Volume 29, Issue 2 April 2023

MS Medicaid PROVIDER BULLETIN

MISSISSIPPI DIVISION OF MEDICAID

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Eligibility Renewals Resume Following End of PHE Continuous Coverage

After three years of continuous Medicaid coverage under the COVID-19 public health emergency (PHE), the Mississippi Division of Medicaid (DOM) officially resumed annual eligibility determinations of its members on April 1, 2023.

Under the Consolidated Appropriations Act (CAA) passed by Congress in December, the continuous coverage provision expired on March 31, and the Centers for Medicare and Medicaid Services (CMS) instructed all states to begin normal redetermination operations by April 1.

Following CMS guidance, DOM has been working to prepare for the return of normal eligibility operations since last year. We have been actively increasing our eligibility workforce through various recruitment and retention efforts, including hiring temporary staff to help with the caseload and streamlining training requirements.

We launched a Stay Covered campaign in January, which includes a Coverage Champions program for community partners, advocates, and providers to

support Medicaid members and prepare for the end of the continuous coverage requirement. The Stay Covered webpage (www.medicaid.ms.gov/staycovered) includes a media toolkit, a link for members to update their contact information, and more important information about the unwinding process.

Additionally, we sent out mass text and email alerts to all the member household phone numbers and email addresses on file, and DOM had hundreds of thousands of awareness postcards printed and mailed directly to all member household addresses. We also received CMS authority to match our

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records against the latest information in the National Change of Address (NCOA) database.

Following federal guidance, redeterminations (often referred to as renewals) for all current Medicaid members must be initiated within 12 months following April 1, and all renewals must be completed within 14 months.

At the beginning of each month, DOM will take that month's caseload and will first try to renew a member's benefits by looking at electronic verification sources. This is known as an "ex parte" renewal.

If we are not able to approve a member this way, DOM will send a pre-populated renewal form to the individual, and the individual has at least 30 days from the date of the renewal form to respond and provide information.

Renewal forms can be returned by traditional mail, online, telephone, fax, or they can be returned in person at the member's nearest regional office. More detailed instructions on how renewals can be submitted will be included with the renewal forms.

If it is determined that a member no longer qualifies, they will receive notice in the mail explaining the decision, along with instructions on how to file an appeal. They are also notified that they may be able to get coverage and help paying for coverage through the Health Insurance Marketplace. DOM will also send their information to the Marketplace to begin an application for them.

If you in the provider community receive questions about eligibility renewals, the key messaging points at this time are:

- Medicaid has resumed eligibility renewals as of April 1.
- It is not too late for members to update their contact information. They can continue to do so at: www.medicaid.ms.gov/staycovered.
- If Medicaid cannot complete a renewal using electronic sources, we will mail that member a renewal form based on their last renewal month.
- This does not mean every member will receive a renewal form in April.
- Members who do receive a renewal form in the mail must complete the form and return it to Medicaid within 30 days by mail, online, in person, telephone or fax.
- The renewal forms will contain more details on how to return the form using those methods.

Remember, the online change-of-address form, as well as DOM's Unwinding Plan, FAQs, and the Toolkit, are located online at: www.medicaid.ms.gov/staycovered.

DOM to remove all co-pays effective May 1, 2023

Effective May 1, 2023, the Mississippi Division of Medicaid (DOM) is eliminating all Medicaid co-pays for pharmacy and health care services.

DOM plans to submit MS State Plan Amendment (SPA) 23-0011 to allow the agency to remove co-pays from Medicaid services. While DOM will still pay providers for their services, providers can no longer collect co-pays from beneficiaries beginning Monday, May 1, 2023.

Pharmacy point-of-sale paid claims will reflect at $0.00 amount in the co-payment field. This change will apply to both FFS and MississippiCAN claims.

WEB PORTAL REMINDER

VISIT DOM'S WEBSITE FOR LATEST UPDATES

Find the latest updates and important information on the DOM website under the Provider Portal at: **https://medicaid.ms.gov/mesa-portal-for-providers/**. The Provider Portal hosts many resources for providers such as webinars, FAQs, training videos, and Late Breaking News.

Click the links below to access portal resources.

PROVIDER COMPLIANCE

Medicaid Prior Authorizations and Crossover Claims

The Division of Medicaid (DOM) contracts with two Utilization Management and Quality Improvement Organization (UM/QIO) vendors, **Alliant** and **Kepro**. Both UM/QIO vendors are responsible for prior authorizations (PAs) for fee-for-service (FFS) members. Alliant handles most medical PAs, except for Advanced Imaging, which is handled by Kepro.

Depending on a number of factors, an individual may qualify for full Mississippi Medicaid health benefits, reduced coverage, or limited benefits in a covered group briefly described on DOM's website at the following link Who Qualifies for Coverage. A PA is not required for members who have Medicare as their primary coverage and ***Medicaid is only responsible for the coinsurance and deductible***. PA requests submitted to Alliant or Kepro for these members will be technically denied by the UM/QIO vendors.

TPL Denials on Dental Claims

Effective February 24, 2023, DOM updated third party liability (TPL) coverage rules in MESA to correct an issue where Dental claims were incorrectly denying for Edit 2504 – TPL for Member Resubmit with TPL EOB. This occurred when the member had TPL Medical coverage on file, but no TPL Dental coverage. Providers are advised to either resubmit or adjust impacted dental claims as follows:

- Resubmit denied dental claims that denied prior to February 24, 2023 with Edit 2504
- Adjust partially paid dental claims that processed prior to February 4, 2023 and contained denied details with Edit 2504

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

Professional Claim TPL Denials for Procedure Code A4554

Effective February 23, 2023, DOM updated TPL coverage rules for Procedure Code A4554 that was causing inappropriate denials impacting Professional claims. Providers are advised to resubmit impacted Professional claims that denied or adjust Professional claims that were partially paid but contained denied details for Procedure Code A4554 with Edit 2504 — TPL for Member Resubmit with TPL EOB.

Should you need assistance, please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or your designated provider field representative. A list of provider field representatives can be found at https://medicaid.ms.gov/wp-content/uploads/2022/12/Provider-Field-Representatives.pdf.

