WHAT'S NEW?

ATTENTION: Providers

12/12/2022 4:40 p.m.

ATTENTION: ALL PROVIDERS

General Claims Submission Information

The process for reconsideration of claims has changed with the transfer of fiscal agent operations from Conduent to Gainwell Technologies effective October 3, 2022. This was shared through the release of a late breaking news in October and posted on the Division's website. Denied claims should be submitted as new day claims with appropriate supporting documents via the Provider Web Portal at https://medicaid.ms.gov/mesa-portal-for-providers/, or paper submission to P.O. Box 23076, Jackson, MS 39225. Electronically submitted claims with attachments must include the new Claim Attachment Form which can be found at https://medicaid.ms.gov/wp-content/uploads/2022/12/Claim-Attachment-Form.pdf. Examples of appropriate supporting documentation may include, but is not limited to consent forms, third-party insurance EOBs, operative reports, physician notes, prior authorization information, MSRPs, invoices, and certificates of medical necessity (CMNs).

Providers receive a Remittance Advice (RA) which provides Detail EOBs (explanation of benefits) for each line on a claim. The corresponding EOB Code and Description are located at the end of the RA and provide guidance to address denied services. A comprehensive list of EOBs may be located at https://medicaid.ms.gov/wp-content/uploads/2022/11/Mississippi-Medicaid-Explanation-of-Benefits_112822.pdf.

The Fiscal Agent is unable to void or adjust medical claims on behalf of the provider. This process must be completed by the provider. Effective November 21, 2022, providers can now void and adjust legacy claims on the MESA Provider Web Portal. The issue affecting providers when attempting to void or adjust legacy claims has now been resolved. Providers should no longer receive an error message.

Claims submitted for services that require a prior authorization (PA) must include the authorization number on the claim. Retroactive authorization of fee-for-service (FFS) medical services will only be granted in cases of retroactive eligibility. Claims lacking a PA number will be denied. Contact the appropriate Utilization Management/Quality Improvement Organization (UM/QIO) to obtain a PA. Providers should contact Magnolia Health, Molina Healthcare or United Healthcare Community Plan for specific prior authorization and documentation requirements for members enrolled in Mississippi Coordinated Access Network (MSCAN).

Continued on next page...

ATTENTION: Providers

12/12/2022 4:40 p.m.

Continued

Claims submitted for services that require a prior authorization (PA) must include the authorization number on the claim. Retroactive authorization of fee-for-service (FFS) medical services will only be granted in cases of retroactive eligibility. Claims lacking a PA number will be denied. Contact the appropriate Utilization Management/Quality Improvement Organization (UM/QIO) to obtain a PA. Providers should contact Magnolia Health, Molina Healthcare or United Healthcare Community Plan for specific prior authorization and documentation requirements for members enrolled in Mississippi Coordinated Access Network (MSCAN).

Timely Filing rules may be found on the Division of Medicaid website at https://medicaid.ms.gov/providers/administrative-code/ (Administrative code Part 200; Chapter 1; Rules 1.6, 1.7 and 1.8). Providers may submit an Administrative Review of a claim when:

- A beneficiary's retroactive eligibility prevents the provider from filing the claim timely and the provider submits the claim within ninety (90) days of the system's add date of the beneficiary's eligibility determination
- The Division of Medicaid adjusts claims after timely filing and timely processing deadlines have expired, or
- The provider has submitted a Medicare crossover claim within one-hundred and eighty (180) days of the Medicare paid date and the provider is dissatisfied with the disposition of the claim.
- The request should include a new day claim, supporting documentation, and a cover letter containing specific details of why the claim denied and actions taken to file timely.

Requests for Administrative Reviews must be submitted to the Office of Appeals at the Division of Medicaid and must include:

- Documentation of timely filing or documentation that the provider was unable to file the claim timely due to the beneficiary's retroactive eligibility,
- Documentation supporting the reason for the Administrative Review, and
- Other documentation as required or requested by the Division of Medicaid.

Submit Administrative Reviews to:
Division of Medicaid
Attention: Office of Appeals
550 High Street, Suite 1000
Phone: 601-359-6050
Fax: 601-359-9153

If you need assistance, please contact the Provider and Beneficiary Services Call Center at 1-800-884-3222 or your designated field representative: https://medicaid.ms.gov/wp-content/uploads/2022/12/Provider-Field-Representatives.pdf

WHAT'S NEW?

ATTENTION: Providers

12/8/2022 2:00 p.m.

