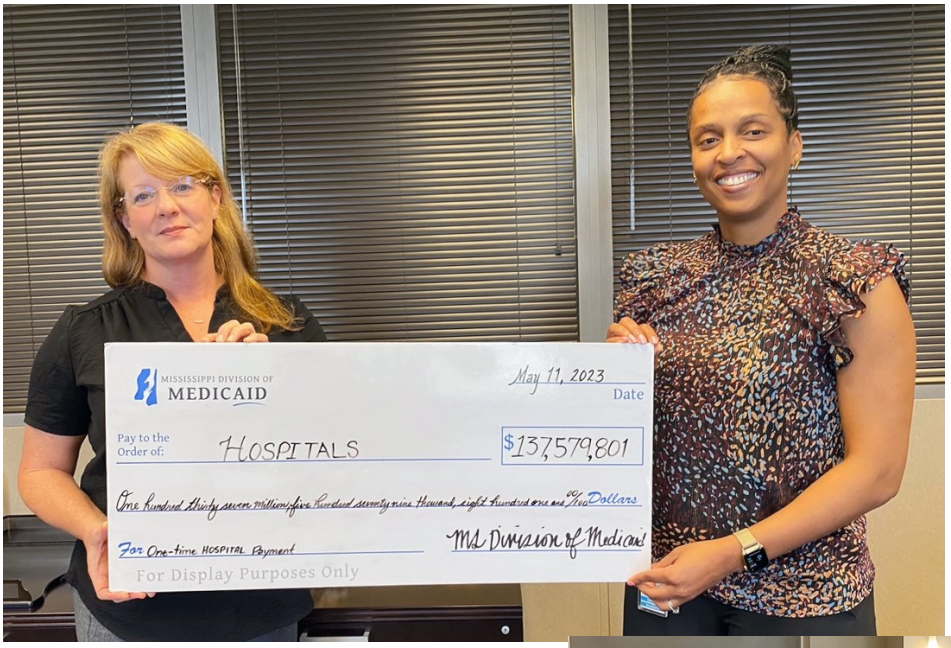
MS Medicaid
PROVIDER BULLETIN
MISSISSIPPI DIVISION OF MEDICAID

# DOM gains approval for $137 million in supplemental payments to qualifying hospitals




In May, the Mississippi Division of Medicaid (DOM) received approval from the Centers for Medicare and Medicaid Services to make a one-time supplemental payment for qualifying hospitals in the total amount of $137 million. The payments were made on May 11, 2023, before the federal public health emergency expired. Pictured are DOM's Jennifer Wentworth (left) and Christine Woodberry.

The supplemental payments were highlighted along with other recent DOM programmatic updates during the latest Medical Care Advisory Meeting, which was held in Jackson on May 12, 2023.

## IN THIS ISSUE

Provider Compliance .....2
Pharmacy News .....8
Coordinated Care News .....9
Provider Field Rep Map ..... 13
Provider Field Rep Listing ..... 14
Calendar of Events ..... 15

# PROVIDER COMPLIANCE

## Centralized Credentialing for MSCAN/ MSCHIP

During the 2021 Mississippi Legislative Session, Senate Bill 2799 was enacted into law that requires the Medicaid Coordinated Care Organizations (CCO) to follow a uniform credentialing process for provider enrollment in the Managed Care Programs. On July 1, 2022, in accordance with this new requirement, the Mississippi Division of Medicaid (DOM) amended the CCO contracts to require the CCOs to accept DOM's provider enrollment and screening process, and not require providers be credentialed by CCOs for Medicaid or CHIP.

Beginning October 1, 2022, providers seeking participation in MississippiCAN and/or CHIP are now required to be enrolled, credentialed, and screened by DOM, and subsequently contract with their CCO of choice. As part of the implementation of the Medicaid Enterprise System Assistance (MESA), DOM implemented a new centralized credentialing process along with NCQA certified Centralized Verification Organization (CVO) that will be responsible for credentialing and recredentialing Medicaid providers seeking to enroll or currently enrolled with our coordinated care programs (MSCAN/CHIP). This new process eliminates the need for a provider to be credentialed or recredentialed multiple times.

