Volume 33, Issue 2 April 2025

MS Medicaid PROVIDER BULLETIN

MISSISSIPPI DIVISION OF MEDICAID

Special enrollment period underway for managed care members until June 1, 2025

A special enrollment period for Medicaid managed care members is currently underway, marking the latest implementation phase of the Mississippi Division of Medicaid's coordinated care contracts for MississippiCAN and the Children's Health Insurance Program (CHIP).

Between March 2025 and June 1, 2025, Medicaid members have the opportunity to change their managed care plan during the Special Open Enrollment period. This one-time enrollment window is designed to help prepare for the operational launch of new coordinated care contracts, which were signed in August 2024.

Beginning July 1, 2025, Molina Healthcare, Magnolia Health, and TrueCare will provide managed care coverage for both the MississippiCAN program and CHIP.

What happens to UnitedHealthcare members?

Members who are currently enrolled with UnitedHealthcare will remain with the plan until June 30, 2025. Letters will be mailed to all managed care members, each of whom will have the choice to select one of the coordinated care organizations (CCOs). UnitedHealthcare members who do not return their enrollment form by June 1, 2025, will be auto-assigned among the three CCOs (Magnolia, Molina, or TrueCare).

Members may only switch once, and after this period closes, members will not be able to switch

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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.

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plans again until the next Open Enrollment which will occur in October 2025.

How can a member switch plans during the special open enrollment period?

Members may switch CCOs by:

- Returning enrollment forms by mail, in the postage paid envelope provided in the packet
- Fax a copy of the form to 1-866-644-6050
- Online Portal: http://medicaid.ms.gov/mississippican-enrollment/

Members may only switch once and will not be able to change health plans until Open Enrollment 2026.

To learn more about the Coordinated Care Procurement, visit https://medicaid.ms.gov/coordinated-careprocurement/.

Current Managed Care CCOs:

Mississippi Coordinated Access Network (MississippiCAN)	Children's Health Insurance Program (CHIP)
Magnolia Health	Molina Healthcare
Molina Healthcare	UnitedHealthcare Community Plan
UnitedHealthcare Community Plan	

Managed Care CCOs Effective July 1, 2025

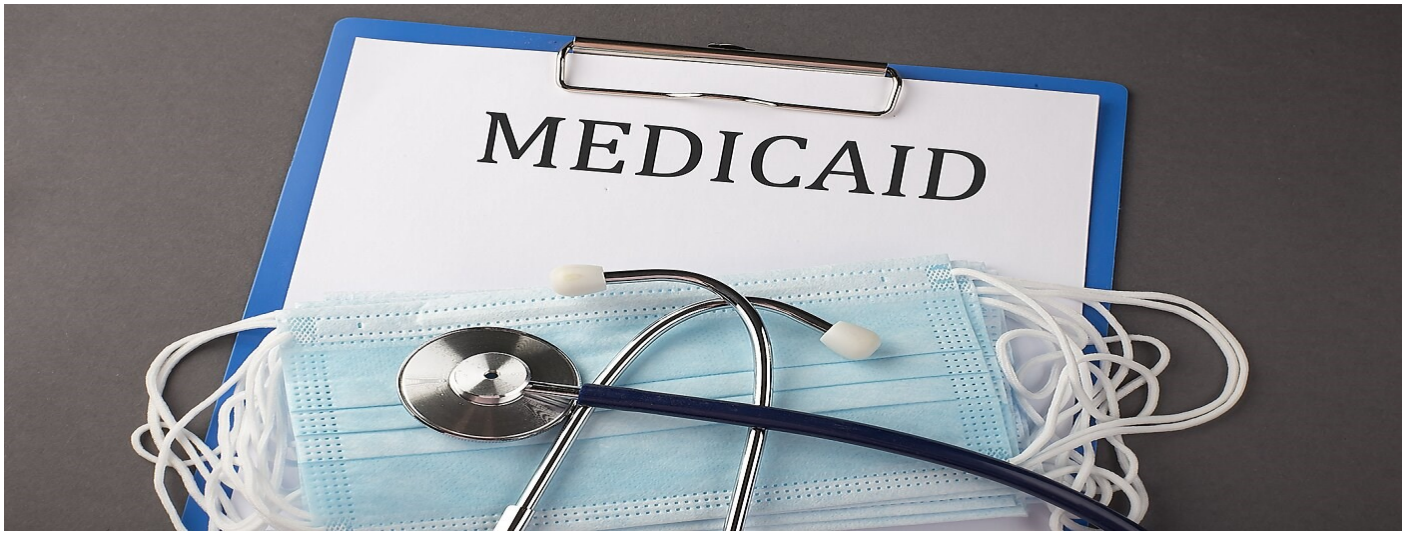
Mississippi Coordinated Access Network (MississippiCAN)	Children's Health Insurance Program (CHIP)
Magnolia Health	Magnolia Health
Molina Healthcare	Molina Healthcare
TrueCare	TrueCare

NEW RO LOCATIONS!

