent of any change(s) to their completed 7/1/2018 – 6/30/2021 Self-Attestation Statement form. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at https://www.ms-medicaid.com/msenvision/.

Additional information can be found on the DOM website (www.medicaid.ms.gov) and Envision Web Portal (www.ms-medicaid.com/msenvision/), including the PCP Self-Attestation General Instructions and the 7/1/2018 – 6/30/2021 Self-Attestation Statement form, or it can be requested by contacting the Conduent Call Center at 800-884-3222.

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Attention Family Planning Waiver Providers!

04/26/2018 1:15pm

The Family Planning Waiver (FPW) standard terms and conditions (STCs) approved by the Centers for Medicare and Medicaid (CMS) effective January 1, 2018 through December 31, 2027, requires the Division of Medicaid (DOM) to report clinical breast exams. As defined by the Centers for Disease Control and Prevention (CDC), a clinical breast exam is an examination by a doctor or nurse, who uses his or her hands to feel for lumps or other changes. A clinical breast exam should be performed during the initial and annual FPW visits.

In an effort to distinguish between the initial/annual visits and follow up visits, effective January 1, 2018, DOM will require FPW initial/annual visits be billed with the appropriate preventive medicine code (99384, 99385, 99386, 99394, 99395, or 99396). Follow-up FPW visits should continue to be billed with the appropriate evaluation and management codes (99201-99205 or 99211-99215).

If you have any questions, please contact the Office of Medical Services at (601) 359-6150.

ATTENTION ALL PROVIDERS - ONLY MEDICAL SUPPLIES, EQUIPMENT AND APPLIANCES ORDERED BY A PHYSICIAN ARE COVERED AND REIMBURSED UNDER THE MEDICAID PROGRAM 04/26/18 1:18 pm

In accordance with 42 C.F.R. § 440.70, only medical supplies, equipment and appliances ordered by a physician are covered and reimbursed under the Medicaid program. As a result of discussions with the Centers for Medicare and Medicaid Services (CMS) regarding proposed State Plan Amendment (SPA) 17-0001 Home Health Services, the Division of Medicaid was instructed by CMS to remove the current SPA language which allows non-physician practitioners to order medical supplies, equipment and appliances. Therefore, effective September 1, 2018, the Division of Medicaid will no longer cover medical supplies, equipment and appliances ordered by non-physician practitioners. Durable Medical Equipment (DME) providers are required to specify the ordering physician's National Provider Identifier (NPI) on any claim for payment to maintain compliance with C.F.R. § 455.440.

For more information regarding the ordering requirements of medical supplies, equipment and appliances, please contact the Office of Medical Services (601) 359-6150.

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Attention Pharmacy Providers! Revised on 04/23/2018 12:25pm

The Division of Medicaid will reprocess 59 Pharmacy Fee For Service claims with Dates of Service from 07/17/2017 to 01/05/2018 for the 17 NDCs listed below, due to a file load error. These claims will be mass adjusted during the week of 4/23/2018 and will be reflected on the Remittance Advice dated 4/30/2018..

NDC	Brand Name	Generic Name
00121065700	ACETAMINOPHEN 160 MG/5 ML S	ACETAMINOPHEN
00121131400	ACETAMINOPHEN 325 MG/10.15	ACETAMINOPHEN
00121197100	ACETAMINOPHEN 650 MG/20.3 M	ACETAMINOPHEN
00074433902	HUMIRA 40 MG/0.8 ML PEN	ADALIMUMAB
00074379902	HUMIRA 40 MG/0.8 ML SYRINGE	ADALIMUMAB
00074433906	HUMIRA PEN CROHN-UC-HS STAR	ADALIMUMAB
00074433907	HUMIRA PEN PSORIASIS-UVEITI	ADALIMUMAB
00115164301	NITROFURANTOIN MCR 50 MG CA	NITROFURANTOIN MACROCRYSTAL
00023530105	RESTASIS MULTIDOSE 0.05% EY	CYCLOSPORINE
00023916305	RESTASIS MULTIDOSE 0.05% EY	CYCLOSPORINE
00310661502	SYMLINPEN 60 PEN INJECTOR	PRAMLINTIDE ACETATE
00078048515	TEKTURNA 150 MG TABLET	ALISKIREN HEMIFUMARATE
00078048615	TEKTURNA 300 MG TABLET	ALISKIREN HEMIFUMARATE
00078052115	TEKTURNA HCT 150-12.5 MG TA	ALISKIREN/ HYDROCHLOROTHIAZIDE
00078052215	TEKTURNA HCT 150-25 MG TABL	ALISKIREN/ HYDROCHLOROTHIAZIDE
00078052315	TEKTURNA HCT 300-12.5 MG TA	ALISKIREN/ HYDROCHLOROTHIAZIDE
00078052415	TEKTURNA HCT 300-25 MG TABL	ALISKIREN/ HYDROCHLOROTHIAZIDE

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Attention Providers! 04/06/18

The Division of Medicaid will reprocess claims for dates of service October 01, 2017 through January 30, 2018 which were billed using the codes J0585, J0586, J0587, and/or J0588. The mass adjustment will appear on your remittance advice dated 04/09/2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION ALL PROVIDERS

SY2018 PHYSICIAN FEE UPDATE 04/06/18 11:09 am

The Division of Medicaid has completed the SFY2018 Physician Fee Update effective July 1, 2017. Claims for dates of service on or after July 1, 2017 through August 21, 2017 will be reprocessed. No further action on the part of the provider is needed. These reprocessed claims will appear on your 4/09/2018 remittance advice. If you have any questions, please contact Conduent Provider and Beneficiary services at 800-884-3222.

Attention All Providers 03/23/18 12:42 p.m.

The March 2018 issue of the provider bulletin has been published and is posted to the Envision web portal and on DOM's website (http://medicaid.ms.gov). DOM providers may download the bulletin by visiting the Envision web portal at https://www.ms-medicaid.com.

Providers now have the option to subscribe (for FREE) and receive the provider bulletin via hard copy print (through postal mail), e-newsletter or both by visiting DOM's website at https://medicaid.ms.gov; click on Providers, Resources, then Forms. The completed subscription form should be faxed to the Office of provider Beneficiary Relations at 601 359-4185.

Attention: Qualified Medicare Beneficiary (QMB) Providers

2017 QMB Claim Error Claim Resubmission may be required

The Centers for Medicare and Medicaid Services (CMS) modified the Medicare Remittance Advice (Medicare RA) for Qualified Medicare Beneficiary (QMB) claims processed on or after October 2, 2017, to indicate the QMB status of patients that also reflect a zero cost-sharing patient liability.

Continued on next page

WHAT'S NEW?

However, the Medicare RA changes caused unforeseen issues affecting the processing of QMB cost-sharing claims directly submitted by providers to state Medicaid agencies, including the MS Division of Medicaid (DOM). To address these issues, CMS temporarily suspended the Medicare RA system changes for QMB claims and reverted to the previous display of beneficiary responsibility on the Medicare RA December 8, 2017.

CMS is working to remediate these issues with the goal of reintroducing QMB information in the Medicare RA without disrupting claims processing in 2018.

In order for DOM to process affected QMB claims previously denied or processed incorrectly due to the RA changes for claims processed between **October 2, 2017 and December 7, 2017**, affected providers should execute the following:

Get the corrected Medicare RA from CMS.

If DOM already paid the claim with the wrong amount (this amount could equate to $0.00 or $XX.XX), provider should void and replace the claim with the corrected patient liability amount based on the corrected Medicare RA.

If a provider has a rejected claim based on the patient liability amount, affected providers should resubmit the claim with revised patient liability amount from the Medicare RA.

For more information, please visit the following webpages:

- https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MM9911Update112017.pdf

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1128.pdf

ATTENTION: HOSPITAL PROVIDERS

(02/23/18) 4:19 p.m.

V.35 HCAC Utility

For last dates of service on or after October 1, 2017, the Health Care Acquired Conditions (HCAC) utility used to process hospital inpatient claims has been updated to V.35. A Mass Adjustment is being completed for all Hospital inpatient claims previously paid under V.34 of the HCAC utility for last dates of service October 1, 2017 through November 5, 2017, the V.35 implementation date.

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

ATTENTION: MATERNITY PROVIDERS

(02/23/18) 4:21 p.m.

The Division of Medicaid will reprocess claims for dates of service October 1, 2015 through October 12, 217 which denied due to edit 0750-TPL BENEFICIARY HAS PRIMARY INSURANCE COVERAGE - RESUBMIT WITH TPL EOB. This mass adjustment will appear on your remittance dated February 26, 2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary services at 800-884-3222.

ATTENTION ALL PROVIDERS

October 2017 HCPCS Code Update
(02/23/18) 4:15 p.m.

The Division of Medicaid will reprocess claims for dates of service October 1, 2017 through December 7, 2017 which were billed using the codes listed in the table below. The mass adjustment will appear on your remittance advice dated February 26, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

C9491	**C9492**	**C9493**	**C9494**

ATTENTION ALL HOSPITAL PROVIDERS

(02/23/18) 4:09 p.m.

The Medicaid Management Information System has been updated to add a date span for capturing the annual changes for POA Exempt diagnosis codes in order to ensure proper payment of hospital inpatient claims. The update was implemented April 18, 2017. A Mass Adjustment is being completed for all related Hospital inpatient claims with last dates of service on or after October 1, 2016, which were processed through April 1, 2017.

Updated Provider Enrollment Application Coming Soon!

Revised on 02/27/2018 2:00pm- (02/01/18) 1:30 p.m.

On May 07, 2018, the Division of Medicaid (DOM) will roll out its Updated Mississippi Medicaid Provider Enrollment Application that has been revised to collect additional information required for enrollments. It is also anticipated that the updated enrollment application will be more efficient by:

Employing a user-friendly format to streamline information entry and
Eliminating entry of duplicate information

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Any online applications that were started and saved via the web portal must be completed and submitted before May 7, 2018. Saved web applications which are not submitted by May 7, 2018, will be cancelled and a new application must be submitted.

Watch for upcoming communications on the DOM website and the Mississippi Envision Web Portal. Providers with questions or needing additional information about the updated enrollment application should contact Provider Enrollment at (800) 884-3222.

Attention Professional Services Providers

(01/26/18) 1:00 p.m.

SFY2018 CPT CODE UPDATE

The Division of Medicaid has corrected errors in the professional services rates posted for the 2018 CPT Code Update. Claims beginning with dates of service 1/1/2018 will be reprocessed for the codes listed below. No further action on the part of the provider is needed. Please watch Late Breaking News for information on the date these corrected claims will appear on your remittance advice. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

00731 00732 00811 00812 00813 15730 15733 19294 20939 31241 31253 31257 31259 31298 32994 33927 33928 33929 34701 34702 34703 34704 34705 34706 34707 34708 34709 34710 34711 34712 34713 34714 34715 34716 36465 36466 36482 36483 38222 38573 43286 43287 43288 55874 58575 64912 64913 71045 71046 71047 71048 74018 74019 74021 81108 81109 81110 81112 81120 81121 81283 81334 81335 81346 81361 81448 81520 81521 86794 87634 87662 93793 94617 94618 95249 96573 96574 97763 99483 99492 99493 99494 99484

January 2018 Code and Fee Updates are Delayed

(01/12/18) 10:00 a.m.

The Division of Medicaid will be delayed in completing the annual and quarterly code and fee updates indicated below which are effective January 1. Once the code and fee updates have been completed, the Division of Medicaid will reprocess impacted claims. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Physician Administered Drug (PAD) Fee Update
Current Procedural Terminology (CPT) Code Update
Healthcare Common Procedure Coding System (HCPCS) Code Update

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Allergen Immunotherapy and Antigen Preparation—NCII Medically Unlikely Edits

(01/10/18) 9:10 a.m.

In accordance with Section 6507 of the Patient Protection and Affordable Care Act, the Division of Medicaid utilizes National Correct Coding Initiative (NCCI) methodologies in claims processing. Effective July 1, 2016, the Medically Unlikely Edits (MUEs) for CPT 95165 changed to 30 units of service. Specific information on Allergen Immunotherapy and Antigen Preparation may be found in the NCCI Policy Manual in Chapter 11, Sections K.3, K.4, and V.3.

Information on NCCI in Medicaid is located at https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html. Providers are encouraged to review the Medicaid NCCI Change Report posted on this webpage regularly to identify changes which may impact claims processing.

Medicaid Provider Bulletin Transition

(01/08/18) 11:40 a.m.

Effective January 2018, the Mississippi Division of Medicaid (DOM) will no longer auto-mail the quarterly publications of the provider bulletin. Providers may still download the bulletin by visiting the Envision web portal at https://www.ms-medicaid.com.

Providers also have the option to subscribe (for **FREE**) and receive the provider bulletin via hard copy print (through postal mail), e-newsletter or both by visiting DOM's website at https://medicaid.ms.gov; click on Providers, Resources, then Forms. The completed subscription form should be faxed to the Office of provider Beneficiary Relations at 601 359-4185.

LATE BREAKING NEWS ***2018***

WHAT'S NEW?

Notice to Pharmacy Providers- this includes Provider types: H01, H02, H04, H07 and ZP0.

(01/05/18) 2:10 p.m.

Effective January 8, 2018 Remittance Advice. This notice affects Pharmacies with Expired Licenses on 12/31/2017 and received claims that were returned as paid for dates of service on or after 1/1/2018. Claims that paid for a pharmacy with an expired license and Medicaid ID will not be pulled into the January 8, 2018 Remittance Advice. They will be reprocessed the week of January 8th, and show up on the January 15, 2018 Remittance Advice. PLEASE BE ADVISED: after the grace period extension to Jan 31, 2018, claims for pharmacies who have still not renewed WILL DENY.

Attention All Elderly and Disabled (E&D) Waiver Case Management Providers

(12/12/17) 4:40 p.m.

RATE CHANGE!

For dates of service on or after November 1, 2017, the rate for Case Management (T2022) has been changed to $180.68 per month. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.

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

(12/12/17) 4:40 p.m.

RATE CHANGE!

For dates of service on or after November 1, 2017, the rate for Adult Day Care has been changed to $3.88 per 15 minute unit for the duration of time the services were provided. Services will be reimbursed by DOM the lessor of the total amount of the 15 minute increment units billed or the maximum daily rate of $62.08. The requirement for a person to attend the ADC for a minimum of four (4) hours per day has been removed. These changes optimize autonomy and independence in choices for ADC attendance.

Also, please note that the procedure code for Adult Day Care has been changed from S5102 to S5100. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

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

(12/12/17) 4:40 p.m.

RATE CHANGE!

For dates of service on or after July 1, 2017, the rate for Personal Care Services (T1019) has been changed to $4.41 per 15 minute unit. A Mass Adjustment is being completed for all Personal Care Service claims previously submitted at the old rate for dates of service on or after July 1, 2017. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.

Attention All Elderly and Disabled (E&D) Waiver In-Home Respite Providers

(12/12/17) 4:40 p.m.

RATE CHANGE!

For dates of service on or after July 1, 2017, the rate for In-Home Respite (S5150) has been changed to $4.41 per 15 minute unit. A Mass Adjustment is being completed for all In-Home Respite claims previously submitted at the old rate for dates of services on or after July 1, 2017. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.

Attention All Providers

(12/07/17) 4:40 p.m.

CPT Code 62319 and 62326

The Division Of Medicaid will reprocess claims for dates of service January 1, 2017 through May 17, 2017 which were billed using the codes 62319 and 62326. The mass adjustment will appear on your remittance advice dates 12/11/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers

(12/01/17) 9:00 a.m.

Various CPT Code Updates

The Division Of Medicaid will reprocess claims for dates of service January 1, 2016 through March 6, 2017 which were billed using the CPT codes listed in the table below. The mass adjustment will appear on your remittance advice dates 12/04/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

73501	73502	73503	73521
73522	73523	73551	73552

Attention All Providers

(12/01/17) 9:00 a.m.

Immunotherapy Code Updates

The Division Of Medicaid will reprocess claims for dates of service July 1, 2016 through May 22, 2017 which were billed using the codes listed in the table below. The mass adjustment will appear on your remittance advice dates 12/04/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

95004	95018	95028	95079	95165
95012	95024	95044	95144	95170
95017	95027	95052	95149	95180

Attention All Providers

(12/01/17) 9:00 a.m.

CPT Code 90686 and 90688

The Division Of Medicaid will reprocess claims for dates of service November 18, 2016 through June 20, 2017 which were billed using the codes 90686 and 90688. The mass adjustment will appear on your remittance advice dates 12/04/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention Telehealth Providers

(12/01/17) 9:00 a.m.

Place Of Service (POS) 02

The Division of Medicaid will reprocess claims for dates of service January 01, 2017 through May 19, 2017 which were billed using place of service (POS) code 02. The mass adjustment will appear on your remittance advice dated 12/04/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

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2018 New Bed Values for Nursing Facilities, ICF-IIDs, PRTFs, and NSFDs

(11/29/17) 2:25 p.m.

The new bed values for 2018 for nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs), psychiatric residential treatment facilities (PRTFs) and Nursing Facilities for the Severely Disabled (NFSDs) have been determined by using the R.S. Means Historical Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

Facility Class	**2018 New Bed Value**
Nursing Facility	$92,875
ICF-IID	$111,450
PRTF	$111,450
NFSD	$162,531

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention Maternity Providers

(10/19/17) 2:04 p.m.

Effective July 1, 2017, Mississippi Division of Medicaid (DOM) received Centers for Medicare and Medicaid Services (CMS) approval of State Plan Amendment (SPA) 17-0003 Screening, Brief Intervention, and Referral to Treatment (SBIRT). As a result, DOM covers early intervention services for pregnant women with nondependent substance use to prevent problematic substance use disorders.

SBIRT is an early intervention approach that targets pregnant women with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.

SBIRT services must include:

1. Screening for risky substance use behaviors using evidence based standardize assessments or validated screening tools,
2. Brief intervention of a pregnant woman showing risky substance use behaviors in a short conversation, providing feedback and advice, and
3. Referral to treatment for brief therapy or additional treatment to a pregnant woman whose assessments or screenings indicate a need for additional services.

DOM covers one (1) SBIRT service per pregnancy when performed by one (1) of the following licensed practitioners:

1. Physician,
2. Nurse Practitioner,
3. Certified Nurse Midwife,
4. Physician Assistant,
5. Licensed Clinical Social Worker,
6. Licensed Professional Counselor, or
7. Clinical Psychologist.

SBIRT services should be billed with HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment, and brief intervention 15 - 30 min) or G0397 (Alcohol and/or substance (other than tobacco) abuse structured assessment >30 min) and is only allowed once per pregnancy.

For more information regarding SPA 17-0003 SBIRT, please refer to the DOM website at medicaid.ms.gov/about/state-plan/approved-state-plan-amendments/ or contact the Office of Medical Services at (601) 359-6150.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

2017 Owner Salary Limits for Long-Term Care Facilities

(10/05/17) 8:30 a.m.

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities as owner's salaries for 2017 are based on 150% of the average salaries paid to non-owner/administrators that receive payment for services related to patient care. The limits apply to all salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2017 are as follows:

Small Nursing Facilities (1 - 60 Beds)	$133,454
Large Nursing Facilities (61+ Beds)	$156,183
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	$133,688
Psychiatric Residential Treatment Facilities (PRTF)	$136,665

Allowable Board of Directors Fees for Long-Term Care Facilities2017 Cost Reports

(10/05/17) 8:30 a.m.

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2017 cost reports filed by nursing facilities (NFs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and psychiatric residential treatment facilities (PRTFs) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for all Urban Consumers - All Items. The amounts listed below are the per-meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2017 are as follows:

Category	Maximum Allowable Cost for 2017
0 – 99 Beds	$ 4,121
100 – 199 Beds	$ 6,182
200 – 299 Beds	$ 8,242
300 – 499 Beds	$10,303
500 Beds or More	$12,363

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers

(10/05/17) 8:30 a.m.

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), effective October 1, 2017, the Division of Medicaid will no longer require a secondary mental illness diagnosis when reimbursing for medically necessary services to treat a substance use disorder (SUD). This change does not affect normal prior authorization requirements.

The final rules under the MHPAEA can be found here:
https://webapps.dol.gov/federalregister/PdfDisplay.aspx?DocId=27169

For questions related to this change, contact the Office of Mental Health at 601-359-9545.

Attention All Elderly and Disabled (E&D) Waiver Home Delivered Meal (HDM) Providers

(9/29/17) 11:00 a.m.

RATE CHANGE!

For dates of service on or after April 1,2017, the Home Delivered Meal (HDM) rate has been increased to $4.96 per unit. A Mass Adjustment is being completed for all Home Delivered Meal claims previously submitted at the old rate for dates of services after the April 1st start date. The procedure code HDM is S5170 and must always be billed with U1 modifier for services provided under the Elderly and Disabled Waiver.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Long-term Care Facilities' Cost Report Preparers

(9/26/17) 3:55 p.m.

"Integrated" Cost Report Forms

DOM has uploaded to its website a new file for the filing of nursing facilities' cost reports. This comprehensive file contains all of the current cost report forms needed for filing with the Division of Medicaid. The forms have been integrated, linked and are formula-driven for ease of use and reporting of costs and other data. The use of this new file and its forms should negate some of the errors and omissions that are occasionally found in cost report submissions. Providers and their cost report preparers are encouraged to utilize this file immediately to complete and submit their 2017 cost reports, as well as subsequent period reports.

The current website listing of each individual cost report form will be maintained for use if needed, especially when only completing and submitting certain amended forms and schedules for current and prior periods.

Please note that the new comprehensive file only combined the current cost report forms into a single file with identifying tabs, and did not make any substantive changes. This new file integrated and linked the cost report forms to one another, as well as inserted formulas, per the cost report instructions, into their applicable cells, columns and rows that were previously the responsibility of the preparers.

The cost report instructions for completing these new "integrated" forms remain the same as for the current individual ones.

If you have questions or concerns on the above, please contact T. J. Walker @ 601-359-6827, or T.J.Walker@medicaid.ms.gov.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers

(9/22/17) 11:00 a.m.

