Volume 24, Issue 4 December 2018

MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

**DREW L. SNYDER**
*Executive Director*
*MS Division of Medicaid*

# DOM's EASE Initiative Aimed at Improving Access to Needed Services for Medicaid Beneficiaries

Effective January 1, 2019, the Mississippi Division of Medicaid (DOM) is increasing the number of physician visits it covers for Medicaid beneficiaries from 12 to 16 visits per state fiscal year, the first of a series of changes the agency plans to roll out in the coming year.

The move is part of the recently announced Medicaid EASE Initiative – Enhancing Access to Services and Engagement – a bundle of programmatic reforms aimed at bolstering Medicaid beneficiaries' access to needed services and to make it easier for them to receive those services in the most appropriate setting.

With the first phase of the EASE Initiative, DOM will raise the physician visit limit for beneficiaries from 12 to 16 visits per state fiscal year. Individuals who participate in the MississippiCAN program will continue to be eligible for enhanced services offered by the managed care company with which they are enrolled, such as unlimited physician visits.

DOM plans to announce additional EASE Initiative reforms in the coming months. These projects are still in development and include increases to the monthly prescription drug limit and home health visit limit, behavioral health and substance use disorder reforms, and an effort to reduce potentially preventable hospital readmissions. We look forward to sharing more information about these projects in the future.

Unveiling the EASE Initiative is a fitting way to bring 2018 to a close as it has been a year of transformation for the Mississippi Medicaid program. During the 2018 legislative session, lawmakers introduced a number of amendments to the Medicaid tech bill, giving the agency more flexibility in how it runs the program. Thanks to those flexibilities, we have spent much of the year exploring policy changes to improve access, quality, and outcomes for the individuals we serve while responsibly stewarding taxpayer dollars.

We believe the EASE Initiative has the potential to positively impact our beneficiaries by improving access to the right services at the right time in the right setting. Furthermore, these changes were developed with ensuring the long-term sustainability of the program in mind for those Mississippians who may require Medicaid services in the future.

Prior to the announcement of this initiative, we began taking steps toward improving beneficiary access to care. For example, DOM is seeking CMS approval to allow certain physician-administered drugs to be billed and reimbursed as either a medical claim or a pharmacy point-of-sale (POS) claim to improve access to those drugs. Previously, many physician-administered drugs

*continued on page 2*

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could only be billed as a medical claim. These include expensive therapies physicians previously may have been reluctant to keep in stock, such as 17-P. If approved, physician administered drugs that are billable through pharmacy POS will be known as Clinician Administered Drugs and Implantable Drug System Devices (CADD). The proposed CADD list can be found at: https://medicaid.ms.gov/providers/pharmacy/pharmacy-resources/ and https://medicaid.ms.gov/providers/fee-schedules-and-rates/. CADDs will not count toward the monthly prescription drug limit.

With the EASE Initiative, we are looking to build on the momentum that began during the 2018 legislative session and the recommendations of important stakeholder groups such as the Mississippi Medical Care Advisory Committee. I look forward to sharing more information about the EASE Initiative as well as other developments in the coming months.

If a provider or individual would like to be added to the distribution list for notification of updates to the State Plan, Administrative Code, or Waiver please notify the Division of Medicaid at DOMPolicy@medicaid.ms.gov.

For general inquiries or to request information, providers can reach the Division of Medicaid at RFI@medicaid.ms.gov.


## WEB PORTAL REMINDER

For easy access to up-to-date information, providers are encouraged to use the **Mississippi Envision Web Portal.** The Web Portal is the electronic approach to rapid, efficient information exchange with providers including eligibility verification, claim submission, electronic report retrieval, and the latest updates to provider information. The **Mississippi Envision Web Portal** is available 24 hours a day, 7 days a week, 365 days a year via the Internet at www.ms-medicaid.com.