Revised Claim Attachment Form

Effective December 9, 2022, the Claim Attachment Form has been revised to remove the requirement for an ICN to be listed. Please use the updated form at https://medicaid.ms.gov/wp-content/uploads/2022/12/Claim-Attachment-Form.pdf and delete any previously saved versions.

WHAT'S NEW?

ATTENTION: Providers

12/8/2022 2:00 p.m.

Attention: Dental Providers

The Mississippi Division of Medicaid (DOM) requires dental claims be submitted on the 2012 American Dental Association (ADA) claim form. As a reminder, claims must be submitted with appropriate Current Dental Terminology procedure codes (CDT). DOM accepts both electronic and paper dental claims. Dental providers are strongly encouraged to bill electronic claims.

Attention: Ambulance Providers

Denial related to Mileage and Base Rate

DOM's new fiscal agent, Gainwell Technologies, completed work on a recent system update to address issues related to claims denying with error code **6402-Mileage charge must have emergency base rate paid**. As part of this system update, Providers will need to resubmit denied claims.

Effective for dates of service on and after January 1, 2023, procedure codes A0380 and A0390 will no longer be covered for fee-for-service (FFS) Medicaid. Providers should use existing procedure code A0425 beginning with the twenty-sixth (26th) patient loaded mile of ground ambulance transportation.

WHAT'S NEW?

ATTENTION: COBA Crossover Providers

12/7/2022 2:00 p.m.

Attention COBA Crossover Providers

The Mississippi Division of Medicaid will reprocess COBA-submitted crossover claims that denied in error for Medicare EOMB is Missing or Does not Match the Services on the Claim. The resubmitted COBA claims will appear on the December 9, 2022, Remittance Advice. No further action is required from the provider.

WHAT'S NEW?

ATTENTION: Hospice Providers
12/1/2022 3:25 p.m.

Hospice Prior Authorization Information

Effective December 1, 2022, Hospice Prior Authorization information will not be available to view in the Medicaid Enterprise System Assistance (MESA) System. All Hospice Prior Authorization information will be viewed on the Alliant Health Solutions web portal. Providers that do not access the Alliant web portal may contact the Alliant Utilization Management team at MSAlliant@alliancehealth.org or 1-888-224-3067 for Hospice Prior Authorization assistance.

Claims Impacted by Explanation of Benefit (EOB) code 0503

Gainwell Technologies identified a claim processing error related to Hospice claims billed with revenue code, '659 – *Hospice Service-Other Hospice Service*', and members enrolled in Medicare Part C Hospice claims processed between October 3, 2022, and November 22, 2022, erroneously denied for Explanation of Benefit (EOB) code, '0503 – *Member is Enrolled in Medicare Part C on the Date(s) of Service'*. MESA has been updated and impacted claims may be resubmitted to Gainwell Technologies at this time.

WHAT'S NEW?

ATTENTION: Dental Providers
12/1/2022 3:25 p.m.

Claim Denials Related to Diagnosis Codes

The Division of Medicaid (DOM) advises Dental Providers to resubmit previously denied dental claims when the claim denied for **edit 257-Primary Diagnosis Code Missing – Detail**. DOM will make temporary modifications to edit 257 to allow Dental Providers more time to update their software to include ICD-10 diagnosis codes. Dental claims submitted without a valid dental related ICD-10 diagnosis code will still receive edit 257; however, the claim will pay. Claims submitted for dates of service on and after April 1, 2023, will begin to deny when submitted without a valid dental-related ICD-10 diagnosis code.

WHAT'S NEW?

ATTENTION: All Providers
11/28/2022 4:40 p.m.

Update: Processing Medicare Crossover Claims

On 11/8/2022, Gainwell published a Late Breaking News article related to improvement processes for Medicare Crossover operations. Please review the following new updates.

1. The functionality of the Web Portal regarding submission of Medicare Part A, B and C Crossover claims (including Dental Part C) was enhanced. The enhanced functionality is available on the Web Portal November 28, 2022. Gainwell Technologies will provide training on Web Portal Crossover Submission during the November 29 and December 1 Webinars. In addition, the Job Aids (training materials) for Inpatient and Professional services associated with Web Portal Crossover Claim submission (including Dental with Medicare Part C) will be updated and posted by November 29, and the Outpatient Job Aid will be posted by December 1, under MESA Tips on the provider portal resource page: https://medicaid.ms.gov/mesa-portal-for-providers/.

Please go to https://medicaid.ms.gov/mesa-provider-workshop-webinars/ for upcoming webinar details.