2016 CLIA Lab Classification and Certification Update

The Division of Medicaid will reprocess claims for dates of service January 1,2015 through February 3,2016 which were billed using codes. The mass adjustment will appear on your remittance advice dated 9/25/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222

G0477 81162 81314 81490 81545 G0478 81170 81412 81493 81595 G0479 81218 81432 81525 88350 G0480 81219 81433 81528 0009M G0481 81272 81434 81535 0010M G0482 81273 81437 81536 G6037 G0483 81276 81438 81538 G6050 80081 81311 81442 81540 0103T

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers

(9/22/17) 11:00 a.m.

The Division of Medicaid will reprocess claims for dates of service January 1,2017 through February 17,2017 which were billed using CPT code 77065, 77066 and 77067. The mass adjustment will appear on your remittance advice dated 9/25/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Elderly and Disabled (E&D) Waiver Home Delivered Meal (HDM) Providers

(8/30/17) 3:45 p.m.

RATE CHANGE!

For dates of service on or after April 1, 2017, the Home Delivered Meal (HDM) rate has been increased to $4.96 per unit. A Mass Adjustment is being completed for all Home Delivered Meal claims previously submitted at the old rate for dates of services after the April 1st start date. The procedure code for HDM is S5170 and must always be billed with a U1 modifier for services provided under the Elderly and Disabled Waiver.

Attention All Vision Providers

(8/25/17) 11:00 a.m.

The Division of Medicaid will reprocess claims for dates of service July 21, 2014 through January 19, 2017 which incorrectly applied a $3.00 copay to code 92341- FITTING OF SPECTACLES EXCEPT FOR APHAKIA; BIFOCAL. The mass adjustment will appear on your remittance advice dated 8/28/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All ID/DD Waiver Providers!

(8/24/17) 8:30 a.m.

Rate Changes

Effective 5/1/2017, Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver rate changes for the following procedure codes are complete.

Procedure Description	Procedure Code	Second Modifier	Updated Rate
Behavior Support Evaluation <6 hours	H002		$310.64 per evaluation
Behavior Support Evaluation >6 hours	H0002	TF	$621.27 per evaluation
Behavior Support Specialist	H2019	HN	$12.70 per 15 minute unit
Behavior Support Consultant	H2019	HO	$18.14 per 15 minute unit
Community Respite	S5150		$2.63 per 15 minute unit
Crisis Intervention Daily	T2034		$525.41 per day
Crisis Intervention Hourly	S9484		$27.68 per hour
Day Services Low Support Level (1, 2)	S5100		$3.78 per 15 minute unit
Day Services Medium Support Level (3)	S5100	TF	$4.10 per 15 minute unit
Day Services High Support Level	S5100	TG	$4.66 per 15 minute unit
Home and Community Supports, Short Term	S5125	TF	$6.18 per 15 minute unit
Home and Community Supports, Long Term	S5125	TG	$4.35 per 15 minute unit
Host Home	T2016		$95.38 per day
In-Home Nursing Respite	T1005		$8.93 per 15 minute unit
Job Discovery	97537		$11.16 per 15 minute unit
Prevocational Low Support Level (1,2)	T2015		$12.48 per hour
Prevocational Medium Support Level (3)	T2015	TF	$13.28 per hour
Prevocational High Support Level (4,5)	T2015	TG	$14.64 per hour
Support Coordination*	T2022		$203.87 per month
Supervised Living , 4 beds or fewer, Low Support (Level 1,2)	S5136	UQ	$184.89 per day
Supervised Living , 5 or more beds, Low Support (Level 1,2)	S5136	UR	$168.53 per day
Supervised Living , Medical Group Home	S5136	TF	$302.23 per day
Supervised Living , Behavioral Health Home	S5136	TG	$465.96 per day
Supported Employment ,Job Development	H2023		$8.80 per 15 minute unit

Procedure Description	Procedure Code	Second Modifier	Updated Rate
Supported Employment 2 Person	H2023	UN	$5.22 per 15 minute unit
Supported Employment 3 Person	H2023	UP	$4.17 per 15 minute unit
Supported Living Intermittent	S5135		$6.34 per 15 minute unit
Supported Living Intermittent, 2 person	S5135	UN	$3.97 per 15 minute unit
Supported Living Intermittent, 3 person	S5135	UP	$3.17 per 15 minute unit
Physical Therapy	G0151		$25.65 per 15 minute unit
Occupational Therapy	G0152		$25.65 per 15 minute unit
Speech Therapy	G0153		$17.80 per 15 minute unit
Crisis Support ICF/IID	H0045		No change to rate
Transition Assistance	T2038		No change to rate

**Support Coordination 2nd Level with Second Modifier of TF has been discontinued.*

Modifier U3 must be added to every procedure code.

A mass adjustment will be made to address these changes for claims billed with dates of service on or after May 1, 2017. If your claims do not appear in the mass adjustment, you will need to adjust the claims.
New and Tiered Service includes Supervised Living, Shared Supported Living, In-Home Respite, Supported Employment – Job Maintenance, and Crisis Intervention – 15 minute. Updates to the Medicaid Management Information System (MMIS) to add these new services and tiered rates are forthcoming and providers will be notified upon completion. Due to the timeframe it will take to implement the new and tiered rates, providers may continue to bill the current procedure codes and adjust their claims once MMIS is updated or providers may hold their claims until the process is complete.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Fee Schedule Updates for Mental Health Providers

(8/21/17) 3:50 p.m.

2017 Annual Fee Updates

Effective 7/1/2017, the Division of Medicaid (DOM) revised reimbursement rates for mental health providers as required by State law and the State Plan. New fee schedules for mental health program areas are posted under the provider tab on the DOM website and accessible through the following links:

Community/Private Mental Health Centers:
https://medicaid.ms.gov/wp-content/uploads/2014/03/CommunityMentalHealthCenter.pdf

Psychiatry:
https://medicaid.ms.gov/wp-content/uploads/2014/03/MentalHealthPsychiatry.pdf

Therapeutic and Evaluative Services for Expanded EPSDT (T&E):
https://medicaid.ms.gov/wp-content/uploads/2015/11/TherapeuticEvaluativeMentalHealth_ExpandedEPSDT.pdf

Please refer to the most current CPT Code Book for the appropriate procedure code(s) for services provided.

You may contact Jessica Bunch or Penny Torrey-Burns at 601-359-9545 with any questions.

Attention All Providers

(7/28/17) 10:00 a.m.

CPT Code 81211 and 81213
The Division of Medicaid will reprocess claims for dates of service March 1, 2016 through January 12, 2017 which were billed using Code 81211 and 81213. The mass adjustment will appear on your remittance advice dated 7/31/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers

(7/28/17) 10:00 a.m.

Various SFY2017 Casting Code Fee Update

The Division of Medicaid will reprocess claims for dates of service July 1, 2016 through July 20, 2016 which were billed using HCPCS Codes listed below. The mass adjustment will appear on your remittance advice dated 7/31/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

'Q4001', 'Q4002', 'Q4003', 'Q4004', 'Q4005', 'Q4006', 'Q4007', 'Q4008', 'Q4009', 'Q4010', 'Q4011', 'Q4012', 'Q4013','Q4014', 'Q4015', 'Q4016', 'Q4017', 'Q4018', 'Q4019', 'Q4020', 'Q4021', 'Q4022', 'Q4023', 'Q4024', 'Q4025', 'Q4026', 'Q4027', 'Q4028', 'Q4029', 'Q4030', 'Q4031', 'Q4032', 'Q4033', 'Q4034', 'Q4035', 'Q4036', 'Q4037', 'Q4038', 'Q4039', 'Q4040', 'Q4041', 'Q4042', 'Q4043', 'Q4044', 'Q4045', 'Q4046', 'Q4047', 'Q4048', and 'Q4049'.

Attention All Providers

(7/28/17) 10:00 a.m.

Various HCPCS Codes

The Division of Medicaid will reprocess claims for dates of service January 1, 2017 through March 29, 2017 which were billed using HCPCS Codes listed below. The mass adjustment will appear on your remittance advice dated 7/31/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

HCPCS Codes

A9587, A9588, C9140, J0883, J2182, J2786, J7175, J7202, J7207, J7209, J7322, J7342, and J8670.

Attention All Providers

(7/14/17) 10:00 a.m.

HCPCS Code J1050

The Division of Medicaid will reprocess claims for dates of service January 1, 2017 through January 17, 2017 which were billed using HCPCS Code J1050. The mass adjustment will appear on your remittance advice dated 7/14/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers

(7/14/17) 10:00 a.m.

The Division of Medicaid will reprocess Healthier MS Waiver (HMW) claims which denied incorrectly due to edit 3955 (Service Not Covered for Beneficiary) for dates of service on or after July 24, 2015 through September 12, 2016 for podiatry, eyeglasses, dental and chiropractic services. The mass adjustment will appear on your remittance advice dated 7/14/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: EPSDT Providers

(7/10/17) 9:00 a.m.

The American Academy of Pediatrics (AAP) released *Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, 4th, Edition*. A summary of the changes can be found at brightfutures.aap.org/about/Pages/About.aspx. To comply with Bright Futures recommendations, effective August 1, 2017 the Division of Medicaid (DOM) will no longer reimburse a separate fee for adolescent counseling when billed on the same date of service (DOS) as a wellness visit (99381-99385 and 99391-99395). Adolescent counseling is included in anticipatory guidance during the preventive medicine visit. Providers may bill adolescent counseling as a separate reimbursable service with evaluation and management codes 99201-99215. Providers may utilize the adolescent counseling form on the DOM website medicaid.ms.gov but the form is not required.

Effective January 1, 2017, DOM reimburses a separate fee in addition to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodic screenings for maternal depression screening. DOM is in the process of updating Mississippi Administrative Code Title 23, Part 223 and Provider Reference Guide to reflect the changes. If you have any questions, please contact DOM Office of Medical Services at (601) 359-6150.

Resources:
Fee Schedule medicaid.ms.gov/wp-content/uploads/2014/03/EPSDT.pdf
Provider Agreement medicaid.ms.gov/wp-content/uploads/2017/04/EPSDT-Provider-Agreement.pdf
Periodicity Examination Schedule medicaid.ms.gov/wp-content/uploads/2016/07/EPSDT-Periodicity-Examination-Schedule.pdf

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention Autism Spectrum Disorder Service Providers

(7/05/17) 2:50 p.m.

On May 24, 2017, the Centers for Medicare & Medicaid Services (CMS) approved Mississippi State Plan Amendment (SPA) 16-0020 Autism Spectrum Disorder (ASD) to allow the Mississippi Division of Medicaid (DOM) to cover ASD services for Early, Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries with an ASD diagnosis when medically necessary, prior authorized and provided by certain providers operating within their scope of practice, effective January 1, 2017.

The SPA can be found on DOM's website under approved State Plan Amendments located at medicaid.ms.gov/about/state-plan/approved-state-plan-amendments/.

ENROLLMENT

For more information on how to enroll as a Medicaid provider, contact Conduent at 800-884-3222 or go online to ms-medicaid.com/msenvision/index.do. Under the Provider tab, click on Provider Enrollment and select to either enroll online or download an enrollment packet.

You must be an enrolled Medicaid provider prior to enrollment with a coordinated care organization (CCO). For more information on how to enroll as a MississippiCAN provider, contact each CCO at:

Magnolia Health Plan
Phone: (866) 912-6285
Online: magnoliahealthplan.com/providers/become-a-provider.html

United Healthcare
Phone: (877) 743-8734
Online: uhc.com/provider

ELIGIBILITY

Eligibility can be determined through the use of either of the following services:

Automated Voice Response System (AVRS) at 1-866-597-2675
Provider/Beneficiary Services Call Center at 1-800-884-3222
Envision Web Portal at ms-medicaid.com

Eligibility and service standards should be verified each time a service is rendered.

PRIOR AUTHORIZATION

- To submit a prior authorization for beneficiaries enrolled in fee for service, contact eQHealth Solutions (eQHS) at (866) 740-2221 or online using the eQHealth Suite at ms.eqhs.org/Home.aspx.

- To obtain more information on how to submit a prior authorization for beneficiaries enrolled with Magnolia Health Plan, contact Cenpatico at (866) 912-6285.
- To obtain more information on how to submit a prior authorization for beneficiaries enrolled with United Healthcare, contact Optum at (877) 743-8734.

CLAIMS SUBMISSION

- To submit a claim for beneficiaries enrolled in fee for service, access the Envision Web Portal at ms-medicaid.com/msenvision/index.do.
- To obtain more information on how to submit a claim for beneficiaries enrolled with Magnolia Health Plan, contact Cenpatico at (866) 912-6285.
- To obtain more information on how to submit a claim for beneficiaries enrolled with United Healthcare, contact Optum at (877) 743-8734.

Billing for these services can begin immediately and are covered for dates of service on or after January 1, 2017. DOM fee schedules are located on the DOM website at medicaid.ms.gov/providers/fee-schedules-and-rates/.

Providers are encouraged to monitor the website for updates and announcements regarding ASD services. Frequently Asked Questions for ASD services are located on DOM's website at medicaid.ms.gov/programs/mental-health/.

For further questions, contact DOM's Office of Mental Health at (601) 359-9545.

Attention All Providers

(7/03/17) 9:00 a.m.

HCPCS Code J0585

The Division of Medicaid will reprocess claims for dates of service July 1, 2015 through March 22, 2017 which were billed using HCPCS Code J0585. The mass adjustment will appear on your remittance advice dated 6/30/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Hospice Providers; Update from August 2016 Notice

(6/22/17) 4:45 p.m.

DOM's Fiscal Agent has successfully updated the Medicaid MMIS claims processing system for Routine Home Care level of Hospice services. As of July 1, 2016, current Hospice claim payments should reflect the new methodology. Payment of the Service Intensity Add-on rate for the last seven days of life will not be paid until additional information is provided.

See Late Breaking News, https://www.ms-medicaid.com/msenvision/index.do, for the additional SIA billing requirements.

DOM anticipates proceeding with the mass adjustment to re-process Routine Home Care level claims for dates of service January 1 through June 30, 2016 during the month of June (2017). The mass adjustment will adjust those claims that were paid at the higher "T1" rate for day 61 and after instead of the lower "T2" rate. In most cases, this will result in a recoupment of funds. Providers will need to resubmit SIA claims with the required additional coding in order to be reimbursed the SIA.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention Hospice Providers; Update from August 2016 Notice

(6/15/17) 10:15 a.m.

DOM's fiscal agent, Conduent Government Healthcare Solutions, has successfully updated the Medicaid MMIS claims processing system to process payment for Routine Home Care (Revenue 0651) level of Hospice services, as required by CMS's methodology change. As of July 1, 2016, current Hospice claim payments should reflect the Tier-1 (T1) and Tier-2 (T2) Routine Home Care Rates. The (T1) higher rate is for the first 60 days of services and the lower rate (T2) is for days 61 and thereafter. Payment of the Service Intensity Add-on (SIA) rate for the last seven (7) days of life, which meet the registered nurse or social worker requirements, will not be paid until the following additional information is provided.

Reimbursement for the SIA component will require providers to identify on their claim when Registered Nurse (RN) or Social Worker (SW) services are provided. For RN services, providers will use 0559 Revenue Code and G0299 Procedure Code, along with the number of units provided. For this combination, one (1) unit is fifteen (15) minutes. For SW services, providers will use 0561 Revenue Code and G0155 Procedure Code for clinical social work services. For non-clinical social work services, Providers will use 0569 Revenue Code and G0155 Procedure Code, along with the number of units provided. These combinations will also be calculated as one (1) unit per fifteen (15) minutes.

DOM anticipates proceeding with the mass adjustment to re-process Routine Home Care level claims for dates of service January 1 through June 30, 2016 during the month of June (2017). The mass adjustment will adjust those claims that were paid at the higher "T1" rate for day 61 and after instead of the lower "T2" rate. In most cases, this will result in a recoupment of funds ranging from $34.55 to $37.28, per day, per beneficiary, depending on the county in which services were provided. Providers will need to resubmit SIA claims with the required additional coding in order to be reimbursed the SIA rate for beneficiaries that expired and had the pre-requisite services during the last seven (7) days of life.

DOM appreciates your patience during this process, and we apologize for the inconvenience.

If you have rate questions, please contact T.J. Walker @ 601-359-6827, or T.J.Walker@medicaid.ms.gov. If you have any claims questions, please contact Jay Horton, 601-359 -9544, or James.Horton@medicaid.ms.gov.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers

(6/12/17) 9:00 a.m.

Mississippi Medicaid Provider Revalidation has begun! To facilitate the revalidation process, do not use any special characters (i.e. apostrophe, hyphen, etc.) in the naming convention/file name of the required PDF files (Provider Disclosure Form and the Medical Assistance Participation Agreement) when completing the Revalidation Form process on the Mississippi Envision web portal. Files uploaded with special characters in the file name will cause delays in revalidation processing. If you have any questions or experience this issue, please contact Conduent Provider Enrollment at 1-800-884-3222.

Attention Nursing Facility and Hospital Providers

(6/5/17) 4:50 p.m.

The Division of Medicaid (DOM) is contracted with ASCEND to administer the Level II Pre-Admission Screening and Resident Review (PASRR). Ascend was purchased by MAXIMUS in 2016 and has transitioned from their current email addresses to accounts through the parent company, MAXIMUS. We want to be sure you continue receiving important policy updates, helpful tips, and educational tools geared toward explaining and simplifying the PASRR assessment process. Please make note of the change, including an email server change to @maximus.com.

Attention Providers

(6/1/17) 3:00 p.m.

The Division of Medicaid (DOM), Office of Program Integrity has contracted with DataMetrix to administer the MS Medicaid Recovery Audit Contractor (RAC) program effective April 1, 2017. The RAC serves a critical role in the overall strategy of protecting the integrity of Medicaid funds from improper payments. DataMetrix is a twelve (12) year old company which specializes in Payment Integrity and Recovery. DataMetrix has experienced staff performing reviews, including: physicians, certified coders, statisticians and credentialed clinical reviewers.

All updates are outlined on the DOM website located at https://medicaid.ms.gov/providers/recovery-auditor-contractors/. Providers are encouraged to monitor the website for updates and announcements regarding the Mississippi Recovery Audit Contractor program. Providers can submit inquiries, complaints and other communications as it relates to the MS Medicaid RAC program to MSRAC@medicaid.ms.gov.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Upcoming Medicaid Revalidation Webinars! Introductory and In-depth webinar materials now available on the Mississippi Envision Web Portal

(6/1/17) 3:00 p.m.

Mississippi Medicaid Provider Revalidation has begun! Introductory and In-depth webinars have been created as resources for providers to prepare for and complete the required revalidation.

Conduent will present the In Depth webinar via WebEx on the following days in June 2017:

Date - Thursday, June 8th – 10:00 a.m. **and** 2:00 pm
Date - Thursday, June 15th – 10:00 a.m. **and** 2:00 p.m.
Date - Wednesday, June 21st – 10:00 a.m. **and** 2:00 p.m.

If you would like to participate, please send an email with the selected day and time to msmedicaidlatebreakingnews@conduent.com. Also, please include the Medicaid provider number, contact phone number, and the attendee's name. If multiple individuals will be calling in from one facility, please use one line in order to allow other interested parties an opportunity to participate in the webinar. The WebEx information will be provided by email 24 hours prior to the session requested. **Reminder, these sessions are conducted via telephone and computer access. There is no physical location.**

The webinars are also located on the MS Envision web portal located at https://www.ms-medicaid.com. Select "Training Materials/CBT" from the Provider tab drop down menu or click the following links:

Provider Revalidation Introductory Training

In-depth Medicaid Provider Revalidation Training

We encourage providers to download and print this information to use as a guide when preparing for and completing the revalidation process. You may contact Conduent Provider Enrollment at 800-884-3222 if you have any questions.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Notice for 340B Pharmacy Providers

(5/31/17) 9:05 a.m.

The Centers for Medicare and Medicaid Services (CMS) requires the Mississippi Division of Medicaid (DOM) to define its policies and oversight activities related to 340B purchased drugs as outlined in CMS state release No. 161, dated Oct. 26, 2012.

In February 2017, letters were mailed to all Medicaid providers identified as 340B covered entities. These letters contained the *340B Covered Entity Initial Attestation Enrollment Form* and billing policy guidelines.

The form completion and submission deadline was extended for 340B Covered Entities from March 1, 2017 to May 1, 2017. Based upon provider feedback, the effective date for 340B billing policy implementation was extended from April 1, 2017 to July 1, 2017.

DOM encourages stakeholder feedback regarding 340B requirements and billing policy guidelines. In an effort to ensure clear and consistent communication regarding 340B attestation and billing policy, DOM will be posting a 340B Question and Answers document online at https://medicaid.ms.gov and hosting an informational conference call.

Please submit your comments and questions for inclusion in the 340B Q&A document to info@medicaid.ms.gov, by Monday, June 5, 2017.

Additional information about the 340B program may be found at the Medicaid website: https://medicaid.ms.gov/providers/pharmacy/340b-program/

Attention Physicians, Practitioners, and Clinics!

(5/26/17) 11:05 a.m.

New Modifiers Effective: 1/1/2013 and 1/1/2016

The Division of Medicaid will reprocess claims for dates of service January 01, 2013 through December 16, 2016 which were billed with following new modifiers: 33, CH, CI, CJ, CK, CL, CM, CN, CP, CT, DA, L1, PT, SZ, and ZA. The mass adjustment will appear on your remittance advice dated 5/292017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers

(5/26/17) 11:05 a.m.

CPT Code 95885 and 95886

The Division of Medicaid will reprocess claims for dates of service January 01, 2012 through August 19, 2016 which were billed using code 95885 and 95886. The mass adjustment will appear on your remittance advice dated 5/29/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

All Providers; Physician Fee Update

(5/26/17) 11:05 a.m.

The Division of Medicaid will reprocess claims for dates of service January 1, 2015 through May 26, 2015. The mass adjustment will appear on your remittance advice dated 5/29/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Outpatient Hospital Providers; Bilateral Surgical Procedure Billing—Outpatient Hospital Claims

(5/19/17) 10:05 a.m.