# LONG-TERM CARE

## Allowable Board of Directors Fees for Long-Term Care Facilities 2018 Cost Reports

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2018 cost reports filed by nursing facilities (NFs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and psychiatric residential treatment facilities (PRTFs) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for all Urban Consumers - All Items. The amounts listed below are the per-meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2018 are as follows:

| Category | Maximum Allowable Cost for 2018 |
|---|---|
| 0 – 99 Beds | $ 4,239 |
| 100 – 199 Beds | $ 6,359 |
| 200 – 299 Beds | $ 8,479 |
| 300 – 499 Beds | $10,598 |
| 500 Beds or More | $12,718 |

## 2018 Owner Salary Limits for Long-Term Care Facilities

The maximum amounts that will be allowed on cost reports filed by nursing facilities (NFs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) and psychiatric residential treatment facilities (PRTFs) as owner's salaries for 2018 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 must 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 2018 are as follows:

| | |
|---|---|
| Small Nursing Facilities (1 - 60 Beds) | $134,193 |
| Large Nursing Facilities (61+ Beds) | $161,177 |
| Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) | $151,292 |
| Psychiatric Residential Treatment Facilities (PRTF) | $143,432 |

# NURSING FACILITIES

## Attention: Nursing Facilities "Save The Date"

The Division of Medicaid and Mississippi State Department of Health (MSDH) Division of Licensure and Certification are hosting a free, one-day educational seminar for nursing home providers and other individuals or organizations interested in applying for a Civil Money Penalty (CMP) Grant. Several speakers experienced in the nursing home industry will share their expertise and perspectives on developing successful CMP grants. Attendees will be able to speak with industry representatives on products and services devoted to improve care and quality of life for nursing home residents. The seminar will be May 7, 2019 from 9:30 a.m. until 4:30 p.m. at the University of Mississippi Medical Center Conference Center, Jackson Medical Mall, 350 W. Woodrow Wilson Drive, Jackson, MS. If your organization is seeking funding from the Centers for Medicare and Medicaid Services (CMS) for a project benefiting nursing home residents, you are urged to attend this educational seminar. A training flyer with the registration link will be forthcoming from the MSDH, so save the date. For more information, please contact the Office of Long Term Care at 601-359-6141.

## 2019 New Bed Values for NFs, ICF-IIDs, PRTFs, and NSFDs

The new bed values for 2019 for nursing facilities (NFs), 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 | 2019 New Bed Value |
|---|---|
| NFs | $96,540 |
| ICF-IID | $115,848 |
| PRTF | $115,848 |
| NFSD | $168,945 |

# INPATIENT REIMBURSEMENT

## Hospital Reimbursement Three-Day Payment Window Policy

Outpatient services provided to a beneficiary by the admitting hospital, or by an entity wholly owned or operated by the admitting hospital, within the three (3) days prior to an inpatient hospital admission that are related to the reason for the inpatient hospital stay must be included in the APR-DRG payment for the inpatient hospital stay. This is referred to as the three (3) day payment window rule.

If outpatient services are provided more than three (3) days prior to admission to a beneficiary by the admitting hospital, or an entity wholly owned or operated by the admitting hospital, and the outpatient service dates span to days outside of the three (3) day window the hospital must: a) Split bill for the outpatient services provided outside of the three (3) day window on a claim separate from the inpatient claim, and b) Include the outpatient services provided that are related to the reason for the inpatient hospital stay within the three (3) day window on the inpatient hospital claim. Maintenance renal dialysis services are excluded from the three (3) day window payment rule.

# FAMILY PLANNING

## Family Planning Waiver Providers

Effective January 1, 2018, the Division of Medicaid (DOM) required Family Planning Waiver (FPW) initial and annual visits to be billed with the appropriate preventive medicine CPT codes – 99384, 99385, 99386, 99394, 99395, or 99396. DOM will reprocess FPW claims that denied incorrectly due to edit 3196 (annual physical assessment/ exam to be performed by EPSDT Provider) for dates of service on or after January 1, 2018 for preventive medicine CPT codes 99384, 99385, 99394, and 99395. Providers should continue to bill the appropriate preventive medicine CPT codes for FPW services. The mass adjustment will appear on a future remittance advice and no further action on the part of the provider is needed.