2. Gainwell Technologies began processing Medicare COBA files in the new MESA system on November 10, 2022, that included a backlog of files from Medicare based on the last file that was processed by the former Division of Medicaid's Fiscal Agent, Conduent. These are claims that cross directly from Medicare to Medicaid. The claims began appearing on the November 13, 2022, Remittance Advice (RA)/835.

Contact the Provider/Beneficiary Services call center at 1-800-884-3222 if you have questions regarding crossover claims that have processed. Please have your Claim ID available for the call center representative to assist with research.

3. Gainwell Technologies is implementing a process that will allow providers to submit a paper EOMB attachment with claims which have been submitted via an EDI 837 transaction. This will improve the claims submission experience for providers related to Medicare Crossover Claims utilizing EDI 837 transactions.

Continued on next page...

ATTENTION: All Providers
11/28/2022 4:40 p.m.

Update: Processing Medicare Crossover Claims

Continued

Providers are required to submit the Explanation of Medicare Benefits (EOMB) with all Medicare Crossover claims. For Medicare Crossover claims submitted via the EDI X12 (electronic submission), the provider must create a unique Attachment Control Number (ACN) for each claim. The ACN must be entered in the 'PWK06' segment of the transaction. Also, a value of 'BM' (for By Mail) must be entered in the 'PWK02' segment. A Claim Attachment Form must accompany each EOMB and must identify the Provider NPI, Attachment Control Number (ACN) as it was entered in the PWK segment, Claim ID/ICN and Member ID Number. The Claim Attachment Form is located at: https://medicaid.ms.gov/resources/forms/

The updated 837 Companion Guides are located at: https://medicaid.ms.gov/edi-technical-documents/

Once GWT receives the 837 electronic claim transaction with the PWK segments completed as instructed, the claim will suspend for 21 days awaiting the attachment. Suspended claims will appear on the Remittance Advice with an EOB 1084 - CLAIM SUSPENDED BECAUSE AN ATTACHMENT WAS INDICATED, BUT NOT RECEIVED. CLAIM WILL SUSPEND FOR UP TO 21 DAYS, UNTIL ATTACHMENT IS RECEIVED, OR AFTER 21 DAYS YOUR CLAIM WILL DENY. This EOB message will not show on the 835 Health Care Payment/Advice Transaction. If the Claim Attachment Form and EOB are not received within 21 days from the claim ID Julian date, the claim will deny with EOB 0989 - CLAIM DENIED. ATTACHMENT WAS NOT RECEIVED WITHIN 21 DAYS OF A CLAIM RECEIPT.

Mail the Claim Attachment Cover Sheet along with the supporting documentation to:
Gainwell Technologies
PO Box 23076
Jackson, MS 39225

WHAT'S NEW?

ATTENTION: All Providers
11/22/2022 3:55 p.m.

Voiding/Adjusting Claims

Effective November 21, 2022, Providers can now void and adjust legacy claims on the MESA Provider Web Portal. There was an issue affecting providers when attempting to void or adjust legacy claims. This issue has now been resolved. Providers should no longer receive an error message.

WHAT'S NEW?

ATTENTION: All Providers
11/21/2022 4:47 p.m.

Prior Authorization Related Issues in MESA

Prior Authorization numbers issued by Alliant or Kepro are case sensitive - The new MESA claims-processing system requires prior authorization (PA) numbers containing an uppercase letter "A" when issued by Alliant or an uppercase letter "K" when issued by Kepro. Providers who submitted a claim with a PA number containing a lowercase "a" or "k" must resubmit denied claims.

PA updates by Alliant – The Mississippi Division of Medicaid (DOM) is aware of an issue related to updated PA information being transmitted to the new MESA system. This appears to be occurring when a PA is changed or updated by Alliant and the update must be transmitted to MESA.

WHAT'S NEW?

ATTENTION: All Providers
11/8/2022 8:20 a.m.

Medicare Crossover Claims

After very productive conversations with providers, the Mississippi Division of Medicaid is working diligently with our Fiscal Agent, Gainwell Technologies, to address the following three issues related to Crossover Claims:

1. The functionality of the Web Portal regarding submission of Medicare Crossover claims in being enhanced. In an effort to reduce provider burden when submitting Medicare Crossover Claims, the Web Portal is being modified to reduce the amount of information required at the detail level for professional crossover and institutional outpatient crossover claims. The Gainwell Technologies team anticipates this being available in Web Portal by week of November 28, 2022.