Updated Sterilization Consent Form

In accordance with Title 42 Code of Federal Regulations (CFR) 441 Subpart F, all sterilizations require a valid consent form. Providers are responsible for using the most current form published on the date the consent is obtained. Effective February 1, 2023, DOM will no longer accept sterilization consent forms with the expiration date of April 30, 2022. The current sterilization consent form has an updated expiration date of July 31, 2025 and is available on DOM's website at Forms – Mississippi Division of Medicaid under Provider Forms.

Additional information regarding policy and procedures for sterilizations can be found in the Mississippi Administrative Code Title 23 Part 202 at https://medicaid.ms.gov/wp-content/uploads/2022/05/Title-23-Part-202-Hospital-Services-05.01.22.pdf.

PROVIDER COMPLIANCE

Attention: Dental Providers

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 (CDT) procedure codes. While DOM accepts both electronic and paper dental claims, dental providers are strongly encouraged to submit claims electronically.

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 have access to the Alliant web portal may contact the Alliant Utilization Management team at MSAlliant@allianthealth.org or 1-888-224-3067 for Hospice Prior Authorization assistance.

Dental Claims must be Submitted with Valid Dental-Related Diagnosis Codes

Dental claims submitted for dates of service on and after April 1, 2023, must be submitted with a valid dental-related ICD-10 diagnosis code.

In December 2022, the Division of Medicaid (DOM) advised Dental Providers to resubmit previously denied dental claims when the claim denied for edit 257-Primary Diagnosis Code Missing – Detail. DOM made temporary modifications to edit 257 to allow Dental Providers more time to update their software to include ICD-10 diagnosis codes.

Since that time, dental claims submitted without a valid dental related ICD-10 diagnosis code have still received edit 257, but the claim would pay. However, 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.

Advanced Imaging Authorizations

Spring is here and so are those headaches!

As the Advanced Imaging Utilization Review Organization for fee-for-service Medicaid members, **Kepro** anticipates seeing an increase in authorization requests for members who suffer from symptoms related to chronic sinusitis and headaches. Certain environmental triggers can be influenced by seasonal changes like an increase in pollen and humidity. Sinus headaches, although rare according to the American Migraine Foundation, can be brought on by bacterial or viral infections. Frequent shifts between sunshine and rain showers can trigger a migraine brought on by the fluctuating barometric pressure.

It is especially important to continue to educate members about protecting themselves against known triggers to help manage their conditions. Reinforcing tasks like keeping track of diet, exercise and sleep cycles may help.

For providers, the need to order advanced imaging for headaches or chronic sinusitis may increase and **Kepro** would like to offer tips to make sure authorization requests are complete. When submitting an authorization request, please include a copy of the physician order and the ordering provider's clinical notes. It is important those notes paint a picture of the patient's clinical situation.

For patients with chronic headaches, notes should include clear information related to (but not limited to):

- Changes in character: frequency, intensity/ severity, duration
- Clarification of headache type: migraines vs cluster or other headaches
- Details on neurological symptoms present on physical exam
- Past/Current physician directed treatment

PROVIDER COMPLIANCE

New onset headaches should include information such as (but not limited to):

- Same information as chronic
- Background: neurological deficits or change in mental status
- Relationship to activity or position
- Age, trauma, immunocompromised state

Complete and accurate authorization requests will be turned around expeditiously so we can get our member treated and on to enjoying Spring and Summer! If you have any questions or need assistance with a review, please contact us at 866-740-2221.

Lead Poisoning Prevention and Healthy Homes Program

Medicaid Provider Updates

- Providers using the ESA Leadcare machine (in-house lead analyzer) must report all blood lead levels to the MS State Department of Health Lead Poisoning Prevention and Healthy Homes Program using the new revised Report of Lead Level Form dated 2/13/23 that can be accessed here: Lead Levels Reporting Form (ms.gov).

- Any capillary blood lead level ≥3.5µg/dL must be confirmed with a venous within the **CDC Timeframe 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 timeframe shown above based on the blood lead level (BLL).*

- Venous blood lead levels ≥3.5µg/dL must be reported to the Lead Poisoning Prevention and Healthy Homes Program immediately to initiate program services. Delayed reporting will result in families not receiving timely services from the program.

- Follow-up Venous Testing should be done within the **CDC Timeframe** below.

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.*

- The program has seen an increase in the number of false positive blood lead tests over the last several months. To minimize this issue, please do the following:
    - Calibrate and test the ESA Leadcare machine as required by the manufacturer.
    - Wash the child's hands with soap and water before drawing the blood lead level.
    - After washing the child's hands, wipe the finger with an alcohol swab before drawing the blood lead level.
    - Call 601-576-7620 to schedule a staff training on proper specimen collection.

Please contact the MS State Department of Health Lead Poisoning Prevention and Healthy Homes Program at 601-576-7620 if there are questions or concerns about the information shared above.

PROVIDER COMPLIANCE

Attention EPSDT Providers

DOM follows the current American Academy of Pediatrics (AAP) Bright Futures Periodicity Schedule for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) well child visits. EPSDT providers must adhere to and schedule all well child screening appointments for EPSDT-eligible beneficiaries according to the AAP Bright Futures Periodicity Schedule.

The periodicity schedule is listed on the next page and includes the age in days for each required visit. Additional information regarding the EPSDT program can be found on DOM's public website at Early and Periodic Screening, Diagnosis, and Treatment - Mississippi Division of Medicaid (ms.gov).