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

# PROVIDER COMPLIANCE

## New Billing Requirements Regarding Medicare Advantage Plan/ Traditional Medicare EOBs

The MS Division of Medicaid and Conduent State Healthcare have completed a recent review of Medicare claims submitted by paper or through the Envision web portal and discovered that there is a vast inconsistency in the information presented as Medicare reimbursement data on the Explanations of Benefits (EOB). Many of the presented EOBs fail to provide adequate and correct information. Therefore, effective 01/01/2019, the MS Division of Medicaid will require that the EOB for Medicare and Medicare Part C services billed to Medicaid must include the following fields:

- Medicaid Beneficiary Name
- Medicare ID or HIC
- Payer name (i.e., Novitas, Wellcare, United Healthcare, etc.)
- Paid Date (date Medicare or Medicare Advantage plan paid)
- Paid Amount (payment received from Medicare or Medicare Advantage plan paid)
- Allowed or Approved Amount- (amount the insurer allows for the service)
- Co-insurance (as specified by Medicare of applicable Health plan)
- Co-Pay (as specified by Part C Health plan)
- Deductible (a specified amount of money that the insured must pay before an insurance company will pay a claim)
- Blood deductible (if indicated – is in addition to any other applicable deductible and coinsurance amounts for which the patient is responsible)
- Sequestration (amounts are not covered by Medicaid and are not considered patient's responsibility)
- Contractual Adjustment (Optional – the amount agreed upon between the provider and the carrier)
- Service Level Information – (line level claims specific information)

Failure to adhere to the above guidelines may result in denial or delays to claims payment. For additional questions and assistance, contact Conduent Provider Services Call Center at 1-800-884-3222.

# COORDINATED CARE NEWS

## *DID YOU KNOW? - PROVIDER SATISFACTION SURVEYS*

Magnolia Health is constantly working to improve relationships and foster communication with our Provider partners. Your feedback is extremely important to us, and helps us tailor our Provider Relations program to better meet your needs. The annual Provider Satisfaction Survey will be sent to you in mid-July, and we encourage you to complete it and include any suggestions you may have to improve. We value our Providers for the wonderful service they provide to our Magnolia members and are certainly open to new ideas to improve our Provider Services.

## *PROVIDER DOCUMENTATION AND CODING TIPS*

Conditions that go undocumented usually also go untreated. This is just one of the important reasons that thorough and accurate coding is critical to patient care. Additionally, comprehensive coding provides specialists and ancillary providers insight into a patient's complete health profile. Please review the tips below to ensure that you are following the appropriate steps for accurate coding.

Provider Documentation and Coding Tips

## *PRIOR AUTHORIZATION TIP OF THE WEEK* URGENT PRIOR AUTHORIZATION REQUESTS

Magnolia Health wants to ensure that all URGENT Prior Authorization requests are expedited and processed in a timely manner with a determination and notification provided as expeditiously as possible. There can be a slight delay with submission via fax, therefore we encourage all providers to submit URGENT requests via the Secure Provider Web-Portal located on the Magnolia Health website at www.magnoliahealthplan.com.

## *PROVIDER PREVENTABLE CONDITIONS*

Consistent with the Affordable Care Act administered through the Centers for Medicare and Medicaid Services (CMS) and 42 CFR 434.6, 438.6, 447.26 and 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act, Magnolia has implemented the requirements related to the "Provider Preventable Conditions" (PPC) initiative, which includes: 1) Adjustment of reimbursement for Health Care-Acquired Conditions (HCAC); 2) Present on Admission (POA) indicator requirements; 3) No reimbursement for Never Events and; 4) Other Provider Preventable Conditions (OPPC) as defined by any additional State Regulations that are in place that expand or further define the CMS regulations.