The Division of Medicaid will reprocess outpatient hospital claims for dates of service January 01, 2013 through December 9, 2014 which were billed with bilateral CPT codes. The mass adjustment will appear on your remittance advice dated 5/222017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Hospital Inpatient APR-DRG Alert – July 1, 2017 Updates

(5/01/17) 2:30 p.m.

The Mississippi Division of Medicaid (DOM) is proposing the following changes to the hospital inpatient APR-DRG payment methodology effective for the payment of hospital inpatient claims for discharges on and after July 1, 2017:

1. DOM will adopt V.34 of the 3M Health Information System APR-DRG Grouper.

2. DOM will adopt V.34 of the Health Care Acquired Conditions (HCAC) utility.

3. Low-side Outlier Payment Reduction – The APR DRG Base Payment may be reduced for low cost non-psych hospital inpatient stays when the DRG Base Payment exceeds the estimated cost of a stay.

4. Charge cap – The APR-DRG allowed amount, (the sum of the DRG Final Base Payment after low-side outlier payment reduction, plus DRG Cost Outlier payment, plus DRG Day Outlier payment), will be limited to the lower of the DRG Payment Amount or the total billed charges on the claim.

5. The following APR-DRG parameters will be updated:
   Neonate policy adjustor – will be changed from 1.45 to 1.40
   Low-side Outlier Threshold - $50,000
   Low-side Outlier Marginal Cost Percent - 50%

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 and after July 1, 2017.

Training will be scheduled with dates to be provided. Hospitals will be notified via e-mail and the DOM website www.medicaid.ms.gov.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers

(4/28/17) 1:30 p.m.

The Division of Medicaid will reprocess claims for dates of service October 01, 2015 through July 20, 2016 billed with codes listed below. The mass adjustment will appear on your remittance advice dated 5/1/2017.No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Diagnosis Codes:

Z34.00	Z34.82	O09.01	O09.40	O09.292	O09.512	O09.619
Z34.01	Z34.83	O09.02	O09.41	O09.293	O09.513	O09.621
Z34.02	Z34.90	O09.03	O09.42	O09.299	O09.519	O09.622
Z34.03	Z34.91	O09.10	O09.43	O09.30	O09.521	O09.623
Z34.80	Z34.92	O09.11	O09.211	O09.31	O09.522	O09.629
Z34.81	Z34.93	O09.12	O09.212	O09.32	O09.529	O09.611
	Z33.1	O09.13	O09.213	O09.33	O09.612	O09.523
	O09.00	O09.291	O09.219	O09.511	O09.613	

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers

(4/28/17) 10:30 a.m.

The Division of Medicaid will reprocess claims for dates of service January 01, 2014 through March 21,2016 which denied due to edit 3105 - ANNL PHYEXM NCOVRD FOR LTC,ETC. The mass adjustment will appear on your remittance advice dated 5/1/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Outpatient Hospital Providers

(4/28/17) 10:30 a.m.

Revenue Code 0515

The Division of Medicaid will reprocess claims for dates of service October 01, 2015 through October 03,2016 which were billed with Revenue Code 0515. The mass adjustment will appear on your remittance advice dated 5/1/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: Qualified Obstetric/Gynecological Providers who need to attest/re-attest to receive increased primary care services payments

(4/27/17) 10:30 a.m.

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers at 100 percent (100%) of the Medicare Physician Fee Schedule for certain primary care Evaluation and Management (E&M) and Vaccine Administration codes. Effective July 1, 2016 and in accordance with House Bill (HB) 1560, DOM began reimbursing eligible obstetricians and gynecologists (OB/GYNs) at 100 percent (100%) of the Medicare Physician Fee Schedule for certain primary care services. Eligible OB/GYNs with a primary specialty/subspecialty designation in obstetric/gynecologic medicine must attest to one (1) of the following:

1) Physician is board certified by the American Congress of Obstetricians and Gynecologists (ACOG) as a specialist or subspecialist in obstetric/gynecologic medicine, or

2) Physician with a primary specialty/subspecialty designation in obstetric/gynecologic medicine and has furnished certain primary care E&M and Vaccine Administration codes that equal at least sixty percent (60%) of the Medicaid codes they have billed during the most recently completed calendar year but does not have an ACOG certification, or

3) Physician, newly enrolled as a Medicaid provider, with a primary specialty/subspecialty designation in obstetric/gynecologic medicine and attests that certain primary care E&M and Vaccine Administration codes will equal at least sixty percent (60%) of the Medicaid codes they will bill during the attestation period, or

4) Non-physician practitioner providing primary care services in a Practice Agreement with a qualified physician enrolled for increased primary care services.

Pursuant to HB 1510, providers who self-attest to a specialty designation in obstetric/gynecologic medicine by ACOG will be eligible to continue receiving an increased payment for certain primary care services effective July 1, 2017. The DOM Primary Care Provider Fee Schedule is updated July 1 of each year based on 100 percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year.

To receive the increased payment for dates of service (DOS) beginning 7/1/2017, eligible providers must send a completed and signed 7/1/2017-6/30/2018 OB/GYN PCP Self-Attestation form to Conduent Provider Enrollment by 6/30/2017. Providers, whose forms are received after 5/31/2017, may experience a delay in the effective date of the increased payment. To receive the increased payment, eligible providers must send a completed and signed 7/1/2017-6/30/2018 OB/GYN PCP Self-Attestation form to Conduent Provider Enrollment through one of the following means:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: Conduent Provider Enrollment, P. O. Box 23078, Jackson, MS 39225

Qualified providers who attest to a specialty designation in family medicine, general internal medicine, pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), and the American Osteopathic Association (AOA) may be eligible for increased payment of certain primary care E&M and Vaccine Administration codes. Providers may submit a 7/1/2016-6/30/2018 Self-Attestation Statement form to Conduent Provider Enrollment and will be eligible to receive the increased payment effective the day the form is processed by Conduent.

Additional information can be found on the DOM website (www.medicaid.ms.gov), including the OB/GYN PCP Self-Attestation General Instructions, the 7/1/2017-6/30/2018 OB/GYN PCP Self-Attestation form, the PCP Self-Attestation General Instructions and the 7/1/2016-6/30/2018 Self-Attestation Statement form. Providers may also find this information on the Envision Web Portal (www.ms-medicaid.com/msenvision/) or it can be requested by calling the Conduent Call Center toll -free at 800-884-3222.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention: Nursing Facility Providers

(4/19/17) 10:40 a.m.

According to the Division of Medicaid Eligibility Determination Policy, Volume III, Section L page 12370, nursing facilities must submit the DOM-317 Exchange of Information between a nursing facility or hospital and Division of Medicaid Regional Office form at the time a resident is discharged from a nursing facility. Upon receipt of the DOM-317, the Regional Office staff will update the beneficiary case to reflect the discharge date. Delayed submission of the form may limit beneficiary access to medications and community services. Providers must submit the DOM-317 in a timely manner.

Attention: Nursing Home Claims: Revenue Code Change

(4/19/17) 10:40 a.m.

Effective July 1, 2017, revenue code 0181-"leave of absence-reserved" will no longer be accepted by DOM for hospital leave claims. Revenue code 0185-"leave of absence-nursing home (for hospitalization)" is required for all hospital leave claims. This change is being made to meet compliance of the National Uniform Billing Committee. If you have any questions, you may call LaShunda Woods at 601-359-5251.

MississippiCAN & CHIP Workshops Are Coming to Your Area!!!

(4/11/17) 9:30 a.m.

The Division of Medicaid Office of Coordinated Care, in conjunction with Magnolia Health Plan and UnitedHealthcare Community Plan, will conduct Provider Workshops beginning May 31, 2017 through September 6, 2017 at locations throughout the state. The workshops will be designed to address questions and concerns that are of most importance to the Medicaid Providers. Office directors, office managers, coders, and billing staff are encouraged to attend these workshops. For more specific information, including dates and locations, please visit the What's New" section of the Mississippi Envision Web Portal at https://www.ms-medicaid.com/msenvision/servlet/DocumentViewerServlet?docType=news&fileName=News2.pdf or the Mississippi Division of Medicaid's website at www.medicaid.ms.gov/mscan/ .

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers

(3/31/17) 10:30 a.m.

The Division of Medicaid will reprocess claims for dates of service January 01, 2016 through June 30, 2016. The mass adjustment will appear on your remittance advice dated 4/3/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: Outpatient Hospital Providers

(3/31/17) 10:30 a.m.

The Division of Medicaid will reprocess claims for dates of service July 01, 2016 through July 25, 2016 which were billed with various CDT codes with incorrectly calculated fees. The mass adjustment will appear on your remittance advice dated 4/3/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Deadline extended for 340B Covered Entity Attestation Enrollment Form

(3/30/17) 9:00 a.m.

The deadline for 340B covered entities to complete the Initial 340B Covered Entity Attestation Enrollment Form and submit to Conduent has been extended to May 1, 2017.

Billing requirements defined in the cover letter and instructions of the Initial 340B Covered Entity Attestation Enrollment Form for providers who have elected to opt-in, will be effective on July 1, 2017.

Additional information about the 340B program may be found at https://medicaid.ms.gov/providers/pharmacy/340b-program/

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Pharmacy Reimbursement changes will be implemented retrospectively upon CMS State Plan Amendment (SPA) approval

(3/30/17) 9:00 a.m.

On February 1, 2016, the Centers for Medicare and Medicaid Services (CMS) published 42 CFR, Part 447: Medicaid Program Covered Outpatient Drugs with final comments (CMS-2345-FC). This rule addresses regulations pertaining to reimbursement for covered outpatient drugs in the Medicaid program. In accordance with this rule, all states must submit an amendment to its State Plan by June 30, 2017 to CMS with an effective date of no later than April 1, 2017, to be in compliance with the new reimbursement requirements.

The Mississippi Division of Medicaid (DOM) submitted State Plan Amendment (SPA) 17-0002 Pharmacy Reimbursement to the Centers for Medicare and Medicaid Services (CMS) on March 15, 2017.

Reimbursement changes will be implemented retrospectively upon CMS approval. Pharmacy POS claims with a date of service on or after April 1, 2017 will be mass adjusted according to the CMS' approved reimbursement methodology. Pharmacy providers will be notified when CMS approves SPA 17-0002.

Attention All Providers!

(3/24/17) 11:50 a.m.

HCPCS Codes B4034,B4035,B4036, B4081,B4082,B4083 and B4087

The Division of Medicaid will reprocess claims for dates of service July 01, 2016 through August 16, 2016 which were billed using codes B4034,B4035,B4036,B4081,B4082,B4083 and B4087.The mass adjustment will appear on your remittance advice dated 03/27/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers: Provider Revalidation Starts April 2017

(3/17/17) 12:30 p.m.

In April 2017, the Division of Medicaid (DOM) will begin implementing Federal Regulation 42 CFR §455.414 which requires state Medicaid agencies to revalidate the enrollment of all providers at least every five years. A rollout process will be used to notify providers enrolled in the Mississippi Medicaid Program five or more years of the revalidation requirement. Revalidation notifications will be issued on a staggered schedule until notices have been issued to all providers due for revalidation.

A revalidation letter will initiate the process with each provider. The letter will provide instructions for completing the revalidation and will indicate the due date. As part of the revalidation, the state must conduct a full screening appropriate to the provider's risk level in compliance with 42 CFR 455 Subparts B & E and the provider must comply with any requests made by the state as part of the revalidation process within the specified timeframe. A complete revalidation must be submitted by the due date in the letter to prevent termination.

To prepare for revalidation, all providers should review the bullets below and complete the following steps immediately:

- The revalidation letter will be sent to the current "Mail Other" address noted on the provider file. If there is no "Mail Other" address noted on the provider file, the notification will be sent to the billing address. To ensure proper notification, please validate your addresses on file with the Division of Medicaid. If changes are needed, please complete the Change of Address form located at:

https://www.medicaid.ms.gov/wp-content/uploads/2014/06/ProviderChangeofAddressForm.pdf

The form must be completed and signed by the provider. The Change of Address form can be faxed to CONDUENT Provider Enrollment at (888) 495-8169.

- Providers must access their revalidation electronically through the Envision web portal. This will allow providers to enter their own information and will streamline the revalidation process. If the revalidating provider is not a registered user, the provider will need to register by going to www.ms-medicaid.com by clicking the "web registration" link to find the registration instructions for becoming a web portal user.

Enrollment must be terminated for any provider who does not comply with revalidation requirements. A new application will then be required for the provider to re-enroll in the Mississippi Medicaid program.

Watch for upcoming communications and webinar information on the DOM website and the Mississippi Envision Web Portal. Providers with questions or needing additional information about revalidation should contact Provider Enrollment at (800) 884-3222.

Attention All Nursing Facility Providers

(3/14/17) 9:15 a.m.

The Division of Medicaid and Mississippi State Department of Health Division of Licensure and Certification are hosting a free, one-day educational seminar for nursing home providers and other individuals or organizations interested in applying for a Civil Money Penalty grant. Several speakers experienced in the nursing home industry will share their expertise and perspectives on developing successful CMP grants. In addition, new and revised information on the grant application process will be discussed. Attendees will be able to speak with industry representatives on products and services devoted to improve care and quality of life for nursing home residents. The seminar will be May 3, 2017 from 8:30 a.m. until 4:30 p.m. at the University of Mississippi Medical Center Conference Center, Jackson Medical Mall, 350 W. Woodrow Wilson Drive, Jackson, MS. If your organization is seeking funding from the Centers for Medicare and Medicaid Services for a project benefiting nursing home residents, you are urged to attend this educational seminar.

The deadline for registration is April 26. You may register at the following link: http://HealthyMs.com/register/cmp/.

For more information, please call 601-359-9529 or 601-359-5251.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Information on the "Present on Admission" (POA) Indicator Claim Exception Edit 0178- VALID POA REQUIRED

(3/10/17) 1:15 p.m.

The Mississippi Division of Medicaid and Conduent are aware of the issue where claims are denying for claim exception 0178- VALID POA REQUIRED. Currently, there is a system fix that is being analyzed and coded. Once the system fix is implemented, we will advise through Late Breaking News/RA banner messages and a mass adjustment will be completed. No further action on the part of the provider is needed.

Consent Form Status Inquiry now available on the Envision Web portal!

(3/10/17) 11:25 a.m.

Effective 03/15/2017, select providers (i.e. Physicians, Physician groups, Hospitals, Rural Health Clinics, Nurses, and Ambulatory Surgery Centers) can now check the status of submitted sterilization consent and hysterectomy acknowledgment forms via the Envision web portal. Providers should have the Security privilege checked for "Consent Form Status Inquiry" in security privileges by their respective Master Administrators. Providers must logon to the secure side of the web portal and select Provider menu- Inquiry Options-Consent Form Status Inquiry to access this function. Please be reminded that the consent and acknowledgment forms are initially reviewed independently. An approved consent form does not ensure payment. This functionality is only applicable to consents submitted for fee-for-service beneficiaries and does not apply to MSCAN beneficiaries. You may contact the Conduent Call Center at 1-800-884-3222 if you have questions.

Attention EPSDT Providers

(3/2/17) 4:15 p.m.

The Division of Medicaid will reprocess EPSDT claims which denied incorrectly due to edit 3700 (Procedure exceeds lifetime limit) or 3234 (Procedure code/ EPSDT age restriction) for paid dates on or after July 1, 2015 through July 4, 2016. The mass adjustment will appear on your remittance advice dated 03/06/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

EPSDT Provider Termination

(2/27/17) 8:50 a.m.

Effective November 1, 2015, Mississippi Division of Medicaid (DOM) received Centers for Medicare and Medicaid Services (CMS) approval of State Plan Amendment (SPA) 15-017 Early and Periodic Screening, Diagnosis and Treatment (EPSDT). SPA 15-017 requires DOM EPDST providers adhere to the American Academy of Pediatrics Bright Futures periodicity schedule for physical, mental, psychosocial and/or behavioral health, vision, hearing, adolescent, and developmental screening services.

Currently enrolled EPSDT providers were required to update their enrollment status by signing and completing the EPSDT Provider Agreement by November 30, 2016. Failure to send the completed and signed EPSDT Provider Agreement by November 30, 2016 results in provider disenrollment from the EPSDT program. Please note you are not being terminated as a Medicaid provider; however, effective March 1, 2017, claims submitted with CPT codes 99381-99395 will deny. If you would like to continue providing EPSDT screening services, please complete the EPSDT Provider Agreement located on the DOM website at www.medicaid.ms.gov.

Please contact the Office of Medical Services at (601) 359-6150 if you have any questions or need additional assistance.

Attention All Providers!

(2/10/17) 8:40 a.m.

CPT Codes 99238 and 99239

The Division of Medicaid will reprocess claims for dates of service October 1, 2015 through October 3, 2016 which were billed with CPT codes 99238 and 99239. The mass adjustment will appear on your remittance advice dated 02/13/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention: Physicians, Practitioners, and Vision/ Hearing Providers

(1/30/17) 8:40 a.m.

CMS-1500 CLAIMS WITH TAXONOMY DENIALS FOR EDITS 3457 AND 3458

The Mississippi Division of Medicaid (DOM) is in the process of correcting the system issue for these Global Surgical Package edits and will reprocess claims once corrected. Any claims which correctly received the edit denial, will again deny when reprocessed causing overpayments to be recovered. This can be avoided by resubmitting a corrected claim by following the information below.

These taxonomy codes are needed to prevent a claim from denying with Edit 3456 GLOBAL PACKAGE APPLIES TO SERVICES REPORTED when multiple claims are billed for the same beneficiary, same billing provider, different rendering provider, and different specialty for either the same date of service or during the assigned post-operative period of a previous service. If the rendering providers are the same specialty, one of the claims will deny.

Edit 3457-GLOBAL PACKAGE CLAIM; RENDERING TAXONOMY CODE DOES NOT MATCH PROVIDER FILE

This edit posts when the taxonomy code billed for the line does not match one of the taxonomy codes listed in the rendering provider file. These two taxonomy codes must match for the claim to bypass this edit. Please verify what taxonomy code is listed in the provider file and use this code to correct the claim lines.

Edit 3458-GLOBAL PACKAGE CLAIM; RENDERING TAXONOMY CODE IS REQUIRED

This edit posts when a taxonomy code for the rendering provider was not billed on the claim line. Please verify what taxonomy code is listed in the rendering provider file and use this code to correct the claim lines.

Resubmit the corrected claim by following these steps:

- If the entire claim denied, the provider will resubmit the corrected claim for processing.
- If the claim partially paid, the provider will void the entire claim resubmit the corrected claim for processing.

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

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers!

(1/27/17) 8:40 a.m.

CPT Codes 58300 and 11981

The Division of Medicaid will reprocess claims for dates of service July 1, 2016 thru November 7, 2016, which were billed with HCPCS codes 58300 and11981. The mass adjustment will appear on your remittance advice dated 1/30/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention EPSDT Providers

(1/06/17) 8:40 a.m.

The Division of Medicaid will reprocess EPSDT claims which denied incorrectly due to edit 0367 (Procedure/servicing provider type conflict) for paid dates on or after November 1, 2015 thru October 17, 2016 for CPT code 96110 (Development screening) and for paid dates on or after July 1, 2015 thru October 17, 2016 for CPT code 96127 (Brief Emotional/Behavioral assessment, with scoring). The mass adjustment will appear on your remittance advice dated 1/9/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2017***

WHAT'S NEW?

Attention All Providers—DOM Coverage of PrEP

(1/03/17) 12:50 p.m.

The Division of Medicaid (DOM) covers HIV Pre-Exposure Prophylaxis (PrEP) for men and women as recommended by the Centers for Disease Control and Prevention (CDC). According to the CDC, "Pre -exposure prophylaxis, or PrEP, is a way for people who do not have HIV but who are at substantial risk of getting it to prevent HIV infection by taking a pill every day. The pill (brand name Truvada) contains two medicines (Emtricitabine and Tenofovir) that are used in combination with other medicines to treat HIV. When someone is exposed to HIV through sex or injection drug use, these medicines can work to keep the virus from establishing a permanent infection."

If you have additional questions regarding coverage, please contact DOM Office of Medical Services at 601.359.6150.

Correction to Billing Reminders for Nursing Facility and ICF/IID residents

(1/03/17) 11:20 a.m.

The article below was published in the 2016 December Medicaid bulletin with the incorrect phone number. The phone number has been corrected and is listed below.

1. Disposable diapers and blue pads were listed as medical supplies to be included in the nursing facility and ICF/IID per diem as of January 2, 2015. Reference: Administrative Code, Part 207, Chapter 2, Rule 2.6, C.10 for Nursing Facility; Administrative Code, Part 207, Chapter 3, Rule 3.4: C.11 for ICF/IID.
2. Individuals residing in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) are exempt from payment of a co-payment. The co-payment exception code of "N" must be indicated on the claim. This exception code applies to facility charges, professional fees, and pharmaceuticals. Reference: Administrative Code, Part 200, Chapter 3: Beneficiary Information, Rule 3.7: Beneficiary Cost Sharing C.4. Nursing Facility.

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

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Using an older Operating System or Web Browser?

(12/22/16) 4:02 p.m.

Due to a recent announcement by Microsoft concerning a security flaw in SHA-1 SSL certificates, the Mississippi Envision Web Portal will be upgrading to a SHA-2 SSL certificate on the night of **12/29/2016**. Users who are using older, unsupported web browsers and/or operating systems may not be able to access this site without upgrading. A list of SHA-2 compatible web browsers and operating systems can be found here: https://www.digicert.com/sha-2-compatibility.htm

Attention All Providers

(12/22/16) 3:43 p.m.

The Division of Medicaid will reprocess all claims submitted with CPT 82105 - ALPHA FETOPROTEIN; SERUM for dates of service beginning 11/1/2015 through 6/10/2016. The mass adjustment will appear on your remittance advice dated 12/26/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

2017 New Bed Values for Nursing Facilities, ICF-IIDs, PRTFs, and NSFDs

(12/12/16) 3:10 p.m.