The CVO will perform recredentialing for both current providers and new providers every three (3) years unless the provider is credentialed by a DOM-approved Delegated Credentialing Entity. Providers identified for credentialing will receive notification from Gainwell Technologies by letter, which is sent to the providers "mail to" address on their provider record. This letter is generated six months in advance of the recredentialing due date on the provider's record to MESA and a link will be available in the portal to start the process.

Facilities with multiple service locations and provider IDs will receive a recredentialing notice for each provider ID. Only one provider ID for the same tax ID, taxonomy, and service location address will need to submit the recredentialing application which will pick up and credential all the taxonomies at that location. If recredentialing is either denied or not completed by the recredential due date, all the facility enrollments at that location will be terminated from participation in MSCAN and MS CHIP. A provider will be required to complete the add program process in the provider portal for each taxonomy at that service location to re-enroll in the MSCAN and/or MSCHIP programs.

Individual providers with multiple provider IDs sharing the same NPI and taxonomy will receive a recredentialing notice for each of the provider IDs. The provider will only need to recredential one of the IDs to satisfy the requirement for all. If recredentialing is either denied or not completed by the recredential due date, all the individual provider's enrollments will be terminated from participation in MSCAN and MSCHIP. A provider will be required to complete the add program process in the provider portal for each taxonomy at that service location to re-enroll in the MSCAN and/ or MSCHIP programs.

Providers can refer to DOM's website where we are posting the **Provider Six-Month Recredentialing Due List** at https://medicaid.ms.gov/. 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.

# PROVIDER COMPLIANCE

## Submission of Administrative Review for Timely Filing

The Mississippi Division of Medicaid (DOM) has established a convenient and efficient way to submit a request for Administrative Review of claim denials for timely filing when attempting to resubmit or adjust the claim. (All requests for Administrative Review for Timely Filing must be submitted within 90 days of the claim denial). This is for providers whose original claim submission was timely and resubmitted a claim during the timely processing period that was denied for timely filing. Claims are considered to comply with timely filing if they are submitted within 365 days from the date of service or 180 days from the Medicare paid date, whichever is applicable.

Providers have 365 days from the date of the original claim submission for Medicaid Fee for Service claims or 180 days from the Medicare Paid date to adjust or resubmit claims, whichever is applicable. Medicaid may request additional information regarding any claims submitted for administrative review. For questions related to appeals, see https://medicaid.ms.gov/wp-content/uploads/2023/03/Title-23-Part-300-Appeals-eff.-03.01.23.pdf.

Review the Administrative Code or contact the appropriate provider representative for questions related to claims or claims billing. The Provider Field Representative list includes email addresses and phone numbers for each representative. This resource document is located at https://medicaid.ms.gov/wp-content/uploads/2022/12/Provider-Field-Representatives.pdf. We understand the importance of streamlining administrative processes to ensure prompt reimbursement

Effective immediately, Medicaid providers can use this user-friendly platform which eliminates the need for traditional paper-based submissions, reducing manual processing time and enhancing accuracy. By transitioning to an online system, we aim to simplify the process while optimizing efficiency for both providers and DOM staff

**Key Benefits of the Online Submission Process:**

- Time-saving: Submit your timely filing requests in a matter of minutes, eliminating the need for making or faxing paperwork.
- 24/7 accessibility: Our online portal is available around the clock, allowing you to submit requests at your convenience.

To access the online submission process, please visit DOM's website at www.medicaid.ms.gov, where the Timely Filing Review Request Form is linked under "Providers," or access the form directly here: https://app.smartsheet.com/b/form/da88ccd3b00f4c7fb87dddda92264d99.

The Division of Medicaid remains committed to delivering quality service and fostering partnerships with our valued providers. Should you have any questions or need assistance regarding the new online submission process, our dedicated support team is ready to assist you. Reach out to DOM's Provider and Beneficiary Call Center at (800) 421-2408 and ask for one of our Provider Customer Service Representatives during regular business hours.