Magnolia identifies Never Events and PPCs in several ways, including referrals, claims data, member and provider complaints, medical record review, and utilization management activities. All Magnolia staff (including Medical Management, Member Services, Provider Services, Provider Relations, MemberConnections® outreach, and Grievance and Appeal staff), independent, facility and ancillary providers, members, Medical Directors, and the Board of Directors may advise the Quality Management (QM) Department of potential PPCs. Never Events are identified by the following ICD-10 diagnosis codes:

* Y65.51 (ICD-10) Performance of wrong operation (procedure) on correct patient
* Y65.52 (ICD-10) Performance of operation (procedure) on patient not scheduled for surgery
* Y65.53 (ICD-10) Performance of correct operation (procedure) on the wrong side/body part

## *A HEALTHY MOTHER'S JOURNEY PROGRAM*

Magnolia Health wants to make a positive impact on important measures such as Infant Mortality and Low Birth Weight. We are partnering with OB providers to make sure we can remove barriers to identification and care of our shared pregnant women using drugs or alcohol. We will be reaching out to your offices to inquire about your needs in this area and to obtain feedback regarding our programs.

Please click the link below to learn more about our program from our Chief Medical Director.

Healthy Mother's Journey Provider Letter (PDF)

## *MAGNOLIA HEALTH DEPARTMENT CONTACT INFORMATION*

Magnolia Health is your partner in the care of your Magnolia Health patients.

If you have any questions, or need additional information, please contact us at the numbers in the link below.

Provider Contact Information Flyer

# COORDINATED CARE NEWS

## *PRIOR AUTHORIZATION TIP OF THE WEEK*

Top 2 Reasons for an Adverse Medical Necessity Authorization Determination:

1. Requested additional information is not submitted timely
2. Medical necessity criteria is not met

Providers can prevent an adverse medical necessity authorization determination by including all pertinent information to support medical necessity with the initial request for authorization. The provider who is requesting the services should be listed as the requesting provider on the prior authorization form. By doing this, it ensures requests for additional information are received timely.

Magnolia Health would like to thank you for the care that you provide to your patients and our members. Please reach out to our Utilization Management team at 1-866-912-6285 with any questions you may have.

## *MAGNOLIA HEALTH INPATIENT AUTHORIZATIONS*

- Magnolia Health requires prior authorization for all **elective** admissions.
- Additionally, requests for **emergency admissions** require notification within one business day and full authorization (which includes all supporting clinical documentation to support medical necessity) within 2 business days.
- Requests for **full admission** must meet InterQual medical necessity criteria and level of care criteria.
  - If the request is for full admission but does not meet InterQual criteria for admission, the request will be denied.
  - The facility has the right to appeal the decision of denial.
  - In the event that a request meets InterQual for both full inpatient admission and Observation, then the full admission will be denied in accordance with the Mississippi Medicaid Administrative Code Title 23 Part 200 General Provider Information Rule 5.1 Medically Necessary B.6. and the facility should maintain the beneficiary in Observation for 48 hours. Magnolia Health does not require authorization for Observation.
- Follow the workflow below to ensure the beneficiary is being treated at the appropriate level of care and the facility receives payment for services.

### Workflow for Inpatient Authorization:

1. Does this beneficiary have a condition for which a hospital stay of greater than 48 hours is expected?
   a. If **no**, maintain the beneficiary in Observation status for 48 hours. Authorization is not required for Observation.
   b. If **yes**, submit authorization request along with all supporting clinical documentation within 2 business days.

2. This beneficiary was denied for full admission because criteria was met for a lower level of care. What next?
   a. Maintain the beneficiary in Observation status. Authorization is not required for Observation.
   b. Submit a claim for Observation stay upon discharge if the beneficiary is discharged within 48 hours.

3. Has the member been in Observation status for 48 hours and remains hospitalized?
   a. If **no**, submit claim for Observation stay when discharged.
   b. If **yes**, contact Magnolia Utilization Management for an additional review. If the request meets InterQual criteria for full admission, it will be approved with dates of service including the Observation stay.

4. A claim was submitted for full admission when criteria was met for a lower level of care and the claim denied. What next?
   a. Submit a claim for Observation stay.
   b. The claim will be paid at the current Medicaid Fee Schedule rate for Observation.

# COORDINATED CARE NEWS

UnitedHealthcare wants to support our Mississippi providers in providing the best possible care. Stay up to date with the latest news, articles, and policies that affect your patients and your practices. Click on https://www.uhccommunityplan.com/health-professionals/ms for featured articles of interest including billing tips, case management resources, latest technology resources and more!