EPSDT Periodicity Schedule with Billing Period Limits

EPSDT Screening Codes		Age of Beneficiary (On Date of Service)	Billing Period Limits (Beneficiaries Age in Days)
New Patient	Established Patient		
99381-EP	99391-EP	3-5 days	>=0 days and <=7 days
99381-EP	99391-EP	0-1 months	>=8 days and <=60 days
99381-EP	99391-EP	2 months	>=61 days and <=122 days
99381-EP	99391-EP	4 months	>=123 days and <=183 days
99381-EP	99391-EP	6 months	>=184 days and <=273 days
99381-EP	99391-EP	9 months	>=274 days and <=364 days
99382-EP	99392-EP	12 months	>=365 days and <=456 days
99382-EP	99392-EP	15 months	>=457 days and <=547 days
99382-EP	99392-EP	18 months	>=548 days and <=729 days
99382-EP	99392-EP	24 months	>=730 days and <=912 days
99382-EP	99392-EP	30 months	>=913 days and <=1094 days
99382-EP	99392-EP	3 years	>=1095 days and <=1459 days
99382-EP	99392-EP	4 years	>=1460 days and <=1824 days
99383-EP	99393-EP	5 years	>=1825 days and <=2189 days
99383-EP	99393-EP	6 years	>=2190 days and <=2554 days
99383-EP	99393-EP	7 years	>=2555 days and <=2919 days
99383-EP	99393-EP	8 years	>=2920 days and <=3284 days
99383-EP	99393-EP	9 years	>=3285 days and <=3649 days
99383-EP	99393-EP	10 years	>=3650 days and <=4014 days
99383-EP	99393-EP	11 years	>=4015 days and <=4379 days
99384-EP	99394-EP	12 years	>=4380 days and <=4744 days
99384-EP	99394-EP	13 years	>=4745 days and <=5109 days
99384-EP	99394-EP	14 years	>=5110 days and <=5474 days
99384-EP	99394-EP	15 years	>=5475 days and <=5839 days
99384-EP	99394-EP	16 years	>=5840 days and <=6204 days
99384-EP	99394-EP	17 years	>=6205 days and <=6569 days
99385-EP	99395-EP	18 years	> =6570 days and <=6934 days
99385-EP	99395-EP	19 years	>=6935 days and <=7299 days
99385-EP	99395-EP	20 years	>=7300 days and <=7664 days

PROVIDER COMPLIANCE

Attention Nursing Facility Providers:

Patient Driven Payment Model Transition (PDPM) - Optional State Assessment (OSA)

Effective October 1, 2023, MDS items necessary for resident classification under a resource utilization group (RUG-IV) based acuity system will no longer be available on the standard MDS item sets. As a result, the Mississippi Division of Medicaid (DOM) will require the submission of the Optional State Assessment (OSA) effective October 1, 2023.

Provider Maintenance Operations (Licensure Review)

Under 42 CFR § 455.412, the Mississippi Division of Medicaid (DOM) is resuming its regular provider maintenance operation of monthly licensure review that was suspended in September 2022 for the implementation of MESA and transfer of our fiscal agent operations from Conduent to Gainwell Technologies. DOM will be updating provider records for both our fee-for-service/MississippiCAN providers as well as our CHIP providers.

Providers identified as having an expired or expiring license will receive notification from Gainwell Technologies by letter. Providers are required to provide their updated licensure information to Medicaid. Failure to provide Medicaid with the updated license could result in closure of the Medicaid provider number.

Providers can submit their licensure information to the Provider Enrollment Department of Gainwell Technologies via secure correspondence in the MESA Provider Portal, fax, or mail. The following information is provided:

MESA Provider Portal: https://medicaid.ms.gov/mesa-portal-for-providers

Provider Services Fax Number:
(866) 644-6148
Attention: Provider Enrollment

Provider Services Mailing Address:
Provider Enrollment/MississippiCAN/MSCHIP
PO Box 23078
Jackson, MS 39225

Providers can utilize the Provider Search Tool located on DOM's website at http://dom-azure-app.medicaid.ms.gov/ to validate if they have an expired license on their Medicaid provider record along with other data elements.

Please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 if you need assistance between the hours of 8 a.m. and 5 p.m. CST.

PROVIDER COMPLIANCE

Providers Can Submit Affiliation Requests Via Portal, Fax, or Mail

Currently, during the individual enrollment process, the provider is not given the option to add a group affiliation. DOM is working on a resolution through a change request (CR), but until the CR is implemented, the following steps should be taken to request that an affiliation be added.

Providers needing to submit affiliation requests to the Provider Enrollment Department of Gainwell Technologies may do so via secure correspondence in the MESA Provider Portal, fax, or mail. Additional information is noted below. Please note the requested effective date for the affiliation within your communication request, otherwise the provider affiliation will be effective the date of processing.

MESA Provider Portal:
https://medicaid.ms.gov/mesa-portal-for-providers/

Provider Services Fax Number:
Attention: Provider Enrollment
(866) 644-6148

Provider Services Mailing Address:
Provider Enrollment/MississippiCAN/MSCHIP
PO Box 23078
Jackson, MS 39225

Delegates for the group that this provider needs to be affiliated with can send in a request through the Secure Correspondence link located on the right side of the Home Page. A delegate of the group can also check the Affiliated Providers link on the Home Page to see a list of all individuals affiliated with the provider.

Should you need assistance, please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or use the Provider Field Representative list on Medicaid's website to identify your designated representative. The Provider Field Representative list includes email addresses and phone numbers for each representative. This resource document is located on page 22 of this bulletin and at **https://medicaid.ms.gov/wp-content/uploads/2022/12/Provider-Field-Representatives.pdf**.

Enhanced Functionality for Delegate Accounts

Providers often use delegates to manage their claims and other clerical functions via the portal for legitimate business reasons. Effective March 26, 2023, additional functionality was added that now allows delegates to perform recredentialing, revalidation and add program functionalities when given permissions by the Provider/Provider Administrators.

Instructions related to delegate accounts can be found at **https://medicaid.ms.gov/wp-content/uploads/2022/10/PRP-100-Job-Aid-Delegate-Accounts.pdf**.

Should you need assistance, please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or use the Provider Field Representative list on Medicaid's website to identify your designated representative.

The Provider Field Representative list includes email addresses and phone numbers for each representative. This resource document is located on page 22 of this bulletin and at **https://medicaid.ms.gov/wp-content/uploads/2022/12/Provider-Field-Representatives.pdf**.

PROVIDER COMPLIANCE

Provider Enrollment Application Fee Increased for 2023

CMS increased the enrollment application fee for institutional providers for the 2023 calendar year from $631 to $688. This application fee will be required in the following instances:

- Initial enrollment, reactivation, revalidation, or reenrollment of providers in Medicaid and the Children's Health Insurance Program (CHIP)
- Addition of New Owners – Change of Ownership
- Providers adding a new Medicaid practice location

Note: Simple changes to the provider enrollment information, that is, new phone numbers, new bank account information, new billing address, change in the name of the provider, or other such updates are not subject to the fee.