Thank you for your ongoing commitment to providing essential healthcare services to Mississippi Medicaid beneficiaries. We appreciate your cooperation in adopting this new online submission process, which will enable us to better serve you and the community.

# PROVIDER COMPLIANCE

## DOM Resumes Provider Maintenance Operations (Licensure Review)

Under 42 CFR § 455.412, the Mississippi Division of Medicaid (DOM) has resumed 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. In addition to the notices mailed by Gainwell Technologies, providers can refer to DOM's website where we are posting the **Provider Six-Month License Due List** at https://medicaid.ms.gov/.

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

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

## Attention: Acute Psychiatric Hospital Providers

### Important Reminder about Discharge/ Aftercare Plan

The Division of Medicaid requires that all Acute Psychiatric Hospital providers adhere to federal and state rules and regulations.

Per **42 CFR 482.43**, Condition of participation: Discharge planning is a mandated procedure that should begin immediately after admission and be updated throughout the inpatient stay.

**42 CFR 482.43(b)** indicates that at the time of discharge all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences be provided to the appropriate post-acute care providers responsible to the patient's follow up or ancillary care.

Proper discharge/aftercare planning allows patients to achieve continuity and coordination of care and treatment by establishing supports in the community that correspond with their level of care.

Specific rules and regulations related to discharge planning and aftercare can be found in **Subchapter 39 of the Minimum Standards of Operation for Psychiatric Hospitals** located on the MS Department of Health (MSDH) website or can be accessed by clicking on the following link:

PsychiatricHospitals_MinimumStandards.pdf

## Attention: In-Patient Hospital Providers, APR-DRG Alert

The Mississippi Division of Medicaid is proposing the following changes to the hospital inpatient APR-DRG payment methodology effective for the payment of hospital inpatient claims for discharges on and after July 1, 2023.

1. DOM will adopt V.40 of the 3M Health Information Systems (3M HIS) APR-DRG Grouper and Hospital-Specific Relative Value (HSRV) weights.

2. Re-center V.40 HSRV weights to a population Case-Mix Index (CMI) of 1.0

3. The following APR-DRG parameters will be updated:

   A. Base Payment — will change from $5,350 to $5,400
   B. Adult mental health policy adjustor — will change from 1.45 to 1.50
   C. Obstetrics policy adjustor — will change from 1.40 to 1.50
   D. Normal newborn policy adjustor — will change from 1.45 to 1.55
   E. Neonate policy adjustor — will change from 1.40 to 1.60
   F. Rehab policy adjustor — will change from 2.0 to 2.10
   G. DRG Cost Outlier Threshold — will change from $60,000 to $66,000
   H. DRG Cost Outlier Marginal Percentage — will change from 50 percent to 45 percent

When using a calendar year 2021 claims data set, DOM estimated the overall impact of the above changes would be a savings of $137,954 in state and federal funds.

# PROVIDER COMPLIANCE

***Continued from page 5***

Please keep in mind that hospitals are not required to purchase 3M software for payment of claims; however, all hospitals that have purchased the 3M software should ensure their internal systems are updated to reflect all changes that occur for hospital discharges beginning on and after July 1, 2023.

Sessions regarding APR-DRG payment updates will be scheduled with dates to be provided. Hospitals will be notified via e-mail and the DOM website www.medicaid.ms.gov.

## Attention: Outpatient Hospital Providers of Acute Partial Hospitalization and Intensive Outpatient Programs

## Reminder: Alliant Prior Authorization Requests

Going forward, please be sure to include the number of units needed when you are entering your initial prior authorization (PA) request for the following procedure codes: H0015, H0035, and S9480.

This should decrease the number of PA related claim denials for these services in the MESA system.