## UnitedHealthcare

UnitedHealthcare Community Plan of Mississippi would like to thank our providers for a great summer! As we move into Fall and Winter, we would like to share a few reminders:

1. **Annual Flu Shots -** We encourage all of our members to receive their annual flu shots. As with all primary care services, we are committed to ensuring that all members have access to flu and other vaccines. If there is ever a challenge obtaining vaccines (or any service), our care management team wants to know. UHC Case Management can be contacted by calling Member Services at 877-743-8731 and specifically requesting Case Management.

2. **New provider website UHCProvider.com -** UnitedHealthcare has a new provider website UHCProvider.com. We encourage our providers to explore this site and become familiar with it and our new resources, UHC On Air and Link. UHC On Air is an on-demand resource that has several short videos that include areas of interest including continuing education and navigating gaps in care. Link is the provider portal that has many shortcuts for providers including interfaces with CAQH for credentialing and OptumRX to determine if prior authorizations are required for drugs.

3. **Annual Provider Satisfaction Survey -** Through the end of the year, UnitedHealthcare is conducting an annual Provider Satisfaction survey. This is being administered by Market Strategies research firm. If you are one of our randomly selected providers, we encourage you to take the short survey. We use the feedback to make improvements in how we administer MississippiCAN and CHIP programs.

4. **UHC Newsletter Updates -** As always, we want our Mississippi providers to stay informed of Mississippi changes. These are usually highlighted in our quarterly provider newsletter which can be found at https://www.uhccommunityplan.com/health-professionals/ms/provider-news.html

5. **Billing Inpatient Hospital Services vs. Outpatient Hospital Services**
   - UnitedHealthcare wishes to remind hospitals that admission notification is required for inpatient stays. When cases do not meet inpatient criteria, providers should bill according to the services provided.
   - If a claim is billed for an inpatient stay but not supported, providers should review the claim to see if observation status could have been an option.
   - As with any claim that a provider wishes to correct, UHC has a "corrected claim" process.
     - This process is used when a provider wishes to discard the originally filed claim and resubmit.
     - Please note, that a "corrected claim" will void ALL information on the original claim, including any line that has paid.
     - Therefore, when a "corrected claim" is submitted, all of the charges should be included (original and edited lines).
     - Alternatively, if a provider believes that the claim was accurately billed but wishes to include additional supporting information, a "reconsideration" with the supplemental information can be submitted.
     - Both the "corrected claim" and "reconsideration" processes can be performed via the provider portal (Link).
   - A quick reference guide can be found at:
     - https://www.uhcprovider.com/content/dam/provider/docs/public/claims/claimsLink-Claim-Reconsideration-Corrected-Claims-QRG.pdf

# COORDINATED CARE NEWS

## Providers Can Now Contract with Molina Healthcare

Although we are new to Mississippi, Molina Healthcare is a FORTUNE 500 company that has been providing managed health care services through government-sponsored programs since 1980. Our mission is to provide quality health services to people receiving government assistance. The organization currently serves approximately 4.1 million members across the U.S. and the Commonwealth of Puerto Rico.

Molina Healthcare is a leader in quality with the majority of its health plans accredited and rated by the National Committee for Quality Assurance (NCQA). Our goal is to assist members in maintaining good health by incentivizing regular doctor visits, and by offering a variety of disease management, health education, and care management programs to MSCAN participants.

Being an integral part of the communities that Molina serves is the foundation of all that we do. Each of our local health plans hosts and contributes to community events such as health fairs and immunization drives, to assist in improving access to care and quality of life. 11 of our 13 plans have earned the Multicultural Health Care Distinction from the Robert Wood Johnson Foundation, for organizations that meet or exceed its rigorous requirements for providing care in a culturally sensitive manner.

This expertise in working with Medicaid patients also serves to support Molina providers. We have a dedicated Provider Field Services team that will services providers in all 82 counties. Our web portal offers a number of functionalities to providers including electronic claims and Prior Authorization submissions, important forms, Medicaid Preferred Drug List (PDL), Preventive Health Guidelines, and More! Web portal trainings will be provided along with weekly Provider Webinars that will cover an array of topics.