2. As you may be aware, Gainwell Technologies has not processed any Medicare COBA files in the new MESA system. These are claims that cross directly from Medicare to Medicaid. While the request for COBA files to be sent to Gainwell from the Medicare contractor was made prior to go-live, Gainwell has not received any of these files in production. Gainwell Technologies received the first 'COBA test files' on October 31, 2022 and is diligently working to ensure they are processing as expected. Once the testing is complete, COBA files will begin to process in the MESA production environment. It is anticipated that Gainwell Technologies will receive a backlog of files from Medicare based on the last file that was processed by the former Division of Medicaid's Fiscal Agent, Conduent. Gainwell Technologies anticipates processing the first of the COBA files the week of November 14, 2022. Please monitor forthcoming communication regarding the status of processing COBA files and when providers can anticipate seeing them on the Remittance Advice (RA)/835.

3. Gainwell Technologies is working to develop a process that will allow providers to submit a paper EOMB attachment with claims which have been submitted via an EDI 837 transaction. This will improve the claims submission experience for providers related to Medicare Crossover Claims utilizing EDI 837 transactions. Testing is currently in progress and it is anticipated this process will be communicated to providers by November 30, 2022.

We want to thank our provider community for working closely with us as we seek to improve our operations.

WHAT'S NEW?

ATTENTION: All Providers
10/31/2022 11:15:00 p.m.

Community/Private Mental Health Centers, LPC/LMFT and BCBA Provider Update

Temporary Fix for Medicare Crossover Claim Errors in MESA

The disposition for Medicare-related claim errors 2502, 2503, and 2505 have been updated for providers in the 261QM0801X Clinic/Center - Mental Health (Including Community Mental Health Center), 101Y00000X Licensed Professional Counselor (includes Marriage and Family Therapist providers) and 103K00000X Board Certified Behavior Analyst (BCBA) taxonomies who were previously receiving denials. While the errors may still post on claims for those providers, they should not result in claim denials. DOM will continue to work with Gainwell to make updates to the Medicare crossover logic for mental health services in the coming weeks and will provide additional provider education to ensure that crossover claims are submitted and adjudicated appropriately.

WHAT'S NEW?

ATTENTION: All Providers
10/24/2022 4:00 p.m.

Denial Code related to PA/Procedure Conflict

The Mississippi Division of Medicaid's (DOM) new fiscal agent, Gainwell Technologies, completed work on a recent system update to address issues related to claims denying with error code **3106-PA/Procedure Conflict**. Providers that have had claims deny for this reason since October 1, 2022 and know that prior authorization had been obtained will need to resubmit claims that denied for error code 3106-PA/Procedure Conflict.

WHAT'S NEW?

ATTENTION: All Providers
10/24/2022 4:00 p.m.

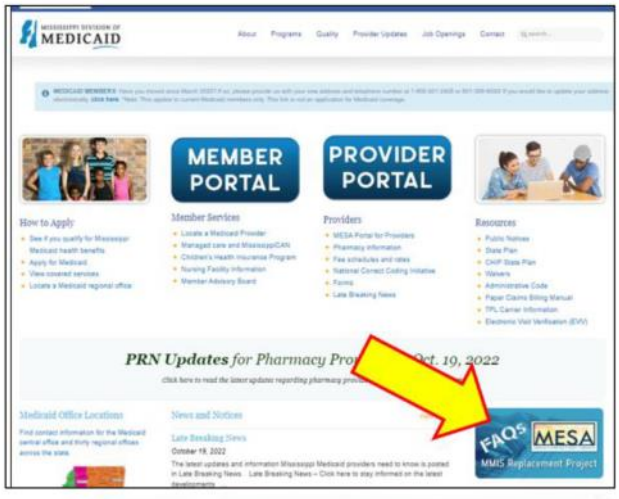
Taxonomy Related Claim Denials

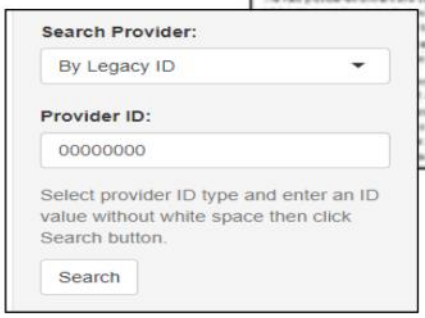
As part of the Mississippi Division of Medicaid's (DOM) transition to a new system, Medicaid Enterprise System Assistance (MESA), important changes were implemented that involve Medicaid Provider IDs. All actively enrolled Medicaid Providers received letters in June 2022 that detailed the changes made to their Provider IDs.