## Attention: Nursing Facility Providers

## October 1, 2023, Changes to Mississippi's Required Nursing Facility MDS Assessment Schedule and Incorporation of the Optional State Assessment (OSA)

States wishing to maintain a RUGS-based base mix reimbursement system must require Medicaid-certified nursing facilities to complete the OSA with each federally-required MDS assessment. Beginning October 1, 2023, the OSA will be the only assessment type that will include all Minimum Data Set (MDS) data elements required for Resource Utilization Group (RUG) classification. As of October 1, 2023, the Mississippi Division of Medicaid (DOM) is requiring that a concurrent OSA be completed, with the same Assessment Reference Date (ARD), as each federally required assessment submitted. This will allow for a RUGs-based case mix score to be calculated and the current RUG-based reimbursement methodology to continue beyond October 1, 2023.

The incorporation of the OSA will result in additional consideration around the determination of delinquent records. Effective for MDS assessments with target dates of October 1, 2023, and after, the determination of delinquent MDS assessments will be as follows:

1. Any assessment record with an assessment reference date (ARD A2300) greater than 92 calendar days from the previous ARD (A2300) is deemed delinquent.
2. Federally required MDS assessment records without a concurrent OSA will be deemed delinquent for all days assigned to the assessment record (beginning on the ARD, Entry Date, Quarter Start Date, etc.).
3. Delinquent assessment records will be assigned a RUG-code and the associated case mix index of BC1 as occurs today.
4. OSA record submissions with an ARD (A2300) that does not match a federally required assessment will be excluded from MDS processing and case mix index calculation, which may result in delinquent record determinations.

DOM recommends that nursing facilities start reviewing their internal software systems for OSA compatibility prior to October 1, 2023, in

# PROVIDER COMPLIANCE

***Continued from page 6***

preparation for the implementation of the OSA requirement. DOM is sympathetic to nursing facility concerns regarding the duplication of information in the OSA, which may increase the administrative burden of completing MDS assessment submissions. As such, it is encouraged that providers work with their respective association representatives and MDS software vendors to streamline data input for fields that are duplicated on federally required assessments and the OSA.

If you have any questions or comments please contact the Mississippi help desk at: 800-773-8609 or MSHelpDesk@mslc.com.

## Attention: Board Certified Behavior Analyst Providers (BCBA) for Autism Spectrum Disorder (ASD) Service

As a reminder, MS Board Certified Behavior Analysts (BCBAs) may only be reimbursed for medically necessary ASD Services.

These services are provided to EPSDT-eligible Medicaid beneficiaries and rendered in accordance with their professional licensure and scope of practice. BCBA providers should reference the Autism Spectrum Disorder Services Fee Schedule for a list of reimbursable services and procedure codes. The ASD fee schedules can be found at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

Failure to obtain prior authorization will result in denial of payment. DOM is contracted with Alliant Health Solutions as the UM/QIO vendor, responsible for determining medical necessity for fee-for-services (FFS) beneficiaries. Please refer to Alliant Health Solutions' provider portal https://ms.allianthealth.org/ or call Alliant directly at 1-888-224-3067.

Please direct questions regarding ASD services to Penny Hall or Kimberly Sartin Holloway at 601-359-9545.

*Click the links below to access portal resources.*



# PHARMACY NEWS

## Vaccine Administration Fee Updates

Since 2021, pharmacy providers have been able to bill all vaccines approved by the Advisory Committee on Immunization Practices (ACIP) for beneficiaries aged 19 and over via NCPDP D.0 pharmacy claims. Vaccine administration fee updates, effective 7/1/23, can be found on Division of Medicaid's Pharmacy website at Pharmacy—Mississippi Division of Medicaid. Please bookmark this site as it is updated often.

Pharmacy providers may also administer vaccines to beneficiaries aged 10-18 if enrolled as a Vaccine for Children (VFC) provider with the Mississippi State Department of Health. DOM is currently working with Gainwell Technologies (GWT) to update the pharmacy claims system to enable vaccine billing by pharmacy VFC providers. COVID-19 vaccines are not included in the VFC program and providers are allowed to administer and bill Medicaid for vaccines to children aged 10 and over.