We encourage providers to enroll with Molina today in order to submit claims and receive timely payment for services rendered to Molina members. Credentialing is an important part of our contracting process. It is imperative that Providers submit correct information when contracting with Molina. Provider information submitted to Molina should be consistent with information that was given for Medicaid provider enrollment.

If you have any questions or would like to enroll as a provider with Molina Healthcare, please contact Molina Provider Services at (844) 826-4335 or email MHMSProviderContracting@molinahealthcare.com.

For more information about Molina, please visit MolinaHealthcare.com.

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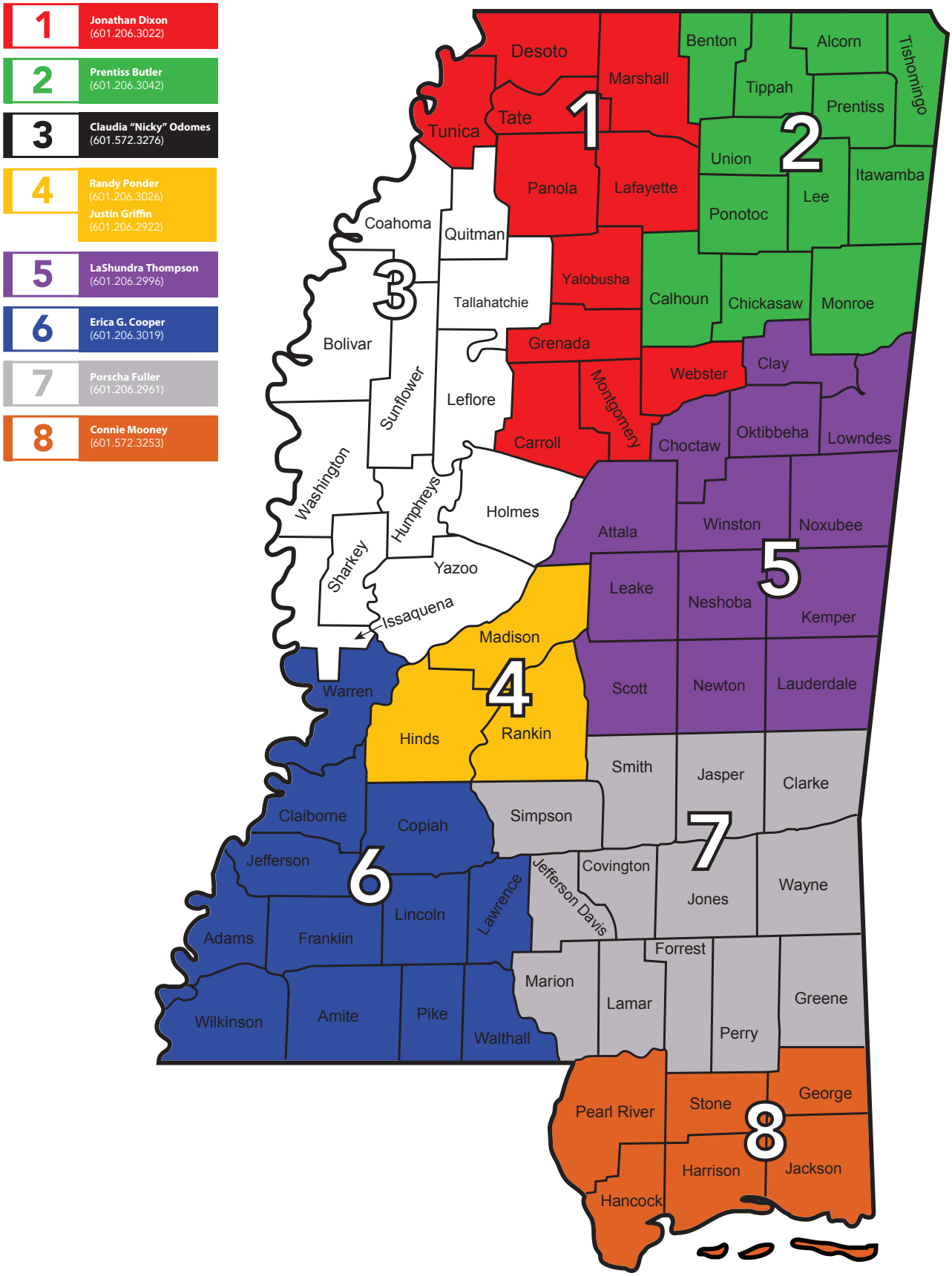
## MS Medicaid Pharmacy Contact and Billing Information