The new bed values for 2017 for nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs), psychiatric residential treatment facilities (PRTFs) and Nursing Facilities for the Severely Disabled (NFSDs) have been determined by using the R.S. Means Historical Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

Facility Class	2017 New Bed Value
Nursing Facility	$93,294
ICF-IID	$111,953
PRTF	$111,953
NFSD	$163,265

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Radiology Providers

(12/8/16) 4:00 p.m.

The Division of Medicaid will reprocess all Advanced Imaging claims for dates of service beginning 07/01/2013 through 06/20/2016 that were denied incorrectly with Claim Exception 0727 - **PRIOR AUTHORIZATION NUMBER ON CLAIM BUT NOT ON FILE** and/or 3341 - **CLAIM REQUIRES PRIOR AUTHORIZATION OR APPROPRIATE MODIFIER**. The mass adjustment will appear on your remittance advice dated 12/12/2016.No further action on the part of the provider is needed.

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

Attention All Providers—Additional Administered Drug Fee Updates

(12/8/16) 4:00 p.m.

The Division of Medicaid will reprocess claims which were billed with codes listed below for dates of service July 1, 2016 through August 22, 2016. The mass adjustment will appear on your remittance dated 12/12/2016.No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Codes A4561, A4562, A9543, A9600, A9604, A9606, J0714, J1322, J1327, J1330, J1573, J1595, J1725, J1744, J1830, J2760, J3145, J3246, J3470, J7188, Q4101, Q4106, Q4131, Q5101, Q9950, S0189.

Attention All Providers—Physician Fee Updates

(12/8/16) 4:00 p.m.

The Division of Medicaid will reprocess claims for dates of service July 1, 2016 through July 21, 2016. The mass adjustment will appear on your remittance dated 12/12/2016.No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(10/21/16) 12:00 p.m.

DME/Medical Supply Fee Corrections The Division of Medicaid will reprocess claims which were billed with codes listed below for dates of service July 1, 2016 through July 15, 2016. The mass adjustment will appear on your remittance dated 10/24/2016. The new DME fee schedule is posted under the provider tab on our website or accessible through the following link http:www.medicaid.ms.gov/wpcontent/uploads/2015/07/DMEOrthoProsth.pdf. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

A4233, A4234, A4235,A4236, A4253, A4256, A4258, A4259, A4450, A4636, A4637, A7000, E0950, E0951, E0952, E0973, E0978, E0990,E0992, E0995, E1020, E2208, E2361, E2363, E2365, E2366, E2371, E2601, E2602, E2603, E2604, E2605, E2606,E2607, E2608, E2611, E2612, E2613, E2614, E2615, E2616, E2619, E2620, E2621, E2622, E2623, E2624, E2625, K0037, K0038, K0039, K0040, K0041, K0043, K0733.

Attention All Providers

(10/21/16) 12:00 p.m.

The Division of Medicaid will reprocess claims for dates of service July 1, 2016 through July 6, 2016 which were billed with impacted physician administered drug codes. The mass adjustment will appear on your remittance advice dated 10/24/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers

(10/21/16) 12:00 p.m.

Physician Fee Updates The Division of Medicaid will reprocess claims for dates of service beginning July 1, 2016 which were billed with impacted CPT/HCPCS on professional claims. The mass adjustment will appear on your remittance dated 10/24/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Hospital Administrators, CFOs, and Billers!

(10/19/16) 2:00 p.m.

Effective July 1, 2015, the Division of Medicaid (DOM) implemented Phase 2 of Outpatient Prospective Payment System (OPPS). Since implementation of Phase 2, certain hospital outpatient claims inappropriately denied for edit 0110-Date Bundling Not Allowed. DOM has implemented a systemic fix for edit 0110-Date Bundling Not Allowed. The affected claims with dates of service July 1, 2015 through August 21, 2016 will be adjusted to correct associated payment errors. Provider training workshops will be held regarding OPPS Date Bundling.

To register for training, please RSVP by emailing Provider Field Service Representative LaShundra Othello at Lashundra.Othello@conduent.com with the following information:

- Full name
- Title
- Facility name
- Contact phone number
- Number of participants

Training workshops will be conducted the following dates and times:

Oct. 25 – North Mississippi: Southaven
Registration: 8:30 a.m. - 9 a.m.
Training: 9 a.m. – 12 p.m.
Hilton Garden Inn
6671 Towne Center Loop
Southaven, MS 38671

Nov. 8 – Central Mississippi, Jackson
Registration: 8:30-9 a.m.
Training: 9 a.m. – 12 p.m.
Central High School Auditorium
359 North West Street
Jackson, MS 39201

Nov. 2 – South Mississippi: Biloxi/Gulfport
Registration: 8:30-9 a.m.
Training: 9 a.m. – 12 p.m.
Courtyard Marriot
1600 East Beach Boulevard
Gulfport, MS 39501

Reference guides and other resources will be available on the DOM website as they become available. For more information about OPPS, visit https://medicaid.ms.gov/providers/finance/.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(10/3/16) 12:30 p.m.

Effective for dates of services on and after October 1, 2016, the Mississippi Division of Medicaid (DOM) will cover the following procedure codes:

E2402 NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE
A6550 WOUND CARE SET, FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, INCLUDES ALL SUPPLIES AND ACCESSORIES

This change will apply to all Medicaid beneficiaries. Additional information regarding coverage of these procedure codes can be found on the applicable Fee Schedule at www.medicaid.ms.gov.

If you have additional questions regarding this change, please contact the Office of Medical Services at 601-359-6150.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(9/30/16) 2:30 p.m.

Code 76770

The Division of Medicaid will reprocess claims for dates of service July 1, 2016 through July 12, 2016 which were billed with CPT code 76770. The mass adjustment will appear on your remittance advice dated 10/3/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers

(9/30/16) 2:30 p.m.

HCPCS Code 99420

The Division of Medicaid will reprocess claims for dates of service November 1, 2015 through June 28, 2016 which were billed with HCPCS code 99420. The mass adjustment will appear on your remittance advice dated 10/03/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers

(9/30/16) 2:30 p.m.

The Division of Medicaid will reprocess claims for dates of service July 1, 2016 through July 18, 2016 billed with procedure code 77427. The mass adjustment will appear on your remittance advice dated 10/03/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers

(9/30/16) 2:30 p.m.

HCPCS Code 90791 and 90792

The Division of Medicaid will reprocess claims for dates of service October 1, 2015 through June 30, 2016 which were billed with HCPCS code 90791 and 90792. The mass adjustment will appear on your remittance advice dated 10/03/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(9/30/16) 2:30 p.m.

The Division of Medicaid will reprocess claims for dates of service October 1, 2013 through July 15, 2016 which were denied with Claim Exception 0188 - PATIENT STATUS INVALID. The mass adjustment will appear on your remittance advice dated Oct 03, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Extension of deadline to submit EPSDT Provider Agreement

(9/29/16) 2:50 p.m.

EPSDT screening providers, currently enrolled in the program, must update their enrollment status by completing the EPSDT Provider Agreement. The EPSDT Provider Agreement is located on the Mississippi Envision website under "What's New?" at www.ms-medicaid.com/msenvision/index.do and on the Division of Medicaid website under "Programs" at https://medicaid.ms.gov/resources/forms/. Providers must send the completed and signed EPSDT Provider Agreement by **November 30, 2016** to:

Division of Medicaid-Office of Medical Services
550 High Street, Suite 1000, Jackson, MS 39202
or via fax to (601) 359-6147

Failure to send the completed and signed EPSDT Provider Agreement by **November 30, 2016** may result in provider disenrollment from the EPSDT program.

Please contact the Office of Medical Services at (601) 359-6150 if you have any questions or need additional assistance.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers!

(9/16/16) 9:10 a.m.

HCPCS Code G0277

The Division of Medicaid will reprocess claims for dates of service January 1, 2015 through April 6, 2016 which were billed with HCPCS code G0277. The mass adjustment will appear on your remittance advice dated 9/19/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Submission of Consent Forms for Beneficiaries

(9/8/16) 8:50 a.m.

As of December 1, 2015, MississippiCAN, Medicaid's Managed Care Program is responsible for both, inpatient and professional service payments. It is imperative that providers verify the beneficiary's eligibility before submitting consent forms to verify whether the beneficiary is enrolled in MississippiCAN or Fee-for-Service Medicaid.

If the beneficiary is enrolled in one of the MississippiCAN Coordinated Care Organizations (CCO), United Healthcare Community Plan or Magnolia Health, providers should follow the guidelines of the CCO for submitting consent forms as they will be responsible for payment of the services. No consent form should be sent to Conduent for beneficiaries that are enrolled in the MississippiCAN.

However, if the beneficiary is enrolled in Fee-for-Service (traditional) Medicaid, providers should continue to fax all consent forms to Conduent Medical Review at 1-888-495-8169.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Extension of deadline to submit EPSDT Provider Agreement

(9/1/16) 1:50 p.m.

EPSDT screening providers, currently enrolled in the program, must update their enrollment status by completing the EPSDT Provider Agreement. The EPSDT Provider Agreement is located on the Mississippi Envision website under "What's New?" at www.ms-medicaid.com/msenvision/index.do and on the Division of Medicaid website under "Programs" at https://medicaid.ms.gov/resources/forms/. Providers must send the completed and signed EPSDT Provider Agreement by **September 30, 2016** to:

Division of Medicaid-Office of Medical Services
550 High Street, Suite 1000, Jackson, MS 39202
or via fax to (601) 359-6147

Failure to send the completed and signed EPSDT Provider Agreement by **September 30, 2016** may result in provider disenrollment from the EPSDT program.

Please contact the Office of Medical Services at (601) 359-6150 if you have any questions or need additional assistance.

Submission of Medicare Part C Claims on the Mississippi Envision Web Portal is Now Available!

(9/1/16) 9:35 a.m.

The Mississippi Envision Web Portal has now been updated to allow providers to submit Part C claims electronically. When entering claims via the Web Portal, providers will not only have the options to submit CMS 1500 and UB-04 claims, but will also have the option to submit "Medicare Part C Institutional" or "Medicare Part C Professional" claims. If entered correctly, these claims should suspend for review of the Explanation of Medicare Benefits (EOMB), edit 0610. ***NOTE: The EOMB must be uploaded and attached to the claim during the submission process***. Please allow up to 30 days to have the claim reviewed and released for payment or denial.

If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Additional Coverage of Services for Beneficiaries Enrolled in Healthier Mississippi Waiver

(07/22/16) 2:27 p.m.

Effective July 24, 2015, Mississippi Division of Medicaid (DOM) received Centers for Medicare and Medicaid Services (CMS) approval to cover all State Plan services for beneficiaries enrolled in Category of Eligibility 045 - Healthier Mississippi Wavier (HMW) except the following services:

- Long-term care services,
- Swing Bed in a skilled nursing facility, and
- Maternity and newborn care.

Currently, the Mississippi Envision Web Portal does not reflect coverage of the following services:

- Chiropractic services,
- Dental services,
- Eyeglasses, and
- Podiatry services.

Providers must contact the Conduent Call Center toll-free at 800-884-3222 to verify beneficiary eligibility. Providers will be notified through Late Breaking News when the Envision Web Portal has been updated to reflect the change in coverage. DOM will reprocess claims which denied incorrectly due to edit 0370-SERVICE EXCLUDED-PLAD WAIVER and edit 3955-SERVICE NOT COVERED FOR BENE. Providers will be notified through Late Breaking News and on their remittance advice when claims are reprocessed.

Attention All Providers

(07/22/16) 8:56 a.m.

The Division of Medicaid will reprocess claims for dates of service January 1, 2016 through April 12, 2016 which billed Place Of service 19 (POS19) Off-Campus-Outpatient Hospital. The mass adjustment will appear on your remittance advice dates 07/25/2016. No further action on the part of the provider is needed. If you have questions, please contact Conduent provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Hospice Providers Update

(07/21/16) 3:32 p.m.

DOM's fiscal Agent, Conduent, has successfully updated the Medicaid MMIS claims processing system to process payment for Routine Home Care (Revenue 0651) level of Hospice services, as required by CMS's methodology change. As of July 1, 2016, current Hospice claim payments should reflect the Tier-1 (T1) and Tier-2 (T2) Routine Home Care Rates. The (T1) higher rate is for the first 60 days of services and the lower rate (T2) is for days 61 and thereafter. Payment of the Service Intensity Add-on (SIA) rate for the last seven (7) days of life, which meet the registered nurse or social worker requirements, will not be paid until the following additional information is provided.

Reimbursement for the SIA component will require providers to identify on their claim when Registered Nurse (RN) or Social Worker (SW) services are provided. For RN services, providers will use 0559 Revenue Code and G0299 Procedure Code, along with the number of units provided. For this combination, one (1) unit is fifteen (15) minutes. For SW services, providers will use 0561 Revenue Code and G0155 Procedure Code for clinical social work services. For non-clinical social work services, Providers will use 0569 Revenue Code and G0155 Procedure Code, along with the number of units provided. These combinations will also be calculated as one (1) unit per fifteen (15) minutes.

In August, DOM anticipates a mass adjustment to re-process prior claims for dates of service January 1, 2016, through June 30, 2016 (start of the new methodology processing). The mass adjustment will correctly adjust those claims that were incorrectly paid at the higher "T1" rate for day 61 and after instead of the lower "T2" rate. In most cases, this will result in a recoupment of funds due Medicaid ranging from $34.55 to $37.28, per day, per beneficiary, depending on the county in which services were provided. Providers will need to resubmit SIA claims with the required additional coding in order to be reimbursed the SIA rate for beneficiaries that expired and had the pre-requisite services during the last seven (7) days of life.

DOM appreciates your patience during this process, and we apologize for the inconvenience.

If you have rate questions, please contact T.J. Walker @ 601-359-6827, or T.J.Walker@medicaid.ms.gov. If you have any claims questions, please contact Jay Horton, 601-359 -9544, or James.Horton@medicaid.ms.gov.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Durable Medical Equipment (DME) Provider Workshops 2016

(07/19/16) 12:21 p.m.

The MS Division of Medicaid and Conduent State Healthcare, LLC will conduct provider workshops for billers at DME facilities in August 2016. The workshop will cover the following topics:

- MS Medicaid Policy
- Top Common Denials
- Web Portal Functionality & Registration
- Managed Care
- Program Integrity
- Claims Resolution
- When is an Invoice Required?
- Fee Schedules
- The Importance of Checking Eligibility
- Manually Priced Claims

For more information regarding dates ,locations, and registration for DME provider workshops, please refer to the "What's New" section of the Mississippi Envision Web Portal at https://www.ms-medicaid.com/msenvision/servlet/DocumentViewerServlet?docType=news&fileName=News3.pdf

Attention All Providers

(07/05/16) 11:42 a.m.

HCPCS Code J2426

The Division Of Medicaid will reprocess claims for dates of service October 1,2015 through November 18, 2015 due to the addition of ICD-10 diagnosis restrictions to HCPCS codes J2426. The mass adjustment will appear on your remittance advice dated 07/18/2016. No further action on part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Provider Information regarding the Zika Virus

(07/14/16) 11:24 a.m.

June 1, 2016 the Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin informing Medicaid Agencies how Medicaid services can help states and territories prevent, detect, and respond to the Zika virus, including efforts to prevent the transmission and address health risks to beneficiaries. The Informational Bulletin may be found at https://www.medicaid.gov/federal-policy-guidance/downloads/cib060116.pdf

The Mississippi Division of Medicaid's (DOM) Zika coverage related to the 6/1/2016 CMCS informational bulletin is as follows:

- **Prevention**

  - ◊ **Vaccine** – The Food and Drug Administration (FDA) has not approved a vaccine for Zika at this time. Should one become available and be FDA approved, DOM will cover the vaccine through State Plan benefits available to all beneficiaries.

  - ◊ **Insect Repellents** – Mosquito repellents applied to the skin can aid in preventing Zika virus infection. The Centers for Disease Control (CDC) recommends people use Environmental Protection Agency (EPA)-registered insect repellents with one of the following active ingredients: DEET, picaridin, IR3535, oil of lemon eucalyptus, or para-menthane-diol.

  - ◊ Effective August 1, 2016, ***DOM will cover mosquito repellents when prescribed by an enrolled Medicaid provider and billed by a Medicaid pharmacy provider*****.** DOM will maintain a list of covered insect repellents which have been assigned National Drug Code (NDC) numbers by national drug databases such as First Databank and Medispan. Please refer to DOM's website at https://medicaid.ms.gov/providers/pharmacy/

  - ◊ Prescription claims for insect repellents ***will not count toward the five (5) prescription monthly service limit***.

  - ◊ A maximum of **two (2) cans/bottles per month per beneficiary** will be allowed for ***all beneficiaries aged 13 and over.***

- **Coverage** – Family Planning Service for Men and Women of Child Bearing Age or Women who are Pregnant

  - ◊ Family Planning Counseling – DOM currently covers this service for all beneficiaries through the Family Planning Waiver, Annual Wellness Exams and in accordance with the EPSDT Bright Futures Wellness periodicity guidelines.

  - ◊ Contraception – DOM covers all forms of contraceptives included in the bulletin (oral contraceptives, condoms, diaphragms, foams, gels, patches, rings, injections, tablets, emergency contraceptives and long acting reversible contraceptives) through the Family Planning Waiver. DOM covers all forms of contraceptives included in the waiver, except for condoms, for all beneficiaries regardless of category of eligibility (COE).

- **Detection of Zika Infection**

    ◊ Diagnostic Services – DOM covers all forms of diagnostic testing included in the bulletin (CT scans, MRIs, ultrasounds, blood tests, urine tests and genetic testing) for all beneficiaries, as medically necessary.

- **Treatment**

    ◊ Targeted Case Management Services – DOM covers targeted case management services for beneficiaries enrolled in certain waivers, the PHRM/ISS Program, the EI Program and through certain MSCAN programs.

    ◊ Physical Therapy and Related Services – DOM covers medically necessary physical, speech and occupational therapy services for all beneficiaries.

    ◊ Prescribed Drugs – DOM covers the drugs specifically mentioned in the letter, for all beneficiaries.

    ◊ Long Term Services and Supports – DOM covers medically necessary long-term rehabilitative services for all beneficiaries in institutional care and covers additional home and community based services through EPSDT benefits and the five HCBS waivers (AL, E&D, ID/DD, IL, TBI/SCI).

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

(07/14/16) 11:24 a.m.

RATE CHANGE!

For dates of service on or after July 1, 2016, the ADC rate is $61.82 per day. This is the maximum rate allowed under the current CMS approved Elderly and Disabled Waiver. The procedure code for ADC is S5102 and must be billed with a U1 modifier for services provided under the Elderly and Disabled Waiver.

Third Party Billing

(07/12/16) 4:25 p.m.

Did you know most third party billing questions or problems can be resolved by simply referring to the MS Administrative Code or the Provider Billing Handbook? This information is available on the Division of Medicaid's website at https://medicaid.ms.gov/providers/. The support staff of the Office of Recovery is available to assist providers with any additional third party billing issues and can be reached at 1-800-421-2408.

Providers can also report third party insurance updates directly to the Third Party Recovery File Maintenance Unit via email at tplpolicyupdate@medicaid.ms.gov. Your email will be promptly handled within three to four business days.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention EPSDT Providers

(07/12/16) 11:08 a.m.

EPSDT screening providers, currently enrolled in the program, must update their enrollment status by completing the EPSDT Provider Agreement. The EPSDT Provider Agreement is located on the Mississippi Envision website under "What's New?" at www.ms-medicaid.com/msenvision/index.do. Providers must send the completed and signed EPSDT Provider Agreement by **August 30, 2016** to:

Division of Medicaid-Office of Medical Services
550 High Street, Suite 1000, Jackson, MS 39202
or via fax to (601) 359-6147

Failure to send the completed and signed EPSDT Provider Agreement may result in provider disenrollment from the EPSDT program. Please contact the Office of Medical Services at (601) 359-6150 if you have any questions or need additional assistance.

Billing Updates for Mental Health Providers

(07/11/16) 9:04 a.m.

2016 Annual Rate Updates
Effective 7/1/2016, the Division of Medicaid (DOM) has revised the rates for our providers based on 90% of the current Medicare rate, as defined in State Law. The new fee schedule for each mental health program area is posted under the provider tab on our website or accessible through the following links:

Community/Private Mental Health Centers:
http://www.medicaid.ms.gov/wp-content/uploads/2016/03/CommunityMentalHealthCenter.pdf

Psychiatry:
http://www.medicaid.ms.gov/wp-content/uploads/2016/03/MentalHealthPsychiatry.pdf

Therapeutic and Evaluative Services for Expanded EPSDT (T&E):
http://www.medicaid.ms.gov/wp-content/uploads/2016/03/TherapeuticEvaluativeMentalHealthChildren.pdf

Please refer to the most current CPT Code Book for the appropriate procedure code(s) for services provided. You may contact Kimberly Evans or Felita Bell at 601-359-9545, should you have questions.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Extension of deadline to submit Self-Attestation Statement form for Qualified Providers who need to self-attest to receive increased primary care services payments

(07/01/16) 4:59 p.m.

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (PPACA), for an increased payment for certain Evaluation and Management (E&M) and Vaccine Administration codes. DOM is extending the deadline for eligible providers to submit their 7/1/2016-6/30/2018 Self-Attestation Statement form to Conduent. Effective July 1, 2016, reimbursement of certain primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule. The DOM Primary Care Provider Fee Schedule is updated July 1 of each year based on 100 percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year. To receive the increased payment for dates of service (DOS) beginning 7/1/2016, eligible providers must send a completed and signed 7/1/2016 – 6/30/2018 Self-Attestation Statement form to Conduent Provider Enrollment by **8/1/2016** through one of the following means:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: P. O. Box 23078, Jackson, MS 39225

Providers whose 7/1/2016-6/30/2018 Self-Attestation Statement forms are e-mailed, postmarked or faxed during the extension timeframe of 6/30/2016 – 8/1/2016, will experience a delay in the reimbursement of the increased payment, which will be retroactively adjusted. Providers must notify Conduent of any change(s) to their completed 7/1/2016-6/30/2018 Self-Attestation Statement form. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at https://www.ms-medicaid.com/msenvision/. You can locate the form on the DOM website under the Forms section and the Envision Web Portal, or request it by calling the Conduent Call Center toll-free at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Extension of deadline to submit Obstetrician/ Gynecologist Self-Attestation Statement form for Qualified Obstetric/Gynecological Providers who need to self-attest to receive increased primary care services payments

(07/01/16) 4:59 p.m.