The Division of Medicaid appreciates the vital role pharmacy providers play in increasing beneficiary access to vaccines and improving overall vaccination rates.

## DOM Covering Drugs Used to Treat Obesity

Effective July 1, 2023, DOM will cover drugs used in the treatment of obesity. A list of these drugs can be found on page 29 of the Universal Preferred Drug List (PDL) at this link: Therapeutic Drug Class. Preferred products are Contrave (naltrexone/bupropion), Saxenda (liraglutide), and Wegovy (semaglutide). Nonpreferred products are legend, generic orlistat, and Xenical (orlistat). Both preferred and nonpreferred products will require prior authorization (PA). PA criteria can be found at Pharmacy Prior Authorization—Division of Medicaid, under Prior Authorization Packets, at the link entitled, Anti-Obesity Select Agents.

# COORDINATED CARE

## Optum/United Behavioral Health Provider Relations

Please contact us with any questions so that together we can make the health care system work better for everyone.

**Rusty Palmer, LPC-S**
**Network Manager (MS) - North**
**Optum/United Behavioral Health**
Email: James.Palmer@optum.com
Phone: (651) 495-5298
Fax: 1-855-291-7422

**Dawn Teeter**
**Network Manager (MS) South**
**Optum/United Behavioral Health**
Email: Dawn.Teeter@optum.com
Phone: (952) 687-4121
Fax: 1-844-328-5129


## United Healthcare

### Access and Availability Standards

As a reminder, primary care providers (PCPs) and obstetricians must be available to members by phone 24 hours a day, 7 days a week, or have arrangements for telephone coverage by another UnitedHealthcare participating PCP or obstetrician. Any coverage arrangements that deviate from this requirement must be approved by a UnitedHealthcare medical director or physician reviewer.

### Standards for Timely Appointment Scheduling:

#### *Emergency Care*

Immediately upon the member's presentation at a service delivery site.

#### *Primary Care*

Urgent, symptomatic office visits must be available from the member's PCP or another care provider within 24 hours. This would involve the presentation of medical symptoms that require immediate attention, but are not life-threatening.

Routine office visits or non-urgent, symptomatic must be available from PCP or another care provider within seven calendar days. A non-urgent, symptomatic office visit would involve medical symptoms that don't require immediate attention.

Non-symptomatic office visits must be available from the member's PCP or another care provider within 30 calendar days. This type of visit could include wellness and preventive care such as physical examinations, annual gynecological examinations, child and adult immunizations or other services.

# COORDINATED CARE

*continued from page 9*

### *Specialty Care*

Specialist and specialty clinics should arrange appointments within 45 days.

### *Behavioral Health (Mental Health and Substance Abuse)*

Behavioral health care providers should arrange appointments for:

- Emergency care (non-dangerous to self or others) immediately upon presentation;
- Urgent problems within 24 hours of the member's request;
- Post discharge from an acute psychiatric hospital within seven days;
- Routine non-urgent issues within 21 days of the mentor's request.

### *After-Hour Care : Members Need to Be Able to Reach a Provider by Phone After Normal Business Hours*

### Physicians (PCP, Specialists, and Behavioral Health) are required to provide 24 hours a day, seven days a week coverage to members.

**Acceptable after-hours messages or responses/coverage are**:

- Primary Care Providers (PCPs) answering service will verify that it will contact the physician on-call for a patient's emergency.
- PCPs triage nurse will verify that he or she will speak with the patient for an emergency call, evaluate the nature of the emergency and contact the physician on-call, or direct the patient to a hospital emergency room.
- PCP can be reached when called directly.
- PCP's office phone message directs the patient to call a specific telephone number to reach the PCP's answering service, who will then contact the physician on-call for the emergency.
- PCP's office answering machine directs the patient to call a specific telephone number to reach a hospital switchboard and/or hospital emergency room that will reach the physician on-call for emergencies.

**Unacceptable after-hours messages or responses/coverage are:**

- PCP's answering machine directs the patient to proceed to the nearest hospital emergency room.
- PCP's office telephone number rings without an answer.