Providers required to submit a fee are:

TAXONOMY	DESCRIPTION
251E00000X	Home Health
251G00000X	Hospice Care, Community Based
261QA1903X	Clinic/Center — Ambulatory Surgical
261QE0700X	Clinic/Center — End-Stage Renal Disease (ESRD) Treatment
261QF0400X	Clinic/Center — Federally Qualified Health Center (FQHC)
261QM0801X	Clinic/Center — Mental Health (Including Community Mental Health Center)
261QR0401X	Clinic/Center – Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)
261QR1300X	Clinic/Center — Rural Health
282N00000X	General Acute Care Hospital
283Q00000X	Psychiatric Hospital
291U00000X	Clinical Medical Laboratory
293D00000X	Physiological Laboratory
314000000X	Skilled Nursing Facility
3140N1450X	Skilled Nursing Facility — Nursing Care, Pediatric
332B00000X	Durable Medical Equipment and Medical Supplies
333600000X	Pharmacy
341600000X	Ambulance

Providers submitting their application fee should make their check payable to the Mississippi Division of Medicaid, annotating on the check the application tracking number (ATN), and mail to Gainwell Technologies, PO Box 6014, Ridgeland, MS 39158. Providers who have already paid the application fee to Medicare or another state's CHIP or Medicaid program have fulfilled the requirement and do not have to pay the fee to Mississippi Medicaid.

For more information or if you need assistance, call 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**.

COORDINATED CARE NEWS

Mississippi Hospital Access Program (MHAP)

The Mississippi Hospital Access Program (MHAP) is a directed payment through managed care that is paid monthly to hospitals and is made up of two components: Fee Schedule Adjustment (FSA) and Quality Incentive Payment Program (QIPP). This program is approved by the Centers for Medicare and Medicaid Services (CMS) through a preprint that is submitted annually. The amount approved for the program in state fiscal year (SFY) 2023 is $560,908,151. This payment is based on the hospital inpatient discharges and outpatient payments from managed care encounters paid in calendar year 2021, but the payment will be reconciled for the rating period (July 1, 2022, through June 30, 2023) in April 2024.

Recently, DOM submitted an amendment to CMS requesting an additional $40,245,451 be added to the program based on the outpatient payment average commercial rate (ACR) and is pending CMS approval. To also address the needs of the hospitals, DOM intends to pay a Section 1135 Waiver emergency hospital payment through the State Plan Amendment (SPA) 23-006 to pay all Mississippi hospitals eligible for supplemental payments under federal and state laws and regulations.

Quality Incentive Payment Program (QIPP)

The Quality Incentive Payment Program (QIPP) is part of the Mississippi Hospital Access Program (MHAP) and is made up of the following components: Potentially Preventable Hospital Returns (PPHR), Potentially Preventable Complications (PPC) and Health Information Network (HIN). For each component, an attestation form is required. The PPHR attestation form and the PPC attestation form require attesting to the receipt of the PPHR and PPC reports provided by DOM. These attestations are associated with the third month of each quarterly MHAP payment for QIPP. The HIN form attests that the hospital is participating and it is connected to one of the two statewide HINs: Mississippi Hospital Association (MHA) or the Mississippi State Medical Association (MSMA). The HIN is associated with the first month of each quarterly MHAP payment for QIPP.

Both the PPHR and PPC components run in three cycles. Currently, cycle two (2) has just ended for PPHR. The January 2023 PPHR report determined the results for those hospitals who were under a Corrective Action Plan (CAP). If the required improvement was not met for any of the hospitals under a CAP, the hospital will forfeit a certain percentage of the entire PPHR portion of QIPP funds for the 2023 state fiscal year. Those funds will be reallocated among the other hospitals in the MHAP program at the end of SFY 2023 along with any forfeited funds due to hospitals who did not submit an attestation form for PPHR, PPC and HIN or did not participate in a HIN.

As of now, the January 2023 PPHR and PPC reports have been delayed, and DOM will update the hospitals from the QIPP mailbox with more information when reports will be available. For any further questions regarding this program, a hospital may reach out to the QIPP mailbox at QIPP@medicaid.ms.gov. For more information regarding the QIPP program, please visit the DOM website and review the SFY 2023 QIPP Resources section: Value-Based Incentives - Mississippi Division of Medicaid (ms.gov).

Transforming Reimbursement for Emergency Ambulance Transportation (TREAT)

Requests for approval of the Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) program have been sent to CMS. In the 2022 regular legislative session, House Bill 657 authorized the additional payments program for emergency ambulance services to be funded with a health care provider fee. This directed payment through managed care will be made quarterly to the eligible ground ambulance providers for SFY 2023. TREAT will also consist of an upper payment limit program for FFS utilization, which will also be paid quarterly. For more information regarding the TREAT program, please visit the following DOM site: Transforming Reimbursement for Emergency Ambulance Transportation (TREAT) - Mississippi Division of Medicaid (ms.gov).

COORDINATED CARE NEWS

Prior Authorization

Molina requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Molina Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Molina website at https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx

Providers are encouraged to use the Molina prior authorization form provided on the Molina web site at https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx

If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Molina ID number).
- Provider demographic information (referring Provider and referred-to Provider/facility, including address and NPI number)
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the medical necessity of the requested service is required including:
  - Pertinent medical history (include treatment, diagnostic tests, examination data).
  - Requested length of stay (for inpatient requests).
  - Rationale for expedited processing.

If you have any questions or concerns, please contact our Utilization Management department at (844) 826-4335.

COORDINATED CARE NEWS

Magnolia MSCAN Remittance/Billing Address Updates

Magnolia reminds providers to promptly notify the health plan of remittance/billing address changes to prevent payment delays. Providers can update their remittance address by emailing Magnoliacredentialing@centene.com. Please include an updated W9 and the previous and new remittance addresses.

Magnolia MSCAN ECHO Provider Tips

Appropriate patient care is essential to the overall health of the ones you serve. Magnolia Health is dedicated to partnering with you to help maximize opportunities to improve patient care and patient satisfaction, for the benefit of you, the physician, and the patient.

Annually, NCQA directs health plans to conduct a survey about the member's experience with behavioral health services. The ECHO Behavioral Health Member Experience Survey measures members' experiences and identifies opportunities for health plans and providers to improve quality of care and access to mental health and substance abuse services.