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (PPACA), for an increased payment for certain primary care Evaluation and Management (E&M) and Vaccine Administration codes. Pursuant to HB 1560, effective July 1, 2016 providers who self-attest to a specialty designation in obstetric/gynecologic medicine by the American Congress of Obstetricians and Gynecologists (ACOG) will be eligible for an increased payment for certain primary care services. DOM is extending the deadline for eligible providers to submit their 7/1/2016-6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement form to Conduent. Effective July 1, 2016, reimbursement of certain primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule. The Medicaid Primary Care Provider Fee Schedule is updated July 1 of each year based on one hundred percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year. To receive the increased payment for dates of service (DOS) beginning 7/1/2016, eligible Obstetric/ Gynecological providers must send a completed and signed 7/1/2016–6/30/2017 OB/GYN Self-Attestation Statement form to Conduent Provider Enrollment by **8/1/2016** through one of the following means:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: P. O. Box 23078, Jackson, MS 39225

Providers whose 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement forms are e-mailed, postmarked or faxed during the extension timeframe of 6/30/2016 – 8/1/2016, will experience a delay in the reimbursement of the increased payment, which will be retroactively adjusted. Providers must notify Conduent of any change(s) to their completed 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement form. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at https://www.ms-medicaid.com/msenvision/. You can locate the form on the DOM website under the Forms section and the Envision Web Portal, or request it by calling the Conduent Call Center toll-free at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

(6/30/16) 4:00 p.m.

Effective November 1, 2015, Mississippi Division of Medicaid (DOM) received Centers for Medicare and Medicaid Services (CMS) approval of State Plan Amendment (SPA) 15-017 Early and Periodic Screening, Diagnosis and Treatment (EPSDT). SPA 15-017 requires DOM EPDST providers adhere to the American Academy of Pediatrics Bright Futures periodicity schedule for physical, mental, psychosocial and/or behavioral health, vision, hearing, adolescent, and developmental screening services. SPA 15-017 also requires DOM EPSDT providers adhere to the requirements of the American Academy of Pediatric Dentistry (AAPD) for dental screening services.

EPSDT screenings must be provided by currently enrolled DOM EPSDT providers who have signed an EPSDT specific provider agreement. EPSDT providers may seek reimbursement for services rendered in accordance with the Bright Futures periodicity schedule for dates of service on and after November 01, 2015.

EPSDT screenings must include:

1. An initial or established age appropriate medical screening which must include, at a minimum:
    - A comprehensive health and developmental history including assessment of both physical and mental health development,
    - A comprehensive unclothed physical exam (which may be accomplished by examining each unclothed body system individually),
    - Appropriate immunizations according to the Advisory Committee for Immunization Practices (ACIP) and specific to age and health history,*
    - Laboratory tests adhering to the AAP Bright Futures periodicity schedule, sexual development and sexuality screening adhering to the AAP Bright Futures periodicity schedule, and
    - Health education, including anticipatory guidance

2. Adolescent counseling and risk factor reduction intervention to include diagnosis with referral to a Mississippi Medicaid enrolled provider for diagnosis and treatment for defects discovered.

3. Developmental screening or surveillance to include diagnosis with referral to a Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

4. Psychosocial/behavioral assessment to include referral to a Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

5. Vision screening at a minimum to include diagnosis with referral to a Mississippi Medicaid optometry or ophthalmology provider for diagnosis and treatment for defects in vision, including eyeglasses.

6. Vision screening at a minimum to include diagnosis with referral to a Mississippi Medicaid optometry or ophthalmology provider for diagnosis and treatment for defects in vision, including eyeglasses.

7. Hearing screening at a minimum to include diagnosis with referral to a Mississippi Medicaid audiologist, otologist, otolaryngologist or other physician hearing specialists for diagnosis and treatment for defects in hearing including hearing aids.

8. Dental screening at a minimum to include diagnosis with referral to a Mississippi Medicaid dental provider for beneficiaries at or the eruption of the first tooth or by twelve (12) months of age for diagnosis and referral to a dentist for treatment and relief of pain and infections, restoration of teeth and maintenance of dental health.

DOM EPSDT providers must schedule and perform all age appropriate screenings and assessments in accordance with Mississippi Administrative Code Title 23, Part 223 Early and Periodic Screening, Diagnosis, and Treatment, which is currently under revision to align with the AAP Bright Futures.

DOM EPSDT providers must refer beneficiaries to other Mississippi Medicaid enrolled licensed practitioners for services necessary to correct or ameliorate physical, mental, psychosocial and/or behavioral health conditions discovered by the screening services, whether or not such services are covered under the Mississippi State Plan.

For more information regarding SPA 15-017 Early and Periodic Screening, Diagnosis and Treatment (EPSDT), please refer to the DOM website at https://medicaid.ms.gov/about/state-plan/approved-state-plan-amendments/ or contact the Office of Medical Services (601) 359-6150.

*DOM does not enroll providers in the VFC Program. To enroll in the VFC program, please contact the Mississippi Department of Health Immunizations at 1-601-576-7751.

Mental Health Provider Enrollment Update

(6/27/16) 11:16 a.m.

Effective January 1, 2016, Licensed Professional Counselors (LPCs) began enrolling as individual MS Division of Medicaid (DOM) providers. Effective July 1, 2016, MS Board Certified Behavior Analysts (BCBAs) may also submit applications to begin the enrollment process as Therapeutic and Evaluative Mental Health Services (T&E) providers. LPCs and BCBAs may be reimbursed for medically necessary T&E services provided to EPSDT-eligible Medicaid beneficiaries and rendered in accordance with their professional licensure and scope of practice. Providers should reference the DOM T&E billing guidelines for a list of reimbursable services and procedure codes. Additional T&E provider guidance is available for reference at https://medicaid.ms.gov/wp-content/uploads/2016/01/Provider-Guidance-Therapeutic-and-Evaluative-Mental-Health-Services.pdf .

Please direct questions regarding T&E services to Kimberly Evans or Charlene Toten at 601-359-9545.

The Envision website contains provider application instructions, documentation and forms required to enroll. Providers may start the enrollment process by completing the Mississippi Medicaid Provider Enrollment Application located at https://msmedicaid.acs-inc.com/msenvision/pef/Login.do.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Long Acting Reversible Contraceptives Inpatient Reimbursement

(6/23/16) 3:52 p.m.

Effective July 1, 2016, Mississippi Division of Medicaid will begin reimbursing hospitals outside of the All Patient Refined- Diagnosis Related Groups methodology (APR-DRG), for insertion of Long Acting Reversible Contraceptive (LARC) devices when the device is placed prior to discharge from a postpartum inpatient stay. To receive reimbursement, the hospital may submit a separate outpatient claim for the device and insertion listing only the correct Current Procedural Terminology (CPT) and/or Healthcare Common Procedural Coding System (HCPCS) code and National Drug Code (NDC). Reimbursement will be at the current outpatient prospective payment system (OPPS) rates for the date of service. All other services provided by the hospital must be billed on the inpatient claim and reimbursed at the appropriate APR-DRG rate.

LARCs inserted in an outpatient hospital or physician setting, will continue to receive reimbursement under applicable reimbursement methodologies, when billed using the correct CPT and/or HCPCS code and NDC.

Inpatient LARC placement postpartum (supplied by HOSPITAL and prior to discharge)

- The hospital may submit an outpatient claim for LARC devices placed during the postpartum inpatient stay, listing only the date of the insertion as the date of service.
- The claim should include only the LARC device and insertion billed under the applicable Revenue code(s) with the appropriate device CPT and/or HCPCS code and the NDC for the product supplied.
- Reimbursement for LARCs will be at the current outpatient prospective payment system (OPPS) rates for the date of service.
- All other services provided by the hospital must be billed on the inpatient claim and reimbursed at the appropriate APR-DRG rate.
- Any professional claims submitted should not duplicatively include a LARC device.

Inpatient LARC placement postpartum (supplied by PHYSICIAN and prior to discharge)

- The hospital will not be reimbursed for the LARC device when it is provided by the physician during the postpartum inpatient stay.
- All other services provided by the hospital must be billed on the inpatient hospital claim and reimbursement will be calculated at the appropriate APR-DRG rate.
- The physician will submit a CMS1500 professional claim for services provided and include the appropriate device HCPCS code, and the NDC for the product supplied.
- Reimbursement for the LARC will be the physician fee for the date of service billed.

Outpatient LARC placement (supplied by the HOSPITAL)

- The hospital may submit an outpatient claim for all services provided and include the LARC device billed under the appropriate Revenue code(s) with the appropriate device CPT and/or HCPCS code and the NDC for the product supplied.
- Reimbursement for LARCs will be at the current outpatient prospective payment system (OPPS) rates for the date of service.
- Any professional claims submitted should not duplicatively include a LARC device.

Outpatient LARC placement (supplied by the PHYSICIAN)

- The hospital will not be reimbursed for the LARC device when it is provided by the physician.
- All other services provided by the hospital must be billed on the outpatient hospital claim and will be reimbursed at the outpatient hospital rate for the date of service billed.
- The physician will submit a CMS-1500 professional claim for services provided and include the appropriate device HCPCS code and the NDC for the product supplied.
- Reimbursement for the LARC will be the physician fee for the date of service billed.

The current reimbursement rates are:

Code	Description	Physician Fee	Outpatient Hospital
J7297	Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3 year duration	$750.00	$750.00
J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration	$972.61	$972.61
J7300	Intrauterine copper contraceptive	$886.80	$886.80
J7301	Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg	$780.38	$780.38
J7307	Etonogestrel (contraceptive) implant system, including implant and supplies	$925.82	$925.82

Attention Maternity Providers

(6/22/16) 2:09 p.m.

The Division of Medicaid (DOM) covers inductions of labor or cesarean sections prior to one (1) week before the treating physician's expected date of delivery when medically necessary in accordance with Part 222, Chapter 1, Rule 1.1 B. DOM does not cover non-medically necessary early elective deliveries. DOM defines an early elective delivery as delivery one (1) week prior to the treating physician's expected date of delivery. An elective delivery performed after one (1) week prior to the treating physician's expected date of delivery, is considered a covered service.

If you have any questions, please contact your Provider Representative or the Office of Medical Services at 601-359-6150.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Rural Health and Federal Qualified Health Clinics Provider Workshops 2016

(6/9/16) 2:45 p.m.

The MS Division of Medicaid and Conduent State Healthcare, LLC will conduct provider workshops for billers at RHC and FQHC facilities.

The workshop will cover the following topics:

- MS Medicaid Policy
- Top Common Denials
- Web Portal Functionality
- Managed Care
- Program Integrity

The specific dates and locations of the workshops are as follows:

Date/Time	Location	Date/Time	Location
June 21, 2016 9:00 a.m. – 4:00 p.m.	**Jackson Convention Complex** 105 E. Pascagoula Street Jackson, MS 39201	June 28, 2016 9:00 a.m. – 4:00 p.m.	**BancorpSouth Arena and Conference Center** 387 E Main Street, Tupelo, MS 38804
June 23, 2016 9:00 a.m. – 4:00 p.m.	**Hilton Garden Inn** 133 Plaza Drive Hattiesburg, MS 39402	June 29, 2016 9:00 a.m. – 4:00 p.m.	**The Alluvian Hotel** 318 Howard Street, Greenwood, MS 38930

Please complete the RSVP section and fax to: 601-206-3119
or email to: msmedicaidlatebreakingnews@conduent.com
Conduent State Healthcare, LLC
ATTN: Provider Field Services RHC and FQHC Workshops

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention Provider Enrollment Credentialing Personnel

(6/1/16) 3:00 p.m.

Effective July 1, 2016, any providers enrolling or submitting a Change of Ownership (CHOW) application to Mississippi Medicaid will be required to submit the new Provider Disclosure Form as part of their application packet. All providers are required to disclose this information based on 42 CFR § 455.104. Applications received on and after July 1 that do not include a completed Provider Disclosure Form are incomplete and will be returned.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Physician visit limit lifted for dually-eligible beneficiaries

(5/26/16) 4:00 p.m.

Effective May 1, 2016, the Medicaid-imposed 12 visit limit on physician visits is no longer applicable to individuals covered by both Medicare and Medicaid, who are eligible for Medicaid payment of crossover claims. These individuals are dually-eligible beneficiaries, who receive some type of health -care coverage from Medicare and Medicaid.

This change means that Medicaid providers may be reimbursed for physician visits deemed medically necessary, which exceed the previous 12 visit limit for dually-eligible beneficiaries.

Submitted claims may still deny until the appropriate system modifications are made. System modifications are tentatively scheduled to be implemented by July 1, 2016.

Providers currently seeking reimbursement for denied claims for visits which exceed the12 visit limit for dually-eligible beneficiaries must follow the standard reconsideration process during this interim system modification period. The Claim Reconsideration Form is available on the Mississippi Division of Medicaid's (DOM) website on the Forms webpage (http:/medicaid.ms.gov/resources/forms/).

This change will apply to all claims previously denied for Claim Exception Code 3708, Physician Office Visit Service Limit Exceeded, and that fall within timely filing requirements as of the effective date of this change. Medicare crossover claims for coinsurance and/or deductibles must be filed with DOM within 180 days of the Medicare pay date. The 180-day filing limitation will be determined using the Medicare payment register date as the date of receipt by DOM. Claims filed after the 180-day timely filing limitation will be denied.

Please be advised that this change will not affect claims denied for Claim Exception Code 3708, Physician Office Visit Service Limit Exceeded, for individuals covered only by DOM.

If you have questions, please contact us toll-free at 800-421-2408 or 601-359-6050. Learn more about the Mississippi Division of Medicaid at http://medicaid.ms.gov.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention Inpatient Hospitals

(5/12/16) 4:40 p.m.

Incorrect Application of Policy Adjuster

The Division of Medicaid will reprocess Inpatient Hospital claims for dates of service October 1, 2015 through November 10, 2015 due to the incorrect application of Obstetric/Newborn Policy adjuster to claims billed with ICD10CM principle diagnosis codes between 022.8X2 - Z99.89. The mass adjustment will appear on your remittance advise dated May 16, 2016. No further action on part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary services at 800-884-3222.

Attention Nurse Practitioners

(5/12/16) 4:40 p.m.

The Division Of Medicaid will reprocess Nurse Practitioner claims for dates of service January 1, 2013 through June 08, 2015, at the Medicaid allowed Fee as required by State Plan Amendment (Attachment - 4.19-B, Page 6d). The mass adjustment will appear on your remittance advise dated May 16, 2016. No further action on the part of the provider is needed. if you have questions, please contact Conduent provider and beneficiary services at 800-884-3222.

Hospice Providers Update

(5/10/16) 4:19 p.m.

Due to programming challenges, the updates to the claims payment system for federally required rate changes have not been completed. Even though a reduction was to begin January 1, rates are currently being paid for Routine Home Care reimbursement at the higher rate for beneficiaries that have reached the 60 day limit for the first rate tier. The **estimated overpayment** for beneficiaries that have or will reach the day 61+ tier rate, range from $34.55 to $37.28, per day, per beneficiary, depending on the county in which services are provided. In addition, the SIA add-on payment is not currently being paid for eligible claims for the last seven days of life.

While there will not be any changes in the way providers submit their claims, there will be some additional information required when submitting claims to ensure proper processing. There will be forthcoming notification on the additional requirements for claim submission.

If you have rate questions, please contact T.J. Walker @ 601-359-6827, or T.J.Walker@medicaid.ms.gov. If you have any claims questions, please contact Jay Horton, 601-359-9544, or james.horton@medicaid.ms.gov.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention Qualified Providers who need to self-attest to receive increased primary care services payments

(5/9/16) 9:15 a.m.

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (PPACA), for an increased payment for certain Evaluation and Management (E&M) and Vaccine Administration codes. Effective July 1, 2016, reimbursement of certain primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule. The DOM Primary Care Provider Fee Schedule is updated July 1 of each year based on 100 percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year. To receive the increased payment for dates of service (DOS) beginning 7/1/2016, eligible providers must send a completed and signed 7/1/2016 – 6/30/2018 Self-Attestation Statement form to Conduent Provider Enrollment by 6/30/2016 through one of the following means:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: P. O. Box 23078, Jackson, MS 39225

Providers whose 7/1/2016-6/30/2018 Self-Attestation Statement forms are e-mailed, postmarked or faxed after 5/31/2016, may experience a delay in the effective date of the increased payment. Providers must notify Conduent of any change(s) to their completed 7/1/2016-6/30/2018 Self-Attestation Statement form. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at https://www.ms-medicaid.com/msenvision/. You can locate the form on the DOM website under the Forms section and the Envision Web Portal, or request it by calling the Conduent Call Center toll-free at 800-884-3222.

Attention Qualified Obstetric/Gynecological Providers who need to self-attest to receive increased primary care services payments

(5/9/16) 9:15 a.m.

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted authority to continue reimbursing eligible providers, as determined by the Patient

Evaluation and Management (E&M) and Vaccine Administration codes. Pursuant to HB 1560, effective July 1, 2016 providers who self-attest to a specialty designation in obstetric/gynecologic medicine by the American Congress of Obstetricians and Gynecologists (ACOG) will be eligible for an increased payment for certain primary care services. Effective July 1, 2016, reimbursement of certain primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule. The Medicaid Primary Care Provider Fee Schedule is updated July 1 of each year based on one hundred percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year. To receive the increased payment for dates of service (DOS) beginning 7/1/2016, eligible Obstetric/Gynecological providers must send a completed and signed 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement form to Conduent Provider Enrollment by 6/30/2016 through one of the following means:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: P. O. Box 23078, Jackson, MS 39225

Providers whose 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement forms are e-mailed, postmarked or faxed after 5/31/2016, may experience a delay in the effective date of the increased payment. Providers must notify Conduent of any change(s) to their completed 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement form. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at https://www.ms-medicaid.com/msenvision/. You can locate the form on the DOM website under the Forms section and the Envision Web Portal, or request it by calling the Conduent Call Center toll-free at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Advanced Imaging Providers

(4/22/16) 11:00 a.m.

Advanced Imaging Claims Denials

For dates of service beginning March 01, 2016, Division of Medicaid (DOM) identified that certain claims billed with advanced imaging CPT codes are denying incorrectly for edit 0727-Prior Authorization Number Not on File. DOM is working to correct this issue and claims will be reprocessed. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222 or DOM at 601-359-6150.

Attention All Providers

(4/22/16) 9:00 a.m.

CPT, CDT & HCPCS Code Corrections

The Division of Medicaid will reprocess claims for dates of service January 1, 2014 through September 28, 2015 which denied due to edit '0306 - EYEGLASS OR DENTAL SERVICES NOT COVERED FOR BENEFICIARY' and '3955 - SERVICE NOT COVERED FOR BENEFICIARY'. This mass adjustment will appear on your remittance advise dated April 25, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(4/22/16) 9:00 a.m.

2016 CPT Lab Codes 0001M - 0010M

The Division Of Medicaid will reprocess claims for dates of service January 1, 2013 through February 8, 2016 which were billed for CPT Lab Codes 0001M - 0010M. The mass adjustment will appear on your remittance advise dated April 25, 2016. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers

(4/22/16) 9:00 a.m.

CPT, CDT & HCPCS Code Corrections

The Division of Medicaid will reprocess claims for dates of service January 1, 2014 through September 28, 2015 which denied due to edit '0306 - EYEGLASS OR DENTAL SERVICES NOT COVERED FOR BENEFICIARY' and '3955 - SERVICE NOT COVERED FOR BENEFICIARY'. This mass adjustment will appear on your remittance advise dated April 25, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Pharmacy Provider Notice

(4/18/16) 9:40 a.m.

For Fee for Service POS Claims

The DOM has implemented a systematic fix for PREFERRED BRAND drugs listed on the PDL which have been reimbursing with an ingredient cost based on the FUL price.

Pharmacists may enter a DAW of '9' on claims to override the FUL price on Preferred Brand drugs found on the PDL.

This fix is retroactive for claims with a Date of Service of 4/11/2016 and forward. Claims that paid incorrectly should be reversed and resubmitted with the original date of service (fill date).

For CAN claims

Pharmacist may call Magnolia or United Healthcare Help Desks for an override.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(4/15/16) 3:52 p.m.

2016 HCPCS and AMA Code Updates
The Division of Medicaid will reprocess claims for dates of service January 1, 2016 through January 15, 2016 due to a delay in annual code updates. The mass adjustment will appear on your remittance advice dated April 18, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Hospitals Providers

(4/8/16) 9:00 a.m.

The Division of Medicaid will reprocess paper claims that were denied incorrectly for Claim Exception 1816-PRINCIPAL SURGICAL PROCEDURE NOT ON DATA BASE' for dates of service October 1, 2015 thru January 18, 2016. The mass adjustment will appear on your Remittance advice dated April 11, 2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222

Attention Outpatient Hospitals and Physician Providers

(4/8/16) 9:00 a.m.

Incorrect Denials on Non-Surgical CPT Codes.
The Division of Medicaid will reprocess outpatient hospital and physician claims for dates of service October 1, 2014 through December 15, 2014 due to incorrect posting of Edit 1003 NOT A BILATERAL CODE-NO MODIFIER 50 ALLOWED and edit 1004 MULTIPLE SURGERY APPLIES-MODIFIER 51 REQUIRED on non- surgical CPT Codes. The mass adjustment will appear on your Remittance advice dated April 11, 2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(4/8/16) 9:00 a.m.

CPT Codes 19302, 19304, 19305, 19306, 19307
The Division of Medicaid will reprocess claims containing codes 19301, 19302, 19304, 19305, 19306, 19307 for dates of service January 1, 2007 through November, 19, 2015 due to Gender changes on CPT Codes 19302, 19304, 19305, 19306, 19307. The mass adjustment will appear on your Remittance advice dated April 11, 2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Hospital Inpatient APR-DRG Alert– July 1, 2016 Updates

(4/1/16) 8:25 a.m.