### United Healthcare

### Reminder: Hospice Payment Guidelines

UHC requires hospice services to be billed with both the applicable revenue code and HCPC code on a UB-04 form. All hospice services require prior authorization. To request a prior authorization, codes T2041-T2045 are used for authorization and identification on a claim.

It was recently identified that the T codes were inappropriately placed back on the United's internal "non- covered" code list and resulted in incorrect claim denials. Any claims impacted by this issue will be adjusted if an authorization is on file and the final claim contains the correct coding.

# COORDINATED CARE

## Magnolia Health

### Updated Claim Dispute Process for MSCAN

Magnolia Health is updating our Claim Appeal timeframe to align with the Division of Medicaid's timeframe of 30 days that went into effect July 1, 2017. MississippiCAN claim appeals must be received within 30 days from the date of notification of payment or denial, rather than 90 days.

- **The First-Time Claim submission timeframe will not change.** First-time clean claims must be submitted within 180 days of the member's service date.
- **The Reconsiderations process and timeframe will not change**. Reconsiderations are optional in the claim dispute process. Reconsiderations must be submitted within 90 days of the Explanation of Payment (EOP) or Denial.
- **Corrected Claims timeframe will not change.** Corrected claims must be received within 90 calendar days from the notification of payment or denial.
- **UPDATE:** The Claim Appeal must be received within 30 days from the date of notification of payment or denial.

**Corrected Claims and Reconsiderations** can be submitted through the Magnolia Secure Provider Portal, through your preferred clearinghouse, or by mail to Magnolia Health, Attn: Corrected Claim, P.O. Box 3090. Farmington, MO 63640-3800.

- The claim should include the appropriate resubmission code, and the original claim number, or EOP must be included with the resubmission code and original claim number (or include the EOP) may result in the claim being denied as a duplicate, a delay in the reprocessing, or denial for exceeding the timely filing limit.

**Request for Claim Reconsideration** can be submitted by logging into your Magnolia Secure Provider Portal or by mail to Magnolia Health, Attn: Reconsideration, P.O. Box 3090, Farmington, MO 63640-3800. Magnolia encourages providers to utilize the Secure Web portal or the **Reconsideration Dispute Form** when submitting a reconsideration request.

- A request for reconsideration is a written communication from the provider about a disagreement of a processed claim.
- Request must include sufficient identifying information which includes, at minimum, the patient's name, ID number, date of service, total charges, and provider name.
- Documentation must also include a detailed description of the reason for the request.

***Important:*** *Please note that that a request for reconsideration cannot be filed after a request for a claim appeal or exhausting the claim dispute process.*

If the corrected claim or the request for reconsideration results in an adjusted claim, you will receive a revised Explanation of Payment. If the original decision is upheld, the provider will receive a revised EOP or letter detailing the decision, and the next step in the claim dispute process.

**Request for Claim Appeal** must be submitted by mail to Magnolia Health, Attn: Dispute, P.O. Box 3090, Farmington, MO 63640-3800.

# COORDINATED CARE

***Continued from page 11***

To ensure timely processing, please utilize the new Claim Appeal form or the request must be marked as “Claim Appeal” at the top of your documentation. Request must include detailed and sufficient information, which includes the reason for the claims appeal request, the patient’s name, patient ID number, date of service, total charges, and provider name.

If the request for a claim appeal is upheld or overturned, you will receive a letter detailing the decision. Please note that reconsideration cannot be filed after an appeal.

If you have questions about this process or want to receive education related to the changes, do not hesitate to contact Provider Services at 1-866-912-6285 or your Provider Engagement Representative.