Effective 10/01/2018

| | Plan | Claims Processor | Pharmacy POS Claims Provider Help Desk | Prior Authorization Provider Help Desk | Banking Identification Number (BIN) | Processor Control Number (PCN) | RX Group | Network Reimbursement ID |
|---|---|---|---|---|---|---|---|---|
| FFS | Medicaid Fee For Service | Conduent | 1-800-884-3222 | 1-877-537-0722 (Change Healthcare) PA Fax: 1-877-537-0720 | 610084 | DRMSPROD/SIPPI | | |
| MSCAN | Magnolia Health Plan – MSCAN | Envolve | 1-800-460-8988 Local Number: 1-866-912-6285 ext. 66409 (Pharmacy should state they've called the **Envolve** Help Desk without resolution.) | 1-866-399-0928 PA Fax: **(Effective 11/1/18)** 1-877-386-4695 | 020545 | RXA371 | RXGMSSTD | RXA371 |
| MSCAN | Molina Healthcare – MSCAN | CVS Caremark | 1-800-364-6331 Local Number: 1-844-826-4335 (Pharmacy should state they've called the **CVS Caremark** Help Desk without resolution.) | 1-844-826-4335 PA Fax: 1-844-312-6371 | 004336 | MCAIDMS | RX6436 | MCAIDMS |
| MSCAN | United Healthcare – MSCAN | OptumRx | 1-877-305-8952 Local Number: 601-718-6549 (Pharmacy should state they've called the **OptumRx** Help Desk without resolution.) | 1-800-310-6826 PA Fax: 1-866-940-7328 | 610494 | 4646 | ACUMS | AMCMS4 SPP-MS |
| CHIP | Magnolia Health Plan – CHIP | Envolve | 1-800-460-8988 Local Number: 1-866-912-6285 ext. 66409 (Pharmacy should state they've called the **Envolve** Help Desk without resolution.) | 1-866-399-0928 PA Fax: **(Effective 11/1/18)** 1-877-386-4695 | 020545 | RXA372 | RXGMSCHIP | RXA372 |
| CHIP | United Healthcare – CHIP | OptumRx | 1-877-305-8952 Local Number: 601-718-6549 (Pharmacy should state they've called the **OptumRx** Help Desk without resolution.) | 1-800-310-6826 PA Fax: 1-866-940-7328 | 610494 | 4747 | ACUMS | OMSCH1 OMSCH2 OMSCH3 SPMSCH |