The Mississippi Division of Medicaid will adopt V.33 of the 3M Health Information System APR-DRG Grouper and V.33 of the Health Care Acquired Conditions (HCAC) utility for payment of hospital inpatient claims for discharges on and after July 1, 2016. APR-DRG parameters will not change effective for hospital inpatient discharges on and after July 1, 2016.

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 and after July 1, 2016.

Hospitals will be notified of all information related to these updates via e-mail, the DOM website www.medicaid.ms.gov, Late Breaking News, and RA Banner Messages.

Attention: Pharmacy Providers

(3/23/16) 4:25 p.m.

In accordance with the Centers for Medicare and Medicaid Services (CMS) Final Rule, implemented at 42 CFR §447.514, the April 2016 revised federal upper limit (FUL) prices will be used in current pharmacy reimbursement methodology beginning on April 11, 2016. Find more information about the final rule on the CMS website: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention: Nursing Facility Providers

(3/2/16) 9:30 a.m.

The Division of Medicaid and Mississippi State Department of Health Division of Licensure and Certification are hosting a free, one-day educational seminar for nursing home providers and other individuals or organizations interested in applying for a Civil Money Penalty grant. The seminar will be April 26, 2016 from 9:00 AM until 3:30pm. The seminar will be held at the University of Mississippi Medical Center Conference Center, Jackson Medical Mall, 350 W. Woodrow Wilson Drive, Jackson, MS. If your organization is seeking funding from Centers for Medicare and Medicaid Services for a project benefiting nursing home residents, please attend this educational seminar.

The deadline for registration is April 12. You may register at the following link: http://healthyms.com/register/cmp/

For more information, please call 601-359-9529 or 601-359-5251.

Provider Information for Leading Testing and Treatment

(2/26/16) 9:15 a.m.

On Feb. 24, the City of Jackson issued a press release regarding elevated levels of lead in some home water samples serviced by the city water system. (City of Jackson Meeting Additional Compliance Measures Related to Lead Exceedance)

To better assist our providers who serve our beneficiaries, the Mississippi Division of Medicaid (DOM) has listed specific instructions about billing and reimbursement related to lead testing and treatment. DOM covers CPT code 83655 (lead testing) outside of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) or wellness benefit for all beneficiaries when billed with a QW modifier. The ICD-10 code for contact with and (suspected) exposure to lead is Z77.011.

Claims for beneficiaries impacted by the recent Mississippi Department of Health announcement related to City of Jackson Public Water System should include ICD-10 code Z77.011, CPT code 83655 (with QW modifier) and an appropriate Evaluation and Management code, when lead testing is performed outside of the EPSDT or wellness benefit. All applicable Administrative Code, State Plan and provider policies apply.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(2/26/16) 8:52 a.m.

CPT-HCPCS Radiology Code Fee Corrections

The Division of Medicaid will reprocess claims for dates of service January 1, 2015 through February 20, 2015 due to CPT-HCPCS Radiology Code Fee Corrections. The mass adjustment will appear on your remittance advice dated February 29, 2016. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers

(2/19/16) 8:40 a.m.

NCCI Edit 6560 Correction

The Division of Medicaid will reprocess claims for dates of service April 1, 2011 through December 1, 2015 which denied due to edit 6560-NCCI Medically Unlikely Edits. The mass adjustment will appear on your remittance advice dated February 22, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers

(2/19/16) 8:40 a.m.

End Date Corrections on Various Pricing Segments

The Division of Medicaid will reprocess claims which were billed with the codes 76390, 27215, 27216, 27217, 27218, 58300, 97010, 97014, 92617, and 93641 for dates of service July 1, 2014 through June 30, 2015. The mass adjustment will appear on your remittance advice dated February 22, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(2/19/16) 8:40 a.m.

CPT Code 73206 & 78102

The Division of Medicaid will reprocess claims for dates of service July 1, 2015 through December 10, 2015 which billed newly opened CPT codes 78102 and 73206. The mass adjustment will appear on your remittance advice dated February 22, 2016. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Mental Health Provider Guidance

(2/12/16) 9:00 a.m.

New guidance for providers of Therapeutic and Evaluative Mental Health Services for Expanded EPSDT is now available on the Division of Medicaid (DOM) website. This document contains helpful information about mental health services offered to DOM beneficiaries under the age of 21 and is accessible at the following link: http://www.medicaid.ms.gov/wp-content/uploads/2016/01/Provider-Guidance-Therapeutic-and-Evaluative-Mental-Health-Services.pdf

If you have any questions about this information, contact Kimberly Evans or Charlene Toten at 601-359-9545.

Attention All Providers

(2/12/16) 9:00 a.m.

CPT Code 88342 Update

The Division of Medicaid will reprocess claims which were billed with CPT code 88342 for dates of service January 1, 2015 through October 30, 2015. The mass adjustment will appear on your remittance advice dated February 15, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(2/12/16) 9:00 a.m.

Code Updates

The Division of Medicaid will reprocess claims which were billed with codes 88342, 96040, 80440, 86152, 86153, J7303, and 88341 for dates of service January 1, 2013 through May 11, 2015. The mass adjustment will appear on your remittance advice dated February 15, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Join Magnolia Health for a webinar on acute inpatient issues and the inpatient transition

(2/8/16) 2:00 p.m.

Join Magnolia Health Plan Thursday, Feb. 11 for an educational webinar on acute inpatient issues and behavioral health.

Webinar: Magnolia Health Inpatient and Behavioral Health Webinar
Date: Thursday, Feb. 11
Time: 2:00 – 3:00 p.m. CDT
Conference Number: 1-855-351-5537
Participant Code: 5440205058
To join the meeting: http://centene.adobeconnect.com/r2yr3d07ypb/

Questions?

Your questions and concerns are important to us. For that reason, we have established a dedicated email box for the inpatient transition. We encourage you to submit your questions about the inpatient transition and your inquiry will be addressed. Contact us by emailing inpatient@medicaid.ms.gov.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Allowable Board of Directors Fees for Nursing Facilities, ICF-IID's and PRTF's 2015 Cost Reports

(2/5/16) 2:00 p.m.

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2015 cost reports filed by nursing facilities (NF's), intermediate care facilities for individuals with intellectual disabilities (ICF-IID's), and psychiatric residential treatment facilities (PRTF's) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for all Urban Consumers - All Items. The amounts listed below are the per meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2015 are as follows

Category	Maximum Allowable **Cost for 2015**
0 – 99 Beds	$ 4,015
100 – 199 Beds	$ 6,022
200 – 299 Beds	$ 8,029
300 – 499 Beds	$10,037
500 Beds or More	$12,044

2016 New Bed Values for Nursing Facilities, ICF-IIDs, and PRTFs

(2/5/16) 2:00 p.m.

The new bed values for 2016 for nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs) and psychiatric residential treatment facilities (PRTFs) have been determined by using the R.S. Means Historical Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

Facility Class	**2016 New Bed Value**
Nursing Facility	$91,462
ICF-IIDs	$109,754
PRTF	$109,754

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

2015 Owner Salary Limits for Long-Term Care Facilities

(2/5/16) 2:00 p.m.

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities as owner's salaries for 2015 are based on 150% of the average salaries paid to non-owner/ administrators that receive payment for services related to patient care. The limits apply to all salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2015 are as follows:

Small Nursing Facilities (1-60 Beds)	$128,285
Large Nursing Facilities (61 + Beds)	$150,977
Intermediate Care Facilities for individuals with intellectual disabilities (ICF-IID)	$140,820
Psychiatric Residential Treatment Facilities (PRTF)	$206,906

Attention All Providers

(2/5/16) 2:00 p.m.

CPT, CDT & HCPCS Code Corrections

The Division of Medicaid will reprocess claims which were billed with the codes listed below for dates of service January 1, 2015 through April 16, 2015. The mass adjustment will appear on your remittance advice date February 8, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-

Change	Code	Pricing Type	Begin Date	End Date	Fee	OPPS Status Code
End date correction	J1626	Outpatient	01/01/2014	12/31/9999	$0.00	N-Bundled
End date correction	77002	Outpatient	09/01/2012	12/31/9999	$0.00	N-Bundled
End date correction	77002	General Fee	07/01/2014	12/31/9999	$74.05	
Discontinued	77082	Outpatient	01/01/2015	12/31/9999	$0.00	D-Discontinued
Discontinued	77082	General Fee	01/01/2015	12/31/9999	$0.00	
End date correction	80400	Outpatient	07/01/2015	12/31/9999	$39.95	M1-MS Med Fee
End date correction	80400	General Fee	07/01/2015	12/31/9999	$39.95	
Discontinued	80440	Outpatient	01/01/2015	12/31/9999	$0.00	D-Discontinued
Discontinued	80440	General Fee	01/01/2015	12/31/9999	$0.00	
Code deleted	D9331	Dental Fee	01/01/2015	12/31/9999	$0.00	Invalid code
Code added	D9931	Dental Fee	01/01/2015	12/31/9999	$0.00	
Code opened	44401	Outpatient	01/01/2015	12/31/9999	$682.91	T-Multi Discount

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(2/5/16) 2:00 p.m.

CPT Codes 99406 & 99407

The Division of Medicaid will reprocess claims for dates of service October 1, 2015 through November 2, 2015 which were billed with CPT codes 99406 & 99407. The mass adjustment will appear on your remittance advice dated February 8, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers

(1/28/16) 4:15 p.m.

CPT Codes 90685 and 90687

The Division of Medicaid will reprocess outpatient hospital claims for dates of service July 1, 2014 through November 25, 2014 due to changes on CPT codes 90685 and 90687. The mass adjustment will appear on your remittance advice dated February 1, 2016. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers

(1/28/16) 4:15 p.m.

OCT 2014 PAD Fee Corrections

The Division of Medicaid will reprocess claims for dates of service October 1, 2014 through May 12, 2015 due to multiple October 2014 Physician Administered Drug Fee corrections. The mass adjustment will appear on your remittance advice dated February 1, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(1/28/16) 4:15 p.m.

Various HCPCS Codes

The Division of Medicaid will reprocess claims billed with various HCPCS codes for dates of service January 1, 2015 through April 7, 2015. The mass adjustment will appear on your remittance advice dated February 1, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers

(1/28/16) 4:15 p.m.

Physician Administered Drug Fee Updates

The Division of Medicaid will reprocess claims for dates of service July 1, 2014 through January 27, 2015 due to Physician Administered Drug Fee updates. The mass adjustment will appear on your remittance advice dated February 1, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers

(1/28/16) 4:15 p.m.

CPT Code 41899

The Division of Medicaid will reprocess claims billed with CPT code 41899 for dates of service October 1, 2014 through February 27, 2015. The mass adjustment will appear on your remittance advice dated February 1, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention All Providers

(1/28/16) 4:15 p.m.

2015 HCPCS Physician Administered Drug Code Update
The Division of Medicaid will reprocess claims for the dates of service January 1, 2015 through January 15, 2015 due to 2015 HCPCS Physician Administered Drug Code Update. The mass adjustment will appear on your remittance advice dated February 1, 2016. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Advanced Imaging Changes

(1/28/16) 11:30 a.m.

Effective March 1, 2016, eQHealth Solutions (eQHS) will begin performing prior authorization reviews for advanced imaging services, in accordance with Mississippi Administrative Code Title 23, Part 220 Radiology Services. Currently, advanced imaging services are prior authorized through MedSolutions (eviCore). The Mississippi Division of Medicaid (DOM) will honor MedSolutions (eviCore) treatment authorization numbers issued to rendering providers for dates of services on or before March 30, 2016. Advanced imaging prior authorization requests pended for additional information by MedSolutions (eviCore) on or after March 1, 2016 must be submitted to eQHS as a new prior authorization request.

eQHS will conduct webinar sessions designed to assist providers with this transition. All providers and staff are encouraged to attend one of these informative sessions. Please visit http://ms.eqhs.org to register for the upcoming sessions. For additional information, please contact eQHS at 601-360-4833 or by email at education@eqhs.org. Providers may also contact DOM Office of Medical Services at 601-359-6150.

This change does not impact Medicaid beneficiaries enrolled in the MS Coordinated Access Networks (MSCAN).

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention Hospice Providers

(1/22/16) 2:27 p.m.

Routine Home Care Reimbursement Methodology Change
Effective January 1, 2016

Effective January 1, the reimbursement methodology and rates for Hospice "Routine Home Care" level services have changed. The new methodology changes the "Routine Home Care" service reimbursement from a single rate to a two tier rate. This change will result in a higher base payment for the first sixty (60) days of hospice care and a reduced base payment rate for days 61 and thereafter. In addition, the change establishes an add-on payment for certain professional services provided during the last seven (7) days of life, provided the services were performed by a Registered Nurse or Social Worker for a beneficiary during the last seven (7) days. The Routine Home Care reimbursement rates will transition from a single rate by county to a two tier rate (Day 1 - 60 and Days 61+) by county, and a Service Intensity Add-On (SIA) payment, if applicable.

DOM will update the new rates on the FY 2016 Hospice Rates (revised) table on our Internet website, as well as in our MMIS payment system. We anticipate the changes in the MMIS payment system to be completed by January 31, 2016. There will not be any changes in the way providers submit their claims.

This change was mandated by CMS regulation. More information can be found in the following CMS publications: 'FY 2016 Medicare Hospice Final Rule' (CMS-1629-F) and 'Medicaid Memorandum: Annual Change in Medicaid Hospice Payment Rates--ACTION'.

If you have questions, please contact T.J. Walker @ 601-359-6827, or T.J.Walker@medicaid.ms.gov.

LATE BREAKING NEWS ***2016***

WHAT'S NEW?

Attention: Family Planning Providers

(1/14/16) 2:52 p.m.

DISCONTINUED CODE J7302 REPLACED WITH J7297 AND J7298 EFFECTIVE 1/1/2016
Effective 12/31/2015, HCPCS code J7302 (Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG) will be discontinued. The new HCPCS codes J7297 (Liletta) and J7298 (Mirena) should be utilized for billing Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG beginning with dates of service on or after 01/01/2016. If you have any questions, please contact your Provider Representative or the Office of Medical Services at 601-359-6150.

Medicaid Program Integrity Education

(1/11/16) 9:30 a.m.

The Center for Program Integrity provides educational resources to educate providers, beneficiaries and other stakeholders in promoting best practices and awareness of Medicaid fraud, waste and abuse. Medicaid Provider Integrity Education (MPIE) materials are applicable to providers, beneficiaries, and State managed care plans. MPIE materials include topic-based information in an easy to read format that aid in furthering education efforts of providers, beneficiaries and other Medicaid stakeholders. The information provided is intended to further the education efforts of Medicaid Program Integrity Education, assist providers with being in compliance with their billing and assist in the fight against fraud, waste and abuse. Please visit Medicaid Program Integrity Education - Centers for Medicare & Medicaid Services to access educational booklets, fact sheets and provider checklist resources and tools which promote efforts to prevent Medicaid fraud, waste and improper payments.

Attention All Providers

(1/7/16) 4:00 p.m.

The Division of Medicaid will reprocess inpatient claims with date of service beginning 10/01/2015 paid through 11/02/2015 that paid incorrectly due to a system issue. The affected claims will be adjusted to correct the associated payment errors. The mass adjustment will appear on your Remittance Advice dated 01/11/2016. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

What's new

Attention: All Providers (12/24/15) 11:00 a.m.

A review of the infusion Current Procedural Codes (CPT) 96372 and 96375 was completed and corrections to the maximum units of these codes have been made. Due to these changes, outpatient hospital claims for CPT code 96372 dates of service beginning September 1, 2012 and CPT code 96375 dates of service beginning July 1, 2013 and through August 12, 2013 will require reprocessing. Physicians claims billed with CPT code 96372 dates of service beginning July 1, 2013 through August 12, 2013 will also require reprocessing. The adjusted claims will appear on your Provider Remittance Advice dated 12/28/2015. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION ALL PROVIDERS (12/24/15) 11:00 a.m.

HCPCS Code J0885 and J0886

The Division of Medicaid will reprocess outpatient hospital claims for dates of service January 1, 2013 through June 16, 2014 due to changes on HCPCS codes J0885 and J0886. The mass adjustment will appear on your remittance advice date 12/28/2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services 800-884-3222.

ATTENTION: PROFESSIONAL AND FACILITY PROVIDERS

(12/24/15) 11:00 a.m.

INFLUENZA VIRUS VACCINE CODES 90686 AND 90688

The Division of Medicaid will reprocess claims for influenza virus vaccines billed using CPT codes 90686 and 90688. All claim lines billed using either code will be reprocess for dates of service beginning July 1, 2013 through February 10, 2014 for 90686 and September 1, 2013 through February 10, 2014 for 90688. These reprocessed claims will appear on your remittance advice dated 12/28/2015. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION PROFESSIONAL AND OUTPATIENT HOSPITAL PROVIDERS (12/24/15) 11:00 a.m.

The Division of Medicaid will reprocess professional and outpatient claims for dates of service January 1, 2014 through April 1, 2014 due to changes in age, diagnosis, and/or maximum units on the CPT/HCPCS codes listed below. The mass adjustment will appear on your remittance advice dated December 28, 2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

CPT/HCPCS Codes: 52287 64612 64613 64614 64615 64616 64617 64642 64643 64644 64645 64647 64650 64653 67345 J0585 J0586 J0587

What's new

Hospital and Nursing Facilities Physician's Signature Notification Announcement (12/23/15) 11:26 a.m.

Effective January 1, 2016, Mississippi Division of Medicaid (DOM) will no longer require the physician's certification, electronic or hardcopy signature, to confirm clinical eligibility of a nursing facility resident. Applicable sections of Mississippi Administrative Code Title 23 are being revised to reflect these changes for Pre-Admission Screening and Resident Review (PASRR), formerly known as the Pre-Admission Screening (PAS). The following sections will be included in this update:

- Part 303, Chapter 1, Rule 1.2: Level I Pre-Admission Screening and Resident Review, and
- Part 207, Chapter 1: Long Term Care Pre-Admission Screening , Rule 1.1: Clinical Eligibility Determination

If you have any questions or need additional information, please contact Gay Gipson or Michele Bates at 601-359-9545. Thank you for your continued participation in the Medicaid program and your service to these Mississippians.

ATTENTION HOSPITAL PROVIDERS (12/23/15) 10:00 a.m.

Effective July 1, 2015, certain hospital outpatient claims began denying inappropriately for edit 0110-Date Bundling Not Allowed. The Division of Medicaid (DOM) is working on a system resolution to correct this issue. A mass adjustment will be done to correct any inappropriately denied claims. No further action on the part of the provider is required. Please continue to check the Mississippi Medicaid website at http://www.medicaid.ms.gov for Late Breaking News regarding updates.

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

What's new

Attention: All Providers! 12/22/2015 10:59 a.m.

EDI Solutions Scheduled Maintenance for January, 2016.

Please be informed that Conduent EDI Solutions will be setting aside the below timeframes for performing our planned maintenance activities in January, 2016. All batch and real time transaction processing (including Switch Vendor) will experience timeouts during this maintenance time frame. This regular maintenance will help us to improve reliability and performance of our systems. We appreciate your understanding and cooperation. If you have any questions, please do not hesitate to contact the EDI Helpdesk or your Switch Vendor Contact.

Start Date/Time	End Date/Time	Duration
Sunday 01/03/2016 12:00 AM EDT	Sunday 01/03/2016 02:00 AM EDT	2 hrs
Sunday 01/10/2016 12:00 AM EDT	Sunday 01/10/2016 02:00 AM EDT	2 hrs
Sunday 01/17/2016 12:00 AM EDT	Sunday 01/17/2016 02:00 AM EDT	2 hrs
Sunday 01/24/2016 12:00 AM EDT	Sunday 01/24/2016 02:00 AM EDT	2 hrs
Sunday 01/31/2016 12:00 AM EDT	Sunday 01/31/2016 02:00 AM EDT	2 hrs

NOTICE TO PHARMACY and Pharmacy DME PROVIDERS ONLY! (12/18/2015) 9:00 a.m.

(Pharmacy Disease Management Providers ARE NOT included)

Pharmacy License Renewal- Final Notice!

Pharmacies enrolled in the MS Medicaid program must be in good standing with their regulatory authority to be a Medicaid provider. Pharmacies who have not submitted their annual pharmacy permit renewal to Conduent by 01/31/2016 will be terminated from the MS Medicaid program, and claims submitted after 01/31/2016 will be denied. Additionally, DOM will recoup monies paid during 1/1/2016 – 1/31/2016 for those pharmacy providers without a valid pharmacy permit on file during January 2016.

To ensure your MS Medicaid provider file is updated, please fax a copy of the pharmacy permit to Conduent at 601-206-3015. A copy of the permit must be provided; letters from the Board of Pharmacy do not suffice as documentation of permit renewal. For questions or additional information, please contact Conduent at 1-800-884-3222.

What's new

Attention: All Providers! (12/18/2015) 9:00 a.m.

ICD-9 Codes 258.01, 258.02 and 258.03

The division of Medicaid will reprocess Outpatient Hospital Claims for dates of service October 1 2007 through July 1 2014 due to changes on ICD-9 Diagnosis codes 258.01, 258.02 and 258.03. The mass adjustment will appear on your Remittance advice dated December 21, 2015. No further action on the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222

Attention: All Providers! (12/18/2015) 9:00 a.m.

The Division of Medicaid will reprocess professional claims for dates of service July 1, 2013 through June 30, 2014 for CPT code 77427. The mass adjustment will appear on your remittance advice dated December 21, 2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: All Providers! (12/18/2015) 9:00 a.m.

The Division of Medicaid will reprocess professional claims for dates of service July 1, 2013 through February 9, 2015 for HCPCS Codes J0881, J0882, J0885 and J0886. The mass adjustment will appear on your remittance advice date December 21, 2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: Outpatient Hospitals! (12/18/2015) 9:00 a.m.