## Magnolia Health

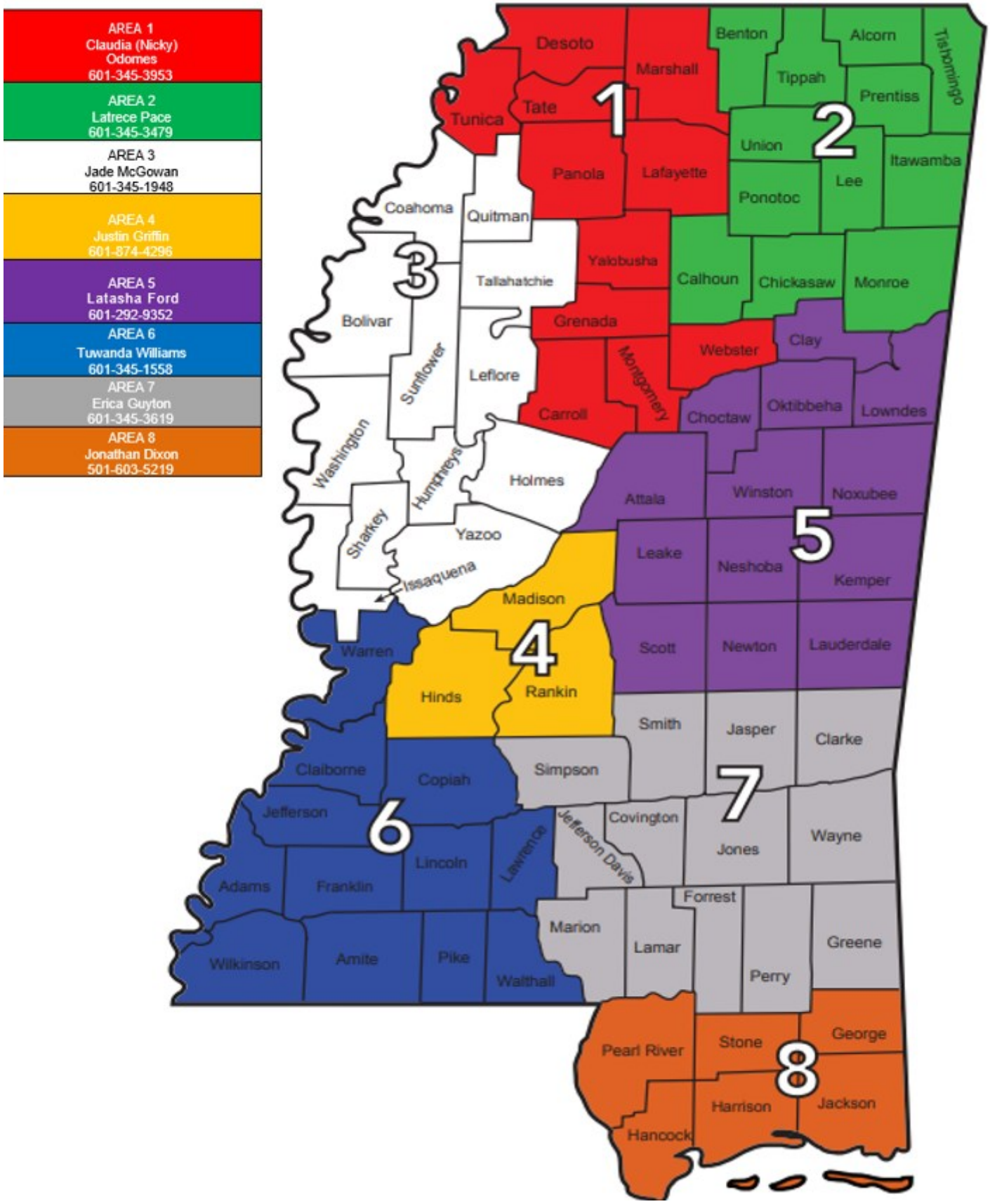
### MSCAN Remittance/Billing Address Update

Magnolia reminds providers to promptly notify the health plan of remittance/billing address changes to prevent payment delays. Providers include an updated W9 and the previous and new remittance addresses.