December 2018

# FIELD REPRESENTATIVE REGIONAL MAP



# PROVIDER FIELD REPRESENTATIVES

| PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY | | |
|---|---|---|
| **AREA 1**<br>**Jonathan Dixon (601.206.3022)**<br>jonathan.dixon@conduent.com | **AREA 2**<br>**Prentiss Butler (601.206.3042)**<br>prentiss.butler@conduent.com | **AREA 3**<br>**Claudia "Nicky" Odomes (601.572.3276)**<br>claudia.odomes@conduent.com |
| **County** | **County** | **County** |
| Desoto | Benton | Coahoma |
| Tunica | Tippah | Quitman |
| Tate | Alcorn | Bolivar |
| Panola | Tishomingo | Sunflower |
| Marshall | Prentiss | Leflore |
| Lafayette | Union | Tallahatchie |
| Yalobusha | Lee | Washington |
| Grenada | Pontotoc | Sharkey |
| Carroll | Itawamba | Humphreys |
| Montgomery | Calhoun | Yazoo |
| Webster | Chickasaw | Holmes |
| | Monroe | Issaquena |
| ***Memphis** | | |
| **AREA 4**<br>**Justin Griffin (601.206.2922)**<br>justin.griffin@conduent.com<br>**Randy Ponder (601.206.3026)**<br>randy.ponder@conduent.com | **AREA 5**<br>**LaShundra Thompson (601.206.2996)**<br>lashundra.othello@conduent.com | **AREA 6**<br>**Erica G. Cooper (601.206.3019)**<br>ERICA.Cooper@conduent.com |
| **County** | **County** | **County** |
| Hinds | Clay | Warren |
| Rankin | Oktibbeha | Claiborne |
| Madison | Choctaw | Jefferson |
| | Attala | Adams |
| | Leake | Franklin |
| | Scott | Wilkinson |
| | Lowndes | Amite |
| | Winston | Copiah |
| | Noxubee | Lincoln |
| | Neshoba | Pike |
| | Kemper | Lawrence |
| | Newton | Walthall |
| | Lauderdale | |
| **AREA 7**<br>**Porscha Fuller (601.206.2961)**<br>porscha.fuller@conduent.com | | **AREA 8**<br>**Connie Mooney (601.572.3253)**<br>connie.mooney@conduent.com |
| **County** | | **County** |
| Simpson | | Pearl River |
| Jefferson Davis | | Stone |
| Marion | | George |
| Lamar | | Hancock |
| Covington | | Harrison |
| Smith | | Jackson |
| Jasper | | |
| Jones | | **Slidell, LA** |
| Forrest | | **Mobile, AL** |
| Perry | | |
| Greene | | |
| Wayne | | |
| Clarke | | |
| **OUT OF STATE PROVIDERS** | **Latasha Ford (601) 572-3298** Latasha.Ford @conduent.com | |

**CONDUENT**
**P.O. BOX 23078**
**JACKSON, MS 39225**

***If you have any questions related to the topics in this bulletin, please contact Conduent at 800 - 884 -3222***

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

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

## DECEMBER 2018

| | |
|---|---|
| MON, DEC 3 | Checkwrite |
| THURS, DEC 6 | EDI Cut Off - 5:00 p.m. |
| MON, DEC 10 | Checkwrite |
| THURS, DEC 13 | EDI Cut Off - 5:00 p.m. |
| MON, DEC 17 | Checkwrite |
| THURS, DEC 20 | EDI Cut Off - 5:00 p.m. |
| MON, DEC 24-<br>TUES, DEC 25 | DOM Closed |
| THURS, DEC 27 | EDI Cut Off - 5:00 p.m. |
| MON, DEC 31<br>TUES, JAN 1 | DOM Closed |

## JANUARY 2019

| | |
|---|---|
| THURS, JAN 3 | EDI Cut Off – 5:00 p.m. |
| MON, JAN 7 | Checkwrite |
| THURS, JAN 10 | EDI Cut Off – 5:00 p.m. |
| MON, JAN 14 | Checkwrite |
| THURS, JAN 17 | EDI Cut Off – 5:00 p.m. |
| MON, JAN 21 | Martin Luther King, Jr. Day<br>DOM Closed |
| THURS, JAN 24 | EDI Cut Off – 5:00 p.m. |
| MON, JAN 28 | Checkwrite |
| THURS, JAN 31 | EDI Cut Off – 5:00 p.m. |

## FEBRUARY 2019

| | |
|---|---|
| MON, FEB 4 | Checkwrite |
| THURS, FEB 7 | EDI Cut Off – 5:00 p.m. |
| MON, FEB 11 | Checkwrite |
| THURS, FEB 14 | EDI Cut Off – 5:00 p.m. |
| MON, FEB 18 | President's Day<br>DOM Closed |
| THURS, FEB 21 | EDI Cut Off – 5:00 p.m. |
| MON, FEB 25 | Checkwrite |
| THURS, FEB 28 | EDI Cut Off – 5:00 p.m. |

**Checkwrites and Remittance Advices are dated every Monday. Provider Remittance Advice is available for download each Monday morning at www.ms-medicaid.com. Funds are not transferred until the following Thursday.**