OUTPATIENT HOSPITAL CLAIMS

ICD9-CM DIAGNOSIS CODE V46.14 GENDER CORRECTION

The Division of Medicaid will reprocess claims due to an error in the gender setting for ICD9-CM Diagnosis Code V46.14. The gender has been corrected and all outpatient claims billed with this code will be reprocessed for dates of service beginning October 1, 2005 through May 1, 2014. These reprocessed claims will appear on your remittance advice dated 12/21/2015. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

What's new

Attention: Outpatient Hospitals! (12/18/2015) 9:00 a.m.

HCPCS CODE J1442

The Division of Medicaid will reprocess outpatient claims for dates of service January 1, 2014 through March 21, 2014 which were billed with HCPCS code J1442. This mass adjustment will appear on your remittance advice dated December 21, 2015. No further action on the part of the provider is required. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: All Providers! (12/11/2015) 3:14 p.m.

DISCONTINUED CODE 0262T REPLACED WITH CODE 33477 EFFECTIVE 1/1/2016

The 2016 CPT code changes include the discontinuance of CPT procedure code 0262T effective 12/31/2015. The new CPT code 33477 should be utilized for billing of this procedure beginning with dates of service 01/01/2016. If you have any questions, please contact your Provider Representative or the Office of Medical Services at 601-359 -6150.

Attention: All Providers! (12/10/2015) 4:26 p.m.

The Division of Medicaid will reprocess claims with adjudication dates from 10/01/2012 through 10/12/2015 for Claim Exception 0143-beneficiary not eligible/not found and/or 0149-beneficiary has partial eligibility. The mass adjustment will appear on your remittance advice date 12/14/2015. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: All Hospital Providers! (12/10/2015) 4:25 p.m.

Inpatient Hospital claims with an adjudication date of June 15, 2014 through April 13, 2015 will require reprocessing due to Claim Exception 0605-AUTHORIZATION/SERVICE DATE CONFLICT not applying correctly. This Mass Adjustment will occur the week of 12/14/2015. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

What's new

Mental Health Provider Enrollment Announcement

(11/25/2015)

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

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

If you have any questions regarding the enrollment application or process, contact a Conduent provider enrollment specialist toll-free at 800-884-3222.

Attention: DME, Medical Supply, Orthotic, and Prosthetic Providers!!! (11/20/2015)

Due to a delay in implementation of the July 1, 2015 Fee Update for these providers, claims for dates of service July 1, 2015 through September 15, 2015 billed with certain impacted codes will require reprocessing. This mass adjustment will appear on your remittance advice dated November 23, 2015. No further action on the part of the provider is required. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Providers (11/20/2015)

The Division of Medicaid will reprocess professional claims for dates of service January 1, 2015 through February 8, 2015 for certain impacted codes due to an update error. the mass adjustment will appear on your remittance advise dated November 23, 2015. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

What's new

****Attention All Hospitals and Providers****

11/18/2015 8:15 a.m.

Join Us for a Webinar on Newborns And The Inpatient Transition

The Mississippi Division of Medicaid (DOM) is preparing for the inclusion of inpatient services into our managed care program (MississippiCAN) and is collaborating with our partners to ensure a smooth transition. This transition will be effective Dec. 1, 2015.

Join us Monday, Nov. 23 to learn about changes affecting newborns from representatives at DOM and our MississippiCAN coordinated care organizations, Magnolia Health and UnitedHealthcare Community Plan. During the webinar we will cover many topics, including: observation, concurrent review, notification, the newborn form, prior authorization, neonatal intensive-care unit policies, interim billing, enrollment challenges and more.

Webinar: Newborns and the inpatient transition for hospitals and providers

Date: Monday, Nov. 23

Time: 1:30 – 3:30 p.m. CDT

To register for the webinar, please RSVP by emailing inpatient@medicaid.ms.gov **with the following information:**

- Hospital or facility name
- Hospital or facility address
- Contact person name
- Contact person phone number
- Contact person email address

The webinar information will be sent after your registration information is received. Please limit attendance to one line per hospital or facility. Capacity is limited.

Questions?

Your questions and concerns are important to us. For that reason, we have established a dedicated email box for the inpatient transition. We encourage you to submit your questions about the inpatient transition and your inquiry will be addressed. Contact us by emailing inpatient@medicaid.ms.gov

What's new

******ATTENTION ALL HOSPITALS AND PROVIDERS!!!******
11/10/2015 11:00am

Join us for a webinar on behavioral health and the inpatient transition
The Mississippi Division of Medicaid (DOM) is preparing for the inclusion of inpatient services into our managed care program (MississippiCAN) and is collaborating with our partners to ensure a smooth transition. This transition will be effective Dec. 1, 2015.

As part of the inpatient services transition, there will also be changes affecting inpatient behavioral health. As a valued Medicaid provider specializing in behavioral health, we want to give you the opportunity to learn about these changes through a webinar.

Join us Tuesday, Nov. 17 to hear from representatives at DOM and our MississippiCAN coordinated care organizations, Magnolia Health and UnitedHealthcare Community Plan. During the webinar we will cover many topics, including: prior authorization processes, reimbursement and claims instructions, applicable policies, provider enrollment for inpatient services and more.

Webinar: Behavioral health and the inpatient transition for hospitals and providers
Date: Tuesday, Nov. 17
Time: 10 a.m. – 12 p.m. CDT

To register for the webinar, please RSVP by emailing inpatient@medicaid.ms.gov with the following information:

- Hospital or facility name
- Hospital or facility address
- Contact person name
- Contact person phone number
- Contact person email address

The webinar information will be sent after your registration information is received. Please limit attendance to one line per hospital or facility. Capacity is limited.

Questions?
Your questions and concerns are important to us. For that reason, we have established a dedicated email box for the inpatient transition. Please don't hesitate to contact us by emailing inpatient@medicaid.ms.gov.

What's new

******ATTENTION ALL PROVIDERS!!!****** 10/29/2015 4:00pm

Please be informed that Conduent EDI Solutions will be setting aside the below timeframes for performing our planned maintenance activities in November 2015. All batch and real time transaction processing (including Switch Vendor) for the states noted above will experience timeouts during this maintenance time frame. This regular maintenance will help us to improve reliability and performance of our systems. We appreciate your understanding and cooperation.

Start Date/Time	End Date/Time
Sunday 11/01/2015 12:00 AM EDT	Sunday 11/01/2015 02:00 AM EDT
Sunday 11/08/2015 12:00 AM EDT	Sunday 11/08/2015 02:00 AM EDT
Sunday 11/15/2015 12:00 AM EDT	Sunday 11/15/2015 02:00 AM EDT
Sunday 11/22/2015 12:00 AM EDT	Sunday 11/22/2015 02:00 AM EDT
Sunday 11/29/2015 12:00 AM EDT	Sunday 11/29/2015 02:00 AM EDT

****ATTENTION ALL HEARING, VISION, AND OPTICAL DISPENSARY PROVIDERS**** 10/23/2015 9:22 am

National Correct Coding Initiative (NCCI) Billing Requirements

The Patient Protection and Affordable Care Act of 2010 (ACA) requires state Medicaid agencies to incorporate National Correct Coding Initiative (NCCI) methodologies for processing of claims effective April 1, 2011. This methodology includes the billing of anatomic modifiers on appropriate vision, hearing, and optical medical device HCPCS codes to prevent denials. In some instances this will require the billing of the same code on two separate lines to provide the correct anatomic modifier for each code. Information on the correct use of NCCI associated modifiers is located in the Medicaid NCCI Policy Manual at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html . Providers should review this NCCI Policy Manual and other articles located on the website for information on correct billing of these modifiers. If you have any questions, please contact your Conduent representative or the Division of Medicaid.

What's new

Attention All Providers!! 10/20/15 2:52 pm

The Automated Voice Response System's (AVRS) menu options have changed. In order to check a beneficiary's eligibility, you will need to press option 2, 2 and 2.

Attention Hospital Providers!! 10/20/15 2:46 pm

Join us for a webinar on the inpatient transition
The Mississippi Division of Medicaid (DOM) is preparing to roll inpatient services into our managed care program (MississippiCAN) and collaborating with our partners to ensure a smooth transition. This transition is set to be effective Dec. 1, 2015. Rolling inpatient services into managed care will change claims submission and other procedures. As a valued Medicaid provider, we want to give you the opportunity to learn about these changes through a webinar. (More webinars will be scheduled in November; one will specifically address behavioral health.)

Join us in a webinar to hear from representatives at DOM and our MississippiCAN coordinated care organizations, Magnolia Health and UnitedHealthcare Community Plan. During the webinar we will cover many topics, including: the prior authorization process, reimbursement and claims instructions, applicable policies, provider enrollment for inpatient services and more.

Webinar: Inpatient transition training and education for hospitals and providers
Date: Monday, October 26
Time: 10 a.m. – 12 p.m. CDT

To register for the webinar, please RSVP by emailing inpatient@medicaid.ms.gov with the following information:

Hospital or facility name
Contact person name
Contact person phone number
Contact person email address

The webinar information will be sent after your registration information is received. Please limit attendance to **one line** per hospital or facility. Capacity is limited.

Questions?
Your questions and concerns are important to us. For that reason, we have a dedicated email box for the inpatient transition. Please don't hesitate to contact us by emailing inpatient@medicaid.ms.gov.

What's new

****** *Attention Providers* ****** 10/15/15 4:30 pm

Providers participating in the Primary Care Provider (PCP) Program were previously notified to re-attest using the 1/1/2015 - 6/30/2016 Self-Attestation form in order to continue receiving increased payments. Previously eligible providers who did not re-attest will have applicable claims retroactively adjusted for the increased portion of their payment for dates of service (DOS) beginning January 1, 2015. Providers whose 1/1/2015 - 6/30/2016 Self-Attestation forms were sent/ postmarked after March 31, 2015, will receive the increased PCP payment for DOS beginning on the date the form is received or postmarked. A mass adjustment of the affected claims will be processed the week of October 19, 2015 to recoup the increased portion of the provider payments. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Notice to Pharmacy Providers Only!!! 10/09/15 4:09 pm

There will be a change to the Automated Voice Response System (AVRS) options to allow Medicaid pharmacies quicker entry into the Pharmacy queue. Previously, upon calling into the AVRS 800-884-3222 pharmacies **pressed 2 (Medicaid Provider), then pressed 2 (Pharmacy),** and after entering their Medicaid ID were obligated to listen to one or more general provider messages. With the new change, scheduled to be implemented at **noon on October 12, 2015**, pharmacies will **press 2 (Medicaid *Provider*), then press 1 (Pharmacy).** After entering their Medicaid ID, they will then be routed directly into the Pharmacy queue, bypassing the general Medicaid Provider messages. This will greatly reduce wait times for pharmacies who need quick resolution on questions regarding Point-of-Sale claims.

Attention Providers!!! 10/07/15 5:09 pm

The Division of Medicaid will reprocess ICD-10 Inpatient claims with date of service spanned across October 1, 2015 due to a system issue in implementation of the ICD-10 project. These claims will appear on the remittance advice dated 10/12/2015. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222 or the Division of Medicaid.

Attention Providers!!! 10/02/15 2:21 pm

The Division of Medicaid will reprocess certain claims with date of service beginning 7/1/2015 paid through 9/14/2015 which posted edit 0110 and denied incorrectly due to a system issue. The affected claims will be adjusted to correct associated payment errors. The mass adjustment will appear on your **10/05/2015** Remittance Advice. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

What's new

NCCI MASS ADJUSTMENT FOR NURSE PRACTITIONER AND PHYSICIAN ASSISTANT CLAIMS 10/02/15 12:20 pm

The Division of Medicaid will reprocess claims due to an error in implementation of the National Correct Coding Initiative (NCCI) methodology required by the Patient Protection and Affordable Care Act of 2010 (H.R 3490 Section 6507). Claims billed by certain group provider for nurse practitioner or physician assistant services for dates of service April 1, 2011 through February 24, 2014 will be reprocessed and will appear on the remittance advice dated 10/05/2015. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222 or the Division of Medicaid.

Attention All Providers!!! April 2015 Quarterly Physician Administered Drug Fee Update 10/02/15 11:27 am

Due to a delay in implementation of the April 2015 Quarterly Physician Administered Drug Fee Update, claims for dates of service April 1, 2015 through June 4, 2015 billed with certain impacted codes will require reprocessing. This mass adjustment will begin with remittance advice dated 10/12/2015. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers!! 09/28/15 4:12 pm

The ICD-10 test region will not be available to receive 837 files for 24 hours, starting at 7 a.m. central time, Sept. 30th through 7 a.m. on Oct. 1, 2015. Please refrain from submitting test files during this period.

Notice: All Providers of Therapeutic and Evaluative Mental Health Services for Children 09/18/15 5:37 pm

Due to the very low number of T&E providers registered to attend and participate, **Medicaid (DOM), Office of Mental Health Programs** has made the decision to **cancel** the **2nd Annual 2015 Medicaid Therapeutic and Evaluative Provider Workshops** that were to be held on **Monday, September 21, 2015** in **Batesville,** and **Thursday, September 24, 2015** in **Gulfport**.
If you are one of the providers that registered and/or planned to attend our **Batesville** or **Gulfport** workshop locations in person, we apologize for any inconvenience to you or your staff.

The following workshop/webinar will occur as scheduled:
Date Time Location
• Wednesday, September 23, 2015 9:00 a.m. until Noon eQHealth Solutions
(5th Floor Conference Room)
460 Briarwood Dr.
Jackson, MS 39206

What's new

If you are a Therapeutic and Evaluative Mental Health Services for Children provider, and have not already done so, we highly encourage you to **register** for and **participate** in our **webinar** scheduled to be held simultaneously with our **September 23, 2015** workshop listed above.
To register for the Webinar please log on to: https://attendee.gotowebinar.com/register/9129009019111890434. The title of this presentation is: ***2015 DOM/2nd Annual Therapeutic and Evaluative Mental Health Services Provider Workshop-Webinar.*** After registration, you will receive a confirmation email containing instructions for joining the Webinar.
DOM will have a recorded version of this training presentation available on the **eQHealth Solutions** website, under the Education tab, no later than **September 30, 2015**, for your reference. The link for this recorded presentation will be: http://ms.eqhs.org/Education/PriorRecordedPresentations.aspx
Any questions and/or concerns regarding this provider workshop should be directed to:
Kimberly Evans at 601-359-3830

NOTICE TO PHARMACY PROVIDERS ONLY 09/11/15 12:00 pm
(DME or Pharmacy Disease Management Providers ARE NOT included)

There will be a point of sale (POS) system outage on Saturday, September 12, 2015 from 11:00PM CT until Sunday, September 13, 2015 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

Attention All Providers!! 08/21/15 3:17 pm
Please be advised that an extended system outage will occur on Sunday, August 23, 2015 from 12:00 AM ET, until Sunday, August 23 , 2015, 8:00 AM ET, to accommodate an EDI upgrade. This scheduled maintenance will affect all batch and real time transactions. Additionally, Switch Vendors will experience timeouts during this timeframe as well. If you submit a claim during this time, you will receive a "System Unavailable" message. If you have any additional questions, please contact Conduent Provider and Beneficiary Services at 1-800-884-3222.

Attention All Providers!! 08/21/15 3:17 pm
Please be advised that an extended system outage will occur on Sunday, August 23, 2015 from 12:00 AM ET, until Sunday, August 23 , 2015, 8:00 AM ET, to accommodate an EDI upgrade. This scheduled maintenance will affect all batch and real time transactions. Additionally, Switch Vendors will experience timeouts during this timeframe as well. If you submit a claim during this time, you will receive a "System Unavailable" message. If you have any additional questions, please contact Conduent Provider and Beneficiary Services at 1-800-884-3222.

Attention All Nursing Facility Providers and Intermediate Care Facilitates for Individuals with Intellectual Disabilities (ICF/IID) Billing Reminder! 08/13/15 9:58 am
Nursing facilities and ICF/IID billing for bedhold 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 Bureau of Long Term Care Institutional Division at: 601-359-6141.

What's new

Attention Providers! 08/07/15 4:02 pm

The Division of Medicaid will reprocess procedure code 76642– ULTRASOUND, BREAST, UNILATERAL, REAL TIME WITH IMAGE DOCUMENTATIONS, INCLUDING AXILLA WHEN PERFORMED; LIMITED', for dates of service January 5, 2015 through March,09, 2015 for certain impacted codes due to an update error. A mass adjustment of affected claims will be processed in near future. No further action on the part of the provider is needed. Please watch for additional information under Late Breaking News or Banner Messages located at www.Medicaid.ms.gov

Attention Providers! 08/07/15 3:59 pm

The Division of Medicaid will reprocess Independent Laboratory Code claims for dates of service January 1 , 2015 through March 25, 2015 for certain impacted codes due to a delay in annual code update. A mass adjustment of affected claims will be processed in near future. No further action on the part of the provider is needed. Please watch for additional information under Late Breaking News or Banner Messages located at www.Medicaid.ms.gov.

Attention All Elderly and Disabled (E&D) Waiver Adult Day Care (ADC) Providers! Rate Change!! 08/07/15 3:45 pm

For dates of service on or after July 1, 2015, the ADC rate is $60.61 per day. This is the maximum rate allowed under the current CMS approved Elderly and Disabled Waiver. Claims submitted with a rate less than $60.61 for dates of service on or after July 1, 2015, will need to be voided and adjusted. The procedure code for ADC is S5102 and must always be billed with a U1 modifier for services provided under the Elderly and Disabled Waiver.

Attention All Medicaid Providers 07/31/15 3:57pm

Effective February 1, 2015 the Mississippi Division of Medicaid (DOM) covers Trumenba (CPT code 90621) and Bexsero (CPT code 90620), two new vaccines to prevent invasive disease caused by Neisserra Meningitis Serogroup B. The vaccines are listed on the most current Mississippi State Department of Health's (MSDH) Vaccine for Children's (VFC) list. Both vaccines are covered services for DOM beneficiaries ages 10 through 25.

Bexsero is limited to one (1) unit for each dose in the two (2) dose series and has a lifetime maximum of two (2) units. Trumenba is limited to one (1) unit for each dose in the three (3) dose series and has a lifetime maximum of three (3) units.

For more information regarding coverage please refer to Title 23: Medicaid Part 224, Immunization, Rule 1.3, Rule 1.4. The MSDH administered VFC Program for vaccines is provided at no cost to participating healthcare providers for eligible children age 18 and under.

http://www.medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-224.pdf

What's new

Attention All Providers 07/23/15 6:14pm

The Division of Medicaid will reprocess claims for dates of service January 1, 2012 through December, 23, 2013 which denied incorrectly for Edit 0760 – NDC BILLED WITH HCPCS CODE MUST BE FOR REBATABLE DRUG due to billing of certain National Drug Codes (NDC) for powdered drugs. The adjusted claims will appear on your Remittance Advice dated August 3, 2015. Please direct your questions or inquiries to Provider and Beneficiary Services at 800-884-3222. No further action on the part of the provider is required.

Attention Dental Providers!! July 2014 Dental Fee Update 07/17/15 5:35pm

The July 1, 2014 Mississippi Division of Medicaid (DOM) dental fee update for professional services is complete and an updated fee schedule has been posted on the DOM Website www.medicaid.ms.gov .Due to a delay in implementation of fee update, claims with dates of service on or after July 1, 2014 billed with certain impacted CDT codes will require reprocessing. No further action on the part of the provider is required. Watch for further information under Late Breaking News and in the Banner Messages located on your remittance advice. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers!! 07/17/15 5:01 pm

The minimum age requirement for CPT codes 64612 – 64617 has been changed to Zero, effective for dates of service on and after November 22, 2013. A mass adjustment of affected claims will be processed the week of 07/20/2015. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers!! 07/17/15 4:43 pm

Please be advised that an extended system outage will occur on Sunday, July 19, 2015 from 12:00 AM ET, until Sunday, July 19 , 2015, 6:00 AM ET, to accommodate an EDI upgrade. This scheduled maintenance will affect all batch and real time transactions. Additionally, Switch Vendors will experience timeouts during this timeframe as well. If you submit a claim during this time, you will receive a "System Unavailable" message. If you have any additional questions, please contact Conduent Provider and Beneficiary Services at 1-800-884-3222.

Attention Providers!! 07/10/15 2:27 pm

The Division Of Medicaid will reprocess Inpatient Newborn Physician Visits for dates of service October 1, 2012 through June 24, 2013 that denied for not having a Prior Authorization for the discharge visit on the 6th day. The adjustments will appear on your Remittance Advice dated July 13th 2015. No further action is required from the provider.

What's new

Attention Providers!! 07/10/15 2:12 pm

Due to a delay in implementation of the January 2015 Annual Independent Laboratory Code update for dates of service January 1, 2015 through March 31, 2015, laboratory codes in Family Planning Waiver will require reprocessing. A mass adjustment of affected claims will be processed in the near future. Please watch for additional information under late Breaking News or Banner Messages located at www.Medicaid.ms.gov.

Attention Providers!! 07/09/15 3:52 pm

The Division Of Medicaid will reprocess claims for dates of service November 17, 2011 through December 18, 2013 for certain immunization administration claim lines which denied incorrectly for Edit 0632 - 90472 MUST BE BILLED WITH 2 VACCINE CODES. The adjusted claims will appear on your Provider Remittance Advise dated July 20th 2015. Please direct questions or inquiries to Provider and Beneficiary Services at 800-884-322. No further action on the part of the provider is needed.

Recovery Audit Contractors (RACs) Upcoming Changes ***07/07/15 8:55 am***

Effective July 1, 2015, PRGX Global Inc. is no longer the Mississippi Medicaid Recovery Audit Contractor (RAC). Until further notice, Division of Medicaid (DOM), Office of Program Integrity will review any outstanding audits initiated by PRGX. Providers must continue to follow current RAC processes as outlined in all correspondence received. Providers can submit inquiries, complaints and other communications as it relates the MS RAC program to MSRAC@medicaid.ms.gov.

All updates are outlined on the DOM website located at http://www.medicaid.ms.gov/providers/recovery-auditor-contractors/. DOM encourages providers to monitor the website for updates and announcements regarding the Mississippi Overpayment Audit Recovery program.