Your patients may be asked the following questions. How do you rate?

Composite Measures	Sample Questions
Getting Treatment Quickly	• How often did you get the professional counseling you needed on the phone? • When you needed counseling or treatment right away, how often did you see someone as soon as you wanted? • Not counting the times you needed counseling or treatment right away, how often did you get an appointment for counseling or treatment as soon as you wanted? (Always, Usually, Sometimes, Never)
How Well Your Clinician Communicates	• How often did the provider listen carefully to you? • How often did the provider explain things in a way that you could understand? • How often did the provider show respect for what you had to say? • How often did the provider spend enough time with you? • How often were you involved as much as you wanted in your counseling or treatment? (Always, Usually, Sometimes, Never)
Information About Treatment Options	• Were you told about self-help or support groups? • Were you given information about different kinds of counseling or treatment that are available? (Yes, No)
Access to Treatment and Information from Health Plan	• How much of a problem, if any, were delays in counseling or treatment while you waited for approval from your health plan? (A Big Problem, A Small Problem, Not a Problem)

COORDINATED CARE NEWS

Continued

Single Item Measures - Sample Questions
• How often were you seen within 15 minutes of appointment time? • Were you told about medication side effects? • Were you given information about your rights as a patient? • Did you feel that you could refuse a specific type of treatment? • Was your care responsive to cultural needs?

Please use the following suggestions to improve your ratings:
• Let patients know your office hours and how to get after hour care. Offer extended hours, if possible. • Ask your patients what is important to them. • Offer to coordinate care with other specialists or primary care physicians. • Provide patients with release of information (ROI) and explain the purpose of releasing information to other providers. • Include family in the treatment plan. • Invite questions and encourage your patient to take notes. • Use the "teach-back" method.

Thank You for Your Continued Partnership!

Click the link below for more managed care resources.

COORDINATED CARE NEWS

Update Your Email Notifications in One Spot

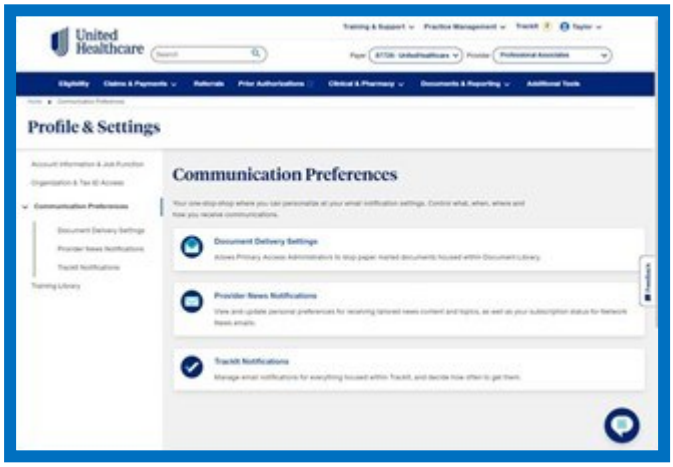
From Document Library email settings to Provider News notifications, and soon, TrackIt

Managing your email settings just got easier. Paperless Delivery Options (PDO) has moved and is no longer a stand-alone tool. You can now go to 1 location in the UnitedHealthcare Provider Portal to change your Document Library email settings and Provider News notifications.

Access Communication Preferences

PDO, now called Document Delivery Settings, is part of Communication Preferences in Profile & Settings. Here's how to get there:

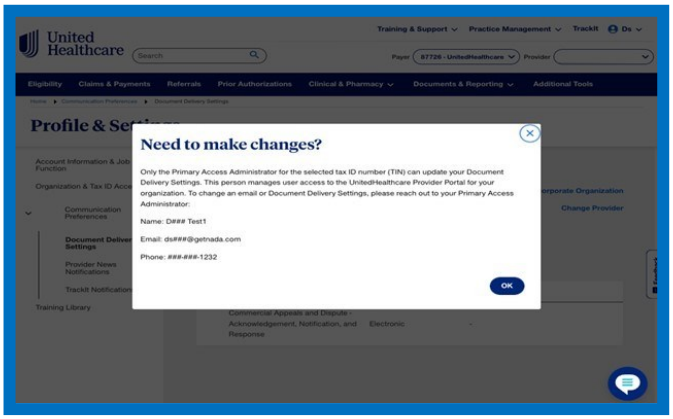
- Sign into the portal with your One Healthcare ID and password
    - If you don't have a One Healthcare ID, vis it **UHCprovider.com/access** to get started
- On the top right, click your profile name
- Then, under Profile & Settings, click **Communication Preferences** and select **Document Delivery Settings**



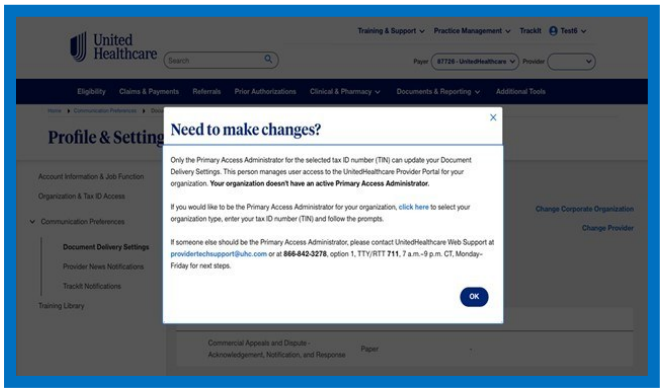
Please note: Every authorized user in your organization can see who has been set up to receive digital notifications. Your organization's Primary Access Administrator is the only person who can make changes, including who receives the notifications. **Communications that UnitedHealthcare has moved to electronic-only delivery cannot be changed back to paper.**

COORDINATED CARE NEWS

Not sure who your Primary Access Administrator is for your organization? You don't have to go far. When you access Document Delivery Settings, you'll see the following pop-up that shows your Primary Access Administrator.



If your organization doesn't have a Primary Access Administrator, a different pop-up will appear. It will give a phone number for you to call for more information.



For more details and instructions on Document Delivery Settings, see the Profile & Settings Interactive Guide.