The letter included the taxonomy code that was assigned which was derived from your current provider type and specialty information. A taxonomy code was issued for each specialty. MESA requires that each service location and taxonomy combination have its own unique provider ID to correctly process claims. **Providers must submit claims with the appropriate taxonomy code to avoid taxonomy related claim denial error codes.**

If you or your clearinghouse submitted claims to MESA via Electronic Data Interchange (EDI) that were not reflected on your remittance advice (RA) or in your portal claims search, the issues you are experiencing may be caused by the incorrect taxonomy being submitted on the claim. Since your claim did not have a taxonomy that matched your provider ID on file, the system could not accurately associate the claim with your account. In these instances, please verify the taxonomy on your provider record as it may have been updated in conversion from the Conduent system to the MESA system. If you determine that the claims were submitted with the incorrect taxonomy originally, please resubmit them with the correct information.

There are also multiple ways to find the assigned taxonomy code. It can be found on the top of the web portal screen after signing in. Additionally, resources are available on DOM's website to help lookup the new MESA Provider ID. Access the lookup tool using this link dom-azure-app.medicaid.ms.gov, or by following the instructions in the images below. The MMIS Replacement Project webpage contains the Provider ID Search Tool.





The dropdown box allows searches by Legacy ID or by NPI number

WHAT'S NEW?

ATTENTION: All Providers
10/21/2022 8:50 p.m.

ATTENTION: ALL PROVIDERS

Claim Reconsideration Form Updates

Effective October 3, 2022, the Claim Reconsideration Form will no longer be available for providers to submit to the new fiscal agent, Gainwell Technologies. Providers are encouraged to submit electronic claims to reduce the potential for error. Resources are available to providers to assist with learning more about how to use the new Medicaid Enterprise System Assistance (MESA) portal (Resource Information - MESA Portal for Providers). Providers who submit electronic claims should adjust claims electronically, which allows for attachments for medical review. Additionally, providers who submit paper claims should refer to their return to provider (RTP) letter and follow instructions in the letter.

Appeal claim reconsideration options are reserved for instances when a claim is denied based on medical necessity. Should an appeal be necessary, please follow the requirements in the Administrative Code, Title 23, Part 300: Appeals.

WHAT'S NEW?

ATTENTION: All Providers
10/19/2022 3:50 p.m.

Waiving copay on COVID-19 claims

COVID-19 related claims that should bypass the copayment requirement must include the CS modifier, as the "V" suffix will not be recognized in the new MESA system.

Directions for waiving $3 copay on COVID-19-related prescriptions

Effective 10/1/2022 and through the end of the Public Health Emergency, the directions for waiving the $3 copay on COVID-19-related prescriptions when:

- The prescriber has indicated a diagnosis of COVID-19 on the prescription,
- 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

The V suffix on the member ID will no longer be accepted.

In **Field # 461-EU** (Prior Authorization Type Code) enter a value of "**4**" (exempt from copay and/or coinsurance)

In **Field # 462-EV** (Prior Authorization Number) enter a value of "**19**"

WHAT'S NEW?

ATTENTION: All Providers
10/19/2022 11:07 a.m.

ATTENTION: DENTAL PROVIDERS

*****Dental Claims Require Valid Diagnosis Codes*****

Effective October 3, 2022, the Division of Medicaid (DOM) transitioned to a new fiscal agent, Gainwell Technologies. The new provider-enrollment and claims-processing solution is called MESA: Medicaid Enterprise System Assistance. Dental claims submitted on or after October 3, 2022, to the new MESA system, require both the Current Dental Terminology (CDT) code and valid International Classification of Diseases-10th Edition (ICD-10) diagnosis codes. Failure to use valid ICD-10 diagnosis codes will result in denied claims. Dental related ICD-10 diagnosis codes are in the range of K000-K1379.

WHAT'S NEW?

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

ATTENTION: ALL PROVIDERS

*****MESA does not accept copay exception codes *****

Effective October 3, 2022, the Division of Medicaid (DOM) transitioned to a new fiscal agent, Gainwell Technologies. The new provider-enrollment and claims-processing solution is called MESA: Medicaid Enterprise System Assistance. DOM claims processing policy removed the need for the submittal of the copay exception codes to bypass copayment. Providers who used a copay exception code in the beneficiary identification number field of their claim received and will continue to receive claim denial edit 2001-MEMBER ID NUMBER NOT ON FILE. Providers should submit new claims without the copay exception code.

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.