Attention Providers! ***06/26/15 10:43 am***

Due to a delay in implementation of the January 2015 Annual Independent Laboratory Code update for dates of service January 1, 2014 through March 2, 2015, certain billed codes will require reprocessing. A mass adjustment of affected claims will be processed in the near future. No attention is required on the part of the provider. Please watch for additional information under Late Breaking News or Banner Messages located at www.Medicaid.ms.gov.

Attention All Hospital Providers!!! **05/29/2015 2:39 pm**

A hospital mass adjustment will be released within the next several weeks to reflect corrections for the proper payment of hospital inpatient and outpatient fee-for-service claims for the application of the three-day window. The payment logic for the three-day window was implemented for hospital inpatient dates of service beginning on or after October 1, 2012, under the APR-DRG payment methodology.

Attention All Hospital Administrators, CFOs, Coders, & Billers **05/20/2015 3:25 pm**

The Division of Medicaid (DOM) Outpatient Prospective Payment System (OPPS) fee schedule will be updated July 1, 2015, as required by the State Plan.

DOM will move forward with OPPS Phase 2 on July 1, 2015. Conduent and DOM will offer training opportunities prior to these changes. The training schedule is as follows:

What's new

- **Via WebEx, Friday, May 29, 2015, 11:00 A.M. – 12:00 P.M. CST**
  The WebEx link will be sent after registration is complete.
- **Via WebEx, Tuesday, June 09, 2015, 2:00 P.M. – 3:00 P.M. CST**
  The WebEx link will be sent after registration is complete.
- **Via WebEx, Thursday, June 11, 2015, 10:00 A.M. – 11:00 A.M. CST**
  The WebEx link will be sent after registration is complete.

DOM strongly encourages coders and billers to participate in these sessions. This is an opportunity for individuals who prepare claims for payment to better understand the DOM OPPS and provide feedback.

You may RSVP for the Webinar and/or forward any questions concerning the Webinar to Elizabeth Gillette at (770) 829-1195 or via email at Elizabeth.Gillette@Conduent.com. The WebEx link and conference call number will be provided via email prior to the training.

DOM's webpage is an excellent source of OPPS information http://www.medicaid.ms.gov/providers/finance/. Documents will be available by Thursday, May 28, 2015:

Updated OPPS Frequently Asked Questions
Updated OPPS Quick Tips
2015 OPPS Provider Training Presentation

Your participation in this training is greatly appreciated.

Attention Hospital Administrators and CFOs!!!! *05/15/15 4:01pm*

In preparation for the Division of Medicaid's (DOM) July 1, 2015 APR-DRG updates, DOM will adopt V.32 of the 3M Health Information System Hospital Inpatient APR-DRG Grouper and V.32 of the Health Care Acquired Conditions (HCAC) utility for payment of hospital inpatient claims effective for discharges on or after July 1, 2015. Hospitals are not required to purchase 3M software in order to be paid. However, all hospitals that have purchased the 3M software should ensure their internal systems are updated to reflect the change to V.32 for discharges on or after July 1, 2015.

This will be Year 4 of the DRG payment method. In addition to the transition from V.31 to V.32 of the 3M APR-DRG grouper and V.32 of the Health Care Acquired Conditions (HCAC) utility, the Division intends to make the following changes to APR-DRG payment policies effective July 1, 2015:

Year 4 is intended to be budget-neutral relative to Years 1, 2 and 3 overall. The statewide DRG base price will remain $6,415. On balance, we expect average payment per stay to be unchanged between Years 1, 2, 3 and 4.

The Cost Outlier Threshold will be increased from $35,175 to $50,000, reflecting the growth in average charges on claims submitted to the Division. The increase also is consistent with the goal that DRG cost outlier payments comprise approximately 5% of DRG payments.

What's new

Year 4 is intended to be budget-neutral relative to Years 1, 2 and 3 overall. The statewide DRG base price will remain $6,415. On balance, we expect average payment per stay to be unchanged between Years 1, 2, 3 and 4.

The Cost Outlier Threshold will be increased from $35,175 to $50,000, reflecting the growth in average charges on claims submitted to the Division. The increase also is consistent with the goal that DRG cost outlier payments comprise approximately 5% of DRG payments.

The DRG Marginal Cost Percentage will be changed from 60% to 50%. This change also is consistent with the goal that DRG cost outlier payments comprise approximately 5% of DRG payments.
The adult mental health policy adjustor will be changed from 1.75 to 1.60.
The obstetrics & newborn policy adjustor will be changed from 1.40 to 1.50.
The neonate policy adjustor will be changed from 1.40 to 1.45.

Please note that the above changes are subject to CMS approval via the State Plan Amendment process.
Please also be aware that according to the current Medicaid Hospital Inpatient State Plan, the following changes will be made effective October 1, 2015:

Mississippi hospital-specific inpatient cost-to-charge ratios (CCRs) will be updated based on cost reports ending in fiscal year 2014. Out-of-state hospital CCRs will be updated based on the Medicare Inpatient Prospective Payment System (IPPS) Final Rule when it is published. CCRs are used in calculating outlier payments.

For teaching hospitals that receive the medical education add-on payment, the payment is expected to be adjusted to reflect the growth in the U.S. hospital market basket index as it will be published in the Medicare Inpatient Prospective Payment System (IPPS) Final Rule.

Although the final ICD-10 code set will not officially be published until late July or August, changes from the current version are expected to be minimal. DOM has been informed by 3M that the APR-DRG payment system/grouper will be ICD-10 compliant with the implementation of V.32 at July 1, 2015, along with V.33 mapper at October 1, 2015.

For the information of hospitals, we will have three webinars. The sessions will show results from the previous years of the DRG payment method, outline the changes for Year 4, and provide billing and documentations tips. DOM strongly encourages each hospital to participate in one of the three webinars.

To register for one of the three webinar training sessions listed below, please RSVP Elizabeth Gillette at (404) 840-0566 or email her at Elizabeth.Gillette@Conduent.com. (Please limit attendance to one line per hospital.)

On the web, Friday, June 12, 2015, 10:00 A.M. – 11:00 A.M.
The WebEx link will be sent after registration is complete.

What's new

On the web, Thursday, June 18, 2015, 2:00 P.M. – 3:00 P.M.
The WebEx link will be sent after registration is complete.

On the web, Tuesday, June 23, 2015, 10:00 A.M. – 11:00 A.M.
The WebEx link will be sent after registration is complete.

The Division's DRG webpage is also an excellent source of information. At http://www.medicaid.ms.gov/providers/finance/, please see in particular the documents below, which will be available by Thursday, June 11, 2015:

Updated DRG Pricing Calculator. This document is an Excel spreadsheet that enables the user to calculate expected payment. It does not calculate the APR-DRG itself but it does include the list of APR-DRGs and associated relative weights.
Updated Frequently Asked Questions
Updated APR-DRG Quick Tips
June 2015 provider training presentation – to be posted the week of June 8.

Attention!!! Long-Term Care Providers and Long-Term Care Cost Report Preparers 05/07/15 1:36 pm

DOM has revised the Medicaid long-term care (LTC) facility cost report instructions to reflect changes in LTC reimbursement methodology. The changes were stated in the 'Nursing Facilities Reimbursement Methodology Revision Report', and presented to providers during the webinar training for LTC facilities on November 10th and 13th, 2014. The Medicaid LTC cost report forms and instructions have been revised or added to reflect the reimbursement changes and have replaced the previous forms on the DOM website. The forms include: Form 1, Form 3, Form 4, Form 5, Form 6, Form 13 and Form 19 (new). Also, DOM updated the 'Instructions for Filing Long-Term Care Facility Cost Report', Pages 1, 3, 7, 9, 11, 14, 22, 27, 28, 31, 34, 35, 53 & 54. Minor changes [ex., intensive care facilities for individuals with intellectual disabilities (ICF-IID) previously, intensive care facilities for the mentally retarded (ICF-MR)] were made to other pages of the instructions, but these changes do not affect reporting.

The above revised forms and instructions will be effective for cost report periods ending in the 2015 calendar year and forward. The previous forms can be used for the cost report periods ended in the 2014 calendar year and prior years filing of amended cost reports. The 2015 forms also can be used to file the 2014 reports as the only difference is the addition of Form 19 for VDC-approved facilities.

Also, cost report preparers filing the 2014 reports should note that the revised instructions for the changes in incontinence supplies reporting (pages 22 & 28) and asset additions capitalization policy (pages 27 & 31), as well as the return on equity (ROE, Form 13) factor percentage change from 9.5% to 5.75%, were retro-active to the 2013 calendar year cost report filings and forward.

If you have questions, please contact Eric Everett @ 601-576-2332 or T. J. Walker @ 601-359-6827.

What's new

Attention Dental Providers 04/30/15 2:35 pm

Replacement of Lost or Broken Retainer

Effective May 1, 2015 the Division of Medicaid will begin covering the replacement of a lost or broken retainer for EPSDT beneficiaries with a prior-authorization and supporting documentation including how the original appliance was lost or stolen. Reimbursement will be based on the fee on file. The replacement of the retainer will be covered once per lifetime; both arches are covered if necessary.

Qualified providers need to self-attest to receive increased primary care services payments 03/27/15 2:16 pm

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

Effective July 1, 2015, reimbursement of primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule. The Medicaid Primary Care Provider Fee Schedule is updated July 1 of each year based on one hundred percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year.

Mississippi primary care providers who are enrolled in Medicaid can still qualify to receive increased payments even though the federal program ended Dec. 31, 2014. To qualify, eligible providers must accurately self-attest by completing the 1/1/2015 – 6/30/2016 Self-Attestation Statement form.

To receive the increased payment for dates of service (DOS) beginning Jan. 1 of this year, eligible providers must send a completed and signed self-attestation statement form to Conduent Provider Enrollment by March 31, 2015 one of the following ways:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: P. O. Box 23078, Jackson, MS

Providers whose forms are sent/postmarked after March 31 will receive the increased payment for DOS beginning on the date the form is sent/postmarked. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at ms-medicaid.com. You can locate the form on the DOM website under the Forms section and the Envision Web Portal, or request it by calling the Conduent Call Center toll-free at 800-884-3222.

What's new

NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included) 03/27/15 2:11 pm

There will be a point of sale (POS) system outage on Saturday, March 28, 2015 from 11:00PM CDT until Sunday, March 29, 2015 4:00AM CDT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a "System Unavailable" message and will not process. Please resubmit POS claims after 4:00AM CDT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

Attention: DME Providers 03/06/15 1:17 pm

A review of Durable Medical Equipment codes E0990, E0994 and E0995 was completed and corrections to the maximum units of these codes have been made. Due to these changes, claims for dates of service July 1, 2012 through July 29, 2014 will require reprocessing. The adjusted claims will appear on your Provider Remittance Advice dated 03/09/2015. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222 or the Division of Medicaid.

Attention Providers!! 03/06/15 1:10 pm

The Division of Medicaid will reprocess claims for dates of service 07/01/2013 through 11/10/2014 for certain outpatient radiology services where prior authorizations were incorrectly applied to another claim line. The adjusted claims will appear on your Provider Remittance Advice dated 03/09/2015. Please direct questions or inquiries to Conduent Provider and Beneficiary Services at 800-884-3222. No further action on the part of the provider is needed.

MississippiCAN Changes 02/20/15 12:26 pm

Transition of Children from regular Medicaid to MississippiCAN

- Children ages 1 to 19 will be transitioned from MS Medicaid Fee-for-Service (FFS) to MississippiCAN, except those excluded as members on Medicare, on waivers, or in institutions.
- Effective Dates - May 1, 2015 to July 31, 2015
- Mailings to Households begin March 2015
- Members or Providers may call
    - Conduent at 1-800-884-3222 or
    - Medicaid at 1-800-421-2408
        - Websites

www.ms-medicaid.com/msenvision/mscanInfo.do

http://www.medicaid.ms.gov/programs/mississippican/

What's new

Attention All Elderly and Disabled Waiver Adult Day Care Providers *02/13/15 12:56 pm*

The Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding new regulations on home and community based service (HCBS) settings requirements to all States. The effective date of the final rule is March 17, 2014. Mississippi Division of Medicaid (DOM) has submitted a transition plan to CMS regarding Adult Day Care (ADC) facilities and the final rules on HCBS settings requirements. In order to meet the HCBS settings requirements, reviews specific to the HCBS settings requirement will be conducted of all ADC providers. All Elderly and Disabled Waiver (E&D) ADC providers are required to conduct a self-assessment of each facility with a valid provider number by February 27, 2015.

Complete the self-assessment by clicking on the link below or copy and paste the link in your web browser. A response to all questions is required as the self-assessment survey cannot be submitted with unanswered questions. Be prepared to complete the survey from start to finish when the link is clicked.

The link is https://www.surveymonkey.com/s/8CVFVFN. If you have any questions, contact Sandra Bracey-Mack at 601-359-6141.

Attention Providers! Mandatory 30 Day Wait Requirement for Non-life Threatening Hysterectomy Surgical Procedure **02/12/15 11:15 a.m.**

The Mississippi Administrative Code, Title 23: Medicaid, Part 202: Hospital Services, Chapter 5: Hospital Procedures, Rule 5.6: Hysterectomy, effective 05/01/2014, requires providers to complete the Sterilization Consent Form and Hysterectomy Acknowledgement Form prior to a medically necessary hysterectomy. If prior acknowledgement is not possible due to a life –threatening emergency, the physician performing the hysterectomy must complete Section C of the Hysterectomy Acknowledgment form. Federal regulation requires that informed consent must be obtained at least 30 days, but not more than 180 days, prior to the date of the sterilization, except in the case of a premature delivery or an emergency abdominal surgery. **As this is a federal requirement, DOM cannot waive the 30 day requirement.** The Division of Medicaid (DOM) covers a hysterectomy when deemed medically necessary in an inpatient or outpatient hospital setting. The Sterilization Content Form and Hysterectomy Acknowledgement Form are located under the Resources section of the Medicaid website at www.medicaid.ms.gov. by clicking on the form link.

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

What's new

Attention Providers!! *02/12/15 11:11 am*

Effective January 1, 2015, the Division of Medicaid covers CPT code 96040 for billing appropriate counseling services. Medicaid providers must seek reimbursement for rendered services according to CPT coding guidelines. These services require a prior authorization approval by the Utilization Management/Quality Improvement Organization (UM/QIO), eQHealth Solutions.

If you have any questions, please contact eQHealth Solutions at 1-866-740-2221 or the DOM Office of Medical Services at 601-359-6150.

Attention Providers!! *02/12/15 11:09 am*

On November 6, 2012, the centers for Medicare & Medicaid Services (CMS) issued the final rules to implement increased Medicaid payments for certain primary care services and vaccine administration billing codes provided by attested qualified practitioners enrolled as a Mississippi Medicaid provider, for calendar years 2013 and 2014. Medicaid began paying these increased rates, for attested qualified providers, for claims submitted on or after July 1, 2013. The 01/19/2015 RA may reflect additional payments/recoupments due to mass adjustments, made by the Division of Medicaid, for impacted claims with dates of service on or after January 1, 2014 through June 30, 2014.

Attention All Providers!!! *02/04/15 4:30 pm*

The Division of Medicaid will reprocess claims for dates of service from 01/01/2014 through 05/19/2014 for certain primary care services that were paid at the incorrect rate for 2014. The adjusted claims will appear on your Provider Remittance Advice dated February 2, 2015. Please direct questions or inquires to Provider and Beneficiary Services at 800-884-3222. No Further Action on the part of the provider is needed.

Attention All Providers!!! *02/03/15 1:20 pm*

Due to the high call volume in our Call Center, providers will experience a longer than normal wait time. Rather than wait, you can visit the web portal at: www.ms-medicaid.com to check claim status, eligibility, and dental/vision service limits. Additionally, Provider Field Representatives are available to assist with complex billing questions and claims issues (See page 13 of the December 2014 Provider Bulletin). We do apologize for the inconvenience; however, we are diligently working towards a resolution.

What's new

Attention Providers!!!* *01/20/15 5:25 pm

2014 Owner Salary Limits for Long-Term Care Facilities

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

The maximum allowable salaries for 2014 are as follows:

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

Attention Providers!!!* *01/20/15 5:20 pm

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

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2014 cost reports filed by nursing facilities (NF's), intermediate care facilities for individuals with intellectual disabilities (ICF-IID's), and psychiatric residential treatment facilities (PRTF's) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for all Urban Consumers - All Items. The amounts listed below are the per meeting maximum with a limit of four (4) meetings per year.

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

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

What's new

Attention Providers!!! ***01/20/15 8:25 am***

Attention All Providers!!!!

Effective January 1, 2015, women and men between the ages of 13- 44 will be eligible for the Family Planning Waiver Program.

Eligibility Requirements:

- Family income is at or below 194% of the federal poverty level (FPL).
- Must be capable of reproducing.
- Must not have had a procedure that prevents them from reproducing.
- Must not have Medicare, CHIP, or any other health insurance or third party medical coverage.

The Family Planning waiver demonstration program is for women and men who receive Medicaid benefits limited to family planning services and family planning related services. This includes one annual visit and subsequent visits related to their birth control methods and family planning services. Beneficiaries cannot exceed a total of four visits per federal fiscal year (Oct. 1-Sept. 30). These beneficiaries are not eligible to receive any other Medicaid benefits.

For your easy reference, a listing of covered drugs under this waiver is posted on the agency's website. Please refer to the DOM Pharmacy section at: http://www.medicaid.ms.gov/providers/pharmacy/, go to Pharmacy Resources, Specific Drugs, and select Family Planning Drugs, 1-1-2015.

Covered diagnosis and procedure code list available on the Division of Medicaid website located at: http://www.medicaid.ms.gov/wp-content/uploads/2015/01/FPW-CODES-UPDATE-2015.pdf.

What's new

Attention All Providers!!!* *01/15/15 3:25 pm

Please be advised that a system outage will occur on Sunday, January 18, 2015 from 12:00 AM ET, until Sunday, January 18, 2015, 5:00 AM ET, to accommodate EDI server maintenance. This scheduled maintenance will affect all batch and real time transactions. Additionally, Switch Vendors will experience timeouts during this timeframe as well. If you submit a claim during this time, you will receive a "System Unavailable" message. You may begin transmitting your claims at 5:15 AM ET. Any claims received prior to the schedule maintenance will process as normal once the server is restored. If you have any additional questions, please contact Conduent Provider and Beneficiary Services at 1-800-884-3222.

Attention Providers!!!* *01/15/15 9:25 am

CPT Code Changes for Mental Health Providers

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

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

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

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

What's new

Attention Providers!!! ***01/14/15 2:25 pm***

Qualified providers may receive increased primary care services payments

During the 2014 legislative session, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (ACA), for certain primary care services at 100 percent of the rate established under Medicare. DOM submitted a public notice to inform providers a State Plan Amendment (SPA) will be submitted, effective Jan. 1, 2015, to continue reimbursement of primary care services to providers who meet the requirements of 42 CFR § 447.440(a) at the same rate as in calendar year 2014.

Effective July 1, 2015, reimbursement of primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule in effect as of January 1 of each year. The Medicaid Primary Care Provider Fee Schedule will be updated July 1 of each year based on one hundred percent of the Medicare Physician Fee Schedule in effect as of January 1 of each year.

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

How to Attest

Providers must complete one 1/1/2015 – 6/30/2016 Self-Attestation Statement form for Jan. 1, 2015 through June 30, 2016. To receive the increased payment for dates of service (DOS) beginning 1/1/2015, eligible providers must send a completed and signed 1/1/2015 – 6/30/2016 Self-Attestation Statement form to Conduent Provider Enrollment by March 31, 2015 through one of the following ways:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Mail: P.O. Box 23078
Jackson, MS 39225

Providers whose 1/1/2015 – 6/30/2016 Self-Attestation Statement forms are sent/postmarked after March 31, 2015, will receive the increased payment for DOS beginning on the date the form is sent/ postmarked. Providers can verify the processing of the electronically submitted 1/1/2015 – 6/30/2016 Self-Attestation Statement forms by accessing the Envision Web Portal. Forms are processed within five business days from receipt.

Self-Attestation Statement form
The 1/1/2015 – 6/30/2016 Self-Attestation Statement form is located on the DOM website at http://medicaid.ms.gov and Envision Web Portal or can be requested by calling the Conduent Call Center toll-free at 800-884-3222.

Continued on next page...

What's new

Continued from previous page…

Completed forms must be submitted to Conduent Provider Enrollment in one of the following ways:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Mail: P.O. Box 23078
Jackson, MS 39225

To find out more information regarding primary care physician self-attestation general instructions and to download the Self-Attestation Statement form, visit the DOM website at http://medicaid.ms.gov.

Attention Providers!!! 01/09/15 11:25 am

The Mississippi Division of Medicaid introduces Mede/Provider Access

Provider Access is a claims-based provider portal available to all providers and their staff who serve Mississippi Medicaid patients. Provider Access gives Mississippi Division of Medicaid (DOM) providers access to clinical information on Medicaid recipients, including medication, diagnoses and procedures history across the continuum of care.

DOM offers this portal **free-of-charge** to Medicaid providers and their staff in an effort to share data and improve the quality, efficiency and cost of healthcare. To learn more, read the Free online service offers Medicaid providers access to patient information article online at http://medicaid.ms.gov.

To register for this product, please contact our Clinical Advocate, Nancy Barton-Marini at nancy.bartonmarini@medeanalytics.com or (662) 231-7715.

Attention Providers!!! 01/06/15 9:25 am

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

RATE CHANGE!

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

What's new

Attention Providers!!! *12/22/14 1:25 pm*

Co-payment for Mental Health Services

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

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

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

Attention Providers!!! *12/19/14 9:25 am*

New Modifiers for Mental Health Services for NCCI Edits

Effective January 1, 2015, NCCI will require the use of modifier XE or XP rather than modifier 59 with certain NCCI edits for Mental Health claims for dates of service on or after January 1, 2015. These modifiers have been developed to provide greater reporting specificity in situations where modifier 59 was previously reported. Modifiers XE or XP should be utilized in lieu of modifier 59 if the clinical situation described by one of these modifiers is present. Modifier 59 will remain a valid procedure to procedure (PTP) modifier, but it should only be utilized if a more specific modifier is not applicable.

The new modifiers are defined as follows:

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

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

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