Future Additions to Communication Preferences

In March, TrackIt notifications will also move to Communication Preferences in Profile & Settings. Later in 2023, you'll also see a section called Training Library with recommended training courses. Watch for more details.

Questions? We're here to help.

For help using the UnitedHealthcare Provider Portal, please contact UnitedHealthcare Web Support at providertechsupport@uhc.com or **866-842-3278**, option 1, TTY/RTT **711**, 7 a.m.–9 p.m. CT, Monday–Friday.

COORDINATED CARE NEWS

Hemoglobin A1c Control for Patients with Diabetes (HBD)

This article is to assist providers in improving HEDIS measures for diabetes management.

Definition: Percentage of members ages 18–75 with diabetes (Types 1 and 2) who had an HbA1c lab test during the measurement year that showed their blood sugar is under control (good control is < 8.0%, poor control is > 9.0%).

Tips and Best Practices to Help Close This Care Opportunity:

HbA1c test must be performed during the measurement year. If multiple tests were performed in the measurement year, the result from the last test is used.

Always list the date of service, result and test together in the medical record**.**

The use of CPT® Category II codes help UnitedHealthcare identify clinical outcomes such as HbA1c level. It can also reduce the need for some chart review.

The following codes can be used to close HEDIS® numerator gaps in care; they are not intended to be a directive of your billing practice:

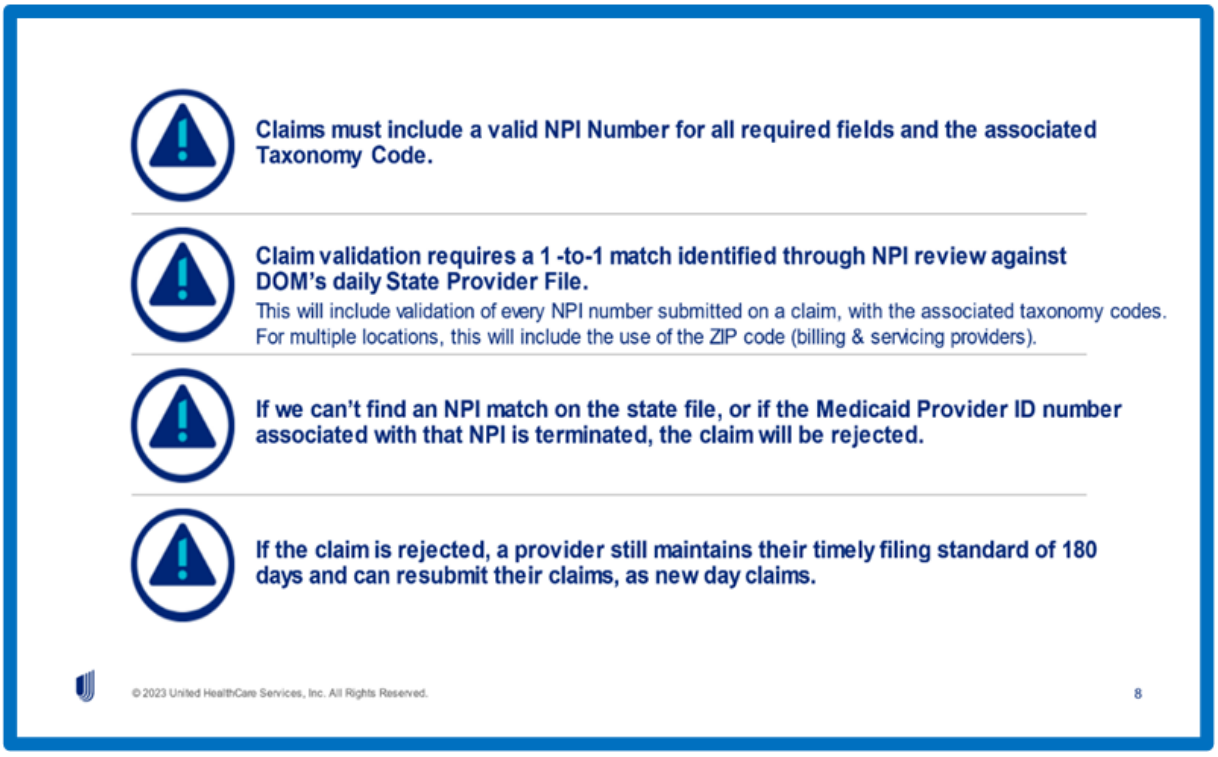
HbA1c Level < 7.0% CPT®/CPT II 3044F SNOMED 165679005

HbA1c ≥ 7.0% and <8.0% CPT®/CPT II 3051F

HbA1c ≥ 8.0% and ≤ 9.0% CPT®/CPT II 3052F

HbA1c > 9.0% CPT®/CPT II 3046F SNOMED 451061000124104

Electronic/Paper Claim Submission Guide



COORDINATED CARE NEWS

DATA Waiver not required for treating OUD

As of Jan. 12, 2023, the federal government no longer requires health care professionals to process a DATA Waiver (X-Waiver) to prescribe buprenorphine and other drugs for treating opioid use disorder (OUD).

What this means for you

As a health care professional, if you have a current DEA registration with Schedule III authority, you may prescribe buprenorphine for treatment, if permissible by applicable state law, with no limits on the number of patients treated.

Evidence-based treatment

Professional organizations, such as the American Medical Association, recommend the use of medication-assisted treatment (MAT) and support removal of the X-Waiver. We encourage health care professionals with DEA-prescribing authority to proactively identify OUD in members and treat them using evidence-based treatment protocols and as permitted by your state licensing board.

Learn more

The following resources can help you identify and treat members with OUD in your practice:

- Review materials available for all health care professionals
- Read the CDC Clinical Practice Guideline for Prescribing Opioids for Pain
- See SAMSHA-funded resources and local training

Questions?

Contact your provider advocate at 877-743-8734 for information on how we can support your practice.

COORDINATED CARE NEWS

Get Automatic Approval for Advanced Imaging Prior Authorization Requests

Molina Healthcare is partnering with MCG health to offer Cite AutoAuth self-service for advanced imaging prior authorization (PA) requests.

What is Cite AutoAuth and How Does it Work?

By attaching the relevant care guideline content to each PA request and sending it directly to Molina, healthcare providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Molina's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include, but are not limited to: MRIs, CTs, and PET scans. To see the full list of imaging codes that require PA, refer to the PA Code LookUp Tool at MolinaHealthcare.com.