## 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.

# PROVIDER FIELD REPRESENTATIVE REGIONAL MAP



# PROVIDER FIELD REPRESENTATIVES

## PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY

| AREA 1<br>Claudia (Nicky) Odomes<br>Claudia.Odomes@gainwelltechnologies.com<br>601-345-3953 | AREA 2<br>Latrece Pace<br>Latrece.Pace@gainwelltechnologies.com<br>601-345-3479 | AREA 3<br>Jade McGowan<br>Jade.McGowan@gainwelltechnologies.com<br>601-345-1948 |
|---|---|---|
| County | County | County |
| Carroll | Alcorn | Bolivar |
| Desoto | Benton | Coahoma |
| Grenada | Calhoun | Holmes |
| Lafayette | Chickasaw | Humphreys |
| 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<br>Justin Griffin<br>Justin.Griffin@gainwelltechnologies.com<br>601-874-4296 | AREA 5<br>Latasha Ford<br>Latasha.Ford@gainwelltechnologies.com<br>601-292-9352 | AREA 6<br>Tuwanda Williams<br>Tuwanda.Williams@gainwelltechnologies.com<br>601-345-1558 |
|---|---|---|
| County | County | County |
| Hinds | Attala | Adams |
| Madison | Choctaw | Amite |
| Rankin | Clay | Claiborne |
| | Kemper | Copiah |
| | Lauderdale | Franklin |
| | Leake | Jefferson |
| | Lowndes | Lawrence |
| | Neshoba | Lincoln |
| | Newton | Pike |
| | Noxubee | Walthall |
| | Oktibbeha | Warren |
| | Scott | Wilkinson |
| | Winston | |

| AREA 7<br>Erica Guyton<br>Erica.Guyton@gainwelltechnologies.com<br>601-345-3619 | | AREA 8<br>Jonathan Dixon<br>Jonathan.Dixon@gainwelltechnologies.com<br>501-603-5219 |
|---|---|---|
| County | | County |
| Clarke | | George |
| Covington | | Hancock |
| Forrest | | Harrison |
| Greene | | Jackson |
| Jasper | | Pearl River |
| Jefferson Davis | | Stone |
| Jones | | |
| Lamar | | |
| Marion | | |
| Perry | | |
| Simpson | | |
| Smith | | |
| Wayne | | |

| OUT OF STATE PROVIDERS | Tanya Stevens Tanya.Stevens@gainwelltechnologies.com 501-232-8689<br>Sheryl Leonard Shryl.Leonard@gainwelltechnologies.com 601-345-2115 |
|---|---|

# CALENDAR OF EVENTS

## 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 |

## AUGUST 2023

| | |
|---|---|
| THURS, AUG 3 | EDI Cut Off – 5:00 p.m. |
| MON, AUG 7 | Checkwrite |
| THURS, AUG 10 | EDI Cut Off – 5:00 p.m. |
| MON, AUG 14 | Checkwrite |
| THURS, AUG 17 | EDI Cut Off – 5:00 p.m. |
| MON, AUG 21 | Checkwrite |
| THURS, AUG24 | EDI Cut Off – 5:00 p.m. |
| MON, AUG 28 | Checkwrite |
| THURS, AUG31 | EDI Cut Off – 5:00 p.m. |

## SEPTEMBER 2023

| | |
|---|---|
| MON, SEPT 4 | Checkwrite |
| THURS, SEPT 7 | EDI Cut Off – 5:00 p.m. |
| MON, SEPT 11 | Checkwrite |
| THURS, SEPT 14 | EDI Cut Off – 5:00 p.m. |
| MON, SEPT18 | Checkwrite |
| THURS, SEPT 21 | EDI Cut Off – 5:00 p.m. |
| MON, SEPT 25 | Checkwrite |
| THURS, SEPT 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 **https://portal.ms-medicaid-mesa.com/MS/Provider**.
Funds are not transferred until the following Thursday.

## UPCOMING DOM HOLIDAYS

| | |
|---|---|
| MON, Sept 4 | **Labor** 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

**GAINWELL TECHNOLOGIES**

P.O. BOX 23078

JACKSON, MS 39225

ms_provider.inquiry@mygainwell.onmicrosoft.com