How to Access and Learning More

Cite AutoAuth can be accessed via the Availity Essentials portal in the Molina's Payer Spaces and in the Molina Provider Portal. It is available 24 hours per day/7 days per week.

This method of submission is strongly encouraged as your primary submission route, existing fax/ phone/email processes are also available.

Watch News Article (molinahealthcare.com) for updates and additional information about Cite AutoAuth.

Removal of OB Authorization Requirements (Molina MississippiCAN/CHIP Only)

Molina Healthcare of Mississippi continues to strive to better serve our members and work efficiently with providers. To align more closely with federal requirements, Molina established that **NO Prior Authorization** is needed to be on file before claims submission for routine deliveries that are **not complicated** and **do not exceed** the routine timeframes (three days for vaginal or five days for C -Section) for the claim to pay.

*Note: Molina continues to **require authorizations** to determine medical necessity on OB delivery stays that are **non-routine or complicated**.*

Therefore, Providers should wait to file a claim for the below maternity stays until receiving an authorization determination letter:

- Scheduled deliveries before 39-week gestation
- Delivery stays that are non-routine or complicated (e.g., O10-O16, O20-O29, O30-O48, O60-O77, O85-O92, O94 -O9A, O09, O00-O08)
- Delivery stays that exceed routine time frames (notification to be filed no later than day 4 for vaginal/ day 6 for C-Section)
- Sick newborns (Sick Baby revenue codes that required an authorization regardless the length of stay, e.g., 172, 173, 174)

Newborns who require services other than normal newborn care (stay beyond 5 days)

Note: The Division of Medicaid (DOM) will continue to require providers to submit newborn enrollment forms. Molina will continue to generate an authorization from the form.

If you have any questions or concerns, please contact our Utilization Management department at (844) 826-4335.

COORDINATED CARE NEWS

Magnolia Health MSCAN Taxonomy Update:

Until further notice, Magnolia is temporarily relaxing the taxonomy edit implemented in October 2022. Magnolia discontinued the denial of claims for invalid or mismatched taxonomy. Instead, providers will receive an informational processing code that indicates an invalid taxonomy. Providers should monitor informational processing codes closely and contact Gainwell or review their MESA provider portal to validate or update information on file.

Providers can find the new informational codes and previous denial reason codes below. Magnolia recommends contacting Gainwell at (800) 884-3222 or logging in to the MESA provider portal to ensure all your information matches to prevent future claim denials.

The claims department is in the process of reprocessing claims denied after 10/3/2022 for the following reasons. Please allow up to 60 days for payment.

New Informational Codes

Medical and Behavioral Health:

EXGr: INFO - INVALID RENDERING TAXONOMY PER MESA MAY RESULT IN FUTURE DENIALS

EXGt: INFO - INVALID BILLING TAXONOMY PER MESA MAY RESULT IN FUTURE DENIALS

OLD Denial Reasons

Medical and Behavioral Health:

- EXFn: NPI AND TAXONOMY MATCH INACTIVE WITH STATE ON DOS

EXFo: NPI, TAXONOMY, ZIP, ZIP PLUS 4 MATCH INACTIVE WITH STATE ON DOS

Please note, the following denial reasons will not be addressed and will continue to be valid for past and future claims where a provider is not registered or inactive for Medicaid.

Medical:

EX1T: DENY: RENDERING PROV INACTIVE/NOT REGISTERED W/ STATE ON DOS

EX1n: DENY: BILLING PROV INACTIVE/NOT REGISTERED W/ STATE ON DOS

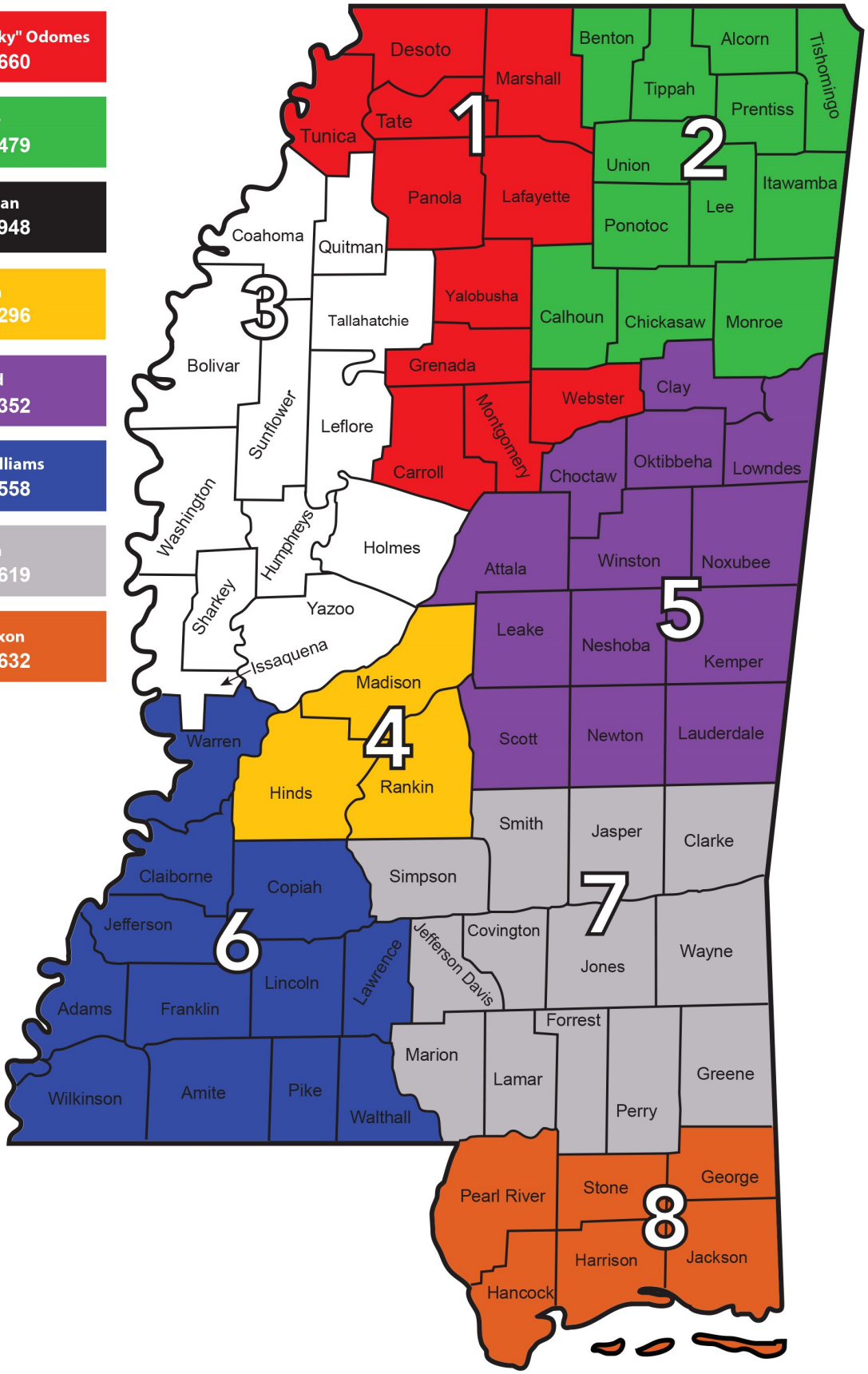
Behavioral Health:

EXRx: DENY: RENDERING PROV INACTIVE/NOT REGISTERED W/ STATE ON DOS

EXRw: DENY: BILLING PROV INACTIVE/NOT REGISTERED W/ STATE ON DOS

PROVIDER FIELD REPRESENTATIVE REGIONAL

1	Claudia "Nicky" Odomes	769-567-9660
2	Latrece Pace	601-345-3479
3	Jade McGowan	601-345-1948
4	Justin Griffin	601-874-4296
5	Latasha Ford	601-292-9352
6	Tuwanda Williams	601-345-1558
7	Erica Guyton	601-345-3619
8	Jonathan Dixon	601-862-2632



PROVIDER FIELD REPRESENTATIVES

PROVIDER FIELD REPRESENTATIVE AREAS BY		
AREA 1 Claudia (Nicky) Odomes Claudia.Odomes@gainwelltechnologies.com **769-567-9660**	**AREA 2** **Latrece Pace** Latrece.Pace@gainwelltechnologies.com **601-345-3479**	**AREA 3** **Jade McGowan** Jade.McGowan@gainwelltechnologies.com 601-345-1948
County	**County**	**County**
Carroll	Alcorn	Bolivar
Desoto	Benton	Coahoma
Grenada	Calhoun	Holmes
Lafayette	Chickasaw	Humphries
Marshall	Itawamba	Issaquena
Montgomery	Lee	Leflore
Panola	Monroe	Quitman
Tate	Pontotoc	Sharkey
Tunica	Prentiss	Sunflower
Webster	Tippah	Tallahatchie
Yalobusha	Tishomingo	Washington
	Union	Yazoo
AREA 4 Justin Griffin Justin.Griffin@gainwelltechnologies.com **601-874-4296**	**AREA 5** Latasha Ford Latasha.Ford@gainwelltechnologies.com **601-292-9352**	**AREA 6** **Tuwanda Williams** Tuwanda.Williams@gainwelltechnologies.com **601-345-1558**
County	**County**	**County**
Hinds	Attala	Adams
Madison	Choctaw	Amite
Rankin	Clay	Claiborn
	Kemper	Copiah
	Lauderdale	Franklin
	Leake	Jefferson
	Lowndes	Lawrence
	Neshoba	Lincoln
	Newton	Pike
	Noxubee	Walthall
	Oktibbeha	Warren
	Scott	Wilkinson
	Winston	
AREA 7 **Erica Guyton** Erica.Guytin@gainwelltechnologies.com 601-345-3619		**AREA 8** **Jonathan Dixon** Jonathan.Dixon@gainwelltechnologies.com **601-862-2632**
County		**County**
Clarke		George
Covington		Hancock
Forrest		Harrison
Greene		Jackson
Jasper		Pearl
Jefferson Davis		Stone
Jones		
Lamar		
Marion		
Perry		
Simpson		
Smith		
Wayne		
OUT OF STATE PROVIDERS	**Tanya Stevens** Tanya.Stevens@gainwelltechnologies.com 501-232-8689 **Sheryl Leonard** Shryl.Leonard@gainwelltechnologies.com 601-345-2115	

CALENDAR OF EVENTS

MAY 2023

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

JUNE 2023

THURS, JUN 1	EDI Cut Off – 5:00 p.m.
MON, JUN 5	Checkwrite
THURS, JUN 8	EDI Cut Off – 5:00 p.m.
MON, JUN 12	Checkwrite
THURS, JUN 15	EDI Cut Off – 5:00 p.m.
MON, JUN 19	Checkwrite
THURS, JUN 22	EDI Cut Off – 5:00 p.m.
MON, JUN 26	Checkwrite
THURS, JUN 29	EDI Cut Off – 5:00 p.m.

JULY 2023

MON, JULY 3	Checkwrite
THURS, JULY 6	EDI Cut Off – 5:00 p.m.
MON, JULY 10	Checkwrite
THURS, JULY 13	EDI Cut Off – 5:00 p.m.
MON, JULY 17	Checkwrite
THURS, JULY 20	EDI Cut Off – 5:00 p.m.
MON, JULY 24	Checkwrite
THURS, JULY 27	EDI Cut Off – 5:00 p.m.
MON, JULY 31	Checkwrite

Checkwrites and Remittance Advices are dated every Monday. Provider Remittance Advice is available for download each Monday morning at https://portal.ms-medicaid-mesa.com/MS/. Funds are not transferred until the following Thursday.

UPCOMING DOM HOLIDAYS

MON, May 29	Memorial Day
TUES, July 4	Independence Day

Mississippi Medicaid Administrative Code and Billing Handbook are on the Web at www.medicaid.ms.gov

Medicaid Provider Bulletins are located on the Web Portal at https://medicaid.ms.gov/providers/provider-resources/provider-bulletins/

CONTACT INFORMATION

MISSISSIPPI DIVISION OF MEDICAID
550 High Street, Suite 1000 Jackson, MS 39201
601-359-6050

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