Hind County Regional Office
500 Clinton Center Drive
Building 3, Floor 2, Clinton, MS 39056

Madison County Regional Office
805 S. Wheatley, Suite 300
Ridgeland, MS 39157

New locations replace the Jackson/Canton regional offices



Medicaid Provider Enrollment and Data Maintenance: Requirements and Process Overview

As we have passed the two-year anniversary of the Division of Medicaid's implementation of its new Medicaid Management Information System (MMIS), MESA, we continue to prioritize the enrollment of providers into the Medicaid program for the State of Mississippi. MESA streamlines the enrollment process and enhances the integrity of claims management, ensuring that both billing and non-billing providers can deliver services efficiently and in compliance with federal and state regulations.

The Centers for Medicare & Medicaid Services (CMS) provides detailed guidance for state Medicaid agencies on the requirements for enrolling providers. This guidance is primarily outlined in federal regulations, including 42 CFR Part 455, Subparts B and E, and is further elaborated in the Medicaid Provider Enrollment Compendium (MPEC) and the Mississippi Division of Medicaid Administrative Code.

Enrolling as a Medicaid provider and maintaining your enrollment data are essential steps for healthcare professionals and organizations who wish to be reimbursed for the delivery of services to Medicaid beneficiaries. The Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies require providers to meet specific enrollment standards to ensure compliance with both federal and state regulations. Below is an overview of the key requirements and steps necessary for enrollment in Medicaid, including differences for billing and non-billing providers.

Why Enrollment is Important

Medicaid provider enrollment serves several purposes:

- **Program Integrity**: Screening and enrollment helps prevent fraud, waste, and abuse in Medicaid by ensuring only qualified providers can participate.
- **Compliance**: Enrolled providers must meet state and federal regulatory standards, including those set forth by CMS.
- **Access to Medicaid Beneficiaries**: Only enrolled providers can submit claims for service rendered to Medicaid beneficiaries and receive reimbursement from Medicaid.

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Enrollment Differences for Billing Providers vs. Non-Billing Performing Providers

Billing Providers

Billing providers are entities or individuals who submit claims to Medicaid for reimbursement of services provided to Medicaid beneficiaries. These providers are responsible for ensuring that claims are accurate and adhere to both federal and state Medicaid regulations.

- **Key Requirements for Billing Providers**:
  - ◊ Must enroll with Medicaid for each service location where services are rendered.
  - ◊ Must submit claims with the NPI and appropriate service location details in accordance with the published Mississippi Division of Medicaid (DOM) guidance, including but not limited to Companion Guides, Job Aids, Paper Billing Manual, Late Breaking News articles, etc.
  - ◊ Billing providers must also ensure that any individual practitioners included on a claim are properly enrolled and affiliated, if applicable.
  - ◊ Billing providers are subject to comprehensive screening as they have direct financial interactions with Medicaid, which may include moderate to high-risk screenings, depending on the provider's taxonomy.

Non-Billing Providers

Non-billing providers are individuals who render services but do not submit claims to Medicaid as well as those providers who Order, Refer, and Prescribe (ORP) services for Medicaid beneficiaries. Instead, these providers' identifying information is present on claims submitted to the Division of Medicaid by an enrolled billing provider (i.e. a hospital or group practice). These providers must still be enrolled in Medicaid to ensure compliance with program requirements, even though they are not responsible for billing.

- **Key Requirements for Non-Billing Providers**:
  - ◊ Non-billing providers are required to enroll in Medicaid to establish their credentials, **but they only need to enroll once per NPI and taxonomy combination**.
  - ◊ They must affiliate with the billing provider (e.g., a group practice) that will submit claims on their behalf at all practice locations at which the non-billing provider renders services.
  - ◊ Since non-billing providers do not submit claims, their screening may be less intensive compared to billing providers, though they are still subject to exclusion screening and credential verification.
  - ◊ Non-billing providers must ensure that the billing provider submits accurate claims that reflect the services rendered, including proper service location details if the service was performed at a location different from the billing provider.

Key Medicaid Provider Enrollment Requirements

1. National Provider Identifier (NPI)

All Medicaid providers eligible to obtain a National Provider Identifier (NPI), must do so before enrolling in Medicaid. This unique identifier, issued by the National Plan and Provider Enumeration System (NPPES), is required for billing purposes and must be used on all Medicaid claims.

- **How to Obtain a NPI:** Providers can apply for a NPI through the NPPES website. You will need to provide details such as your provider type, taxonomy(ies), and practice location(s).

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- **Atypical Provider Exception:** Atypical providers are generally not eligible to obtain a NPI. Atypical providers are individuals or organizations that do not provide healthcare services as defined by the Health Insurance Portability and Accountability Act (HIPAA). These can include providers such as non-emergency medical transportation services, personal care services, or other support services not related to direct medical care. Since atypical providers are not generally required to obtain a NPI, a Medicaid ID will be assigned at enrollment and the provider is required to use the assigned Medicaid ID on all submissions for prior authorization requests, claims, etc.

2. CMS Application Fees

Under federal regulations, CMS requires that certain providers pay an application fee when enrolling in Medicaid. This fee helps cover the costs associated with the provider screening process. The application fee is reviewed and updated annually by CMS.

- **Who Must Pay the Fee**: Institutional providers (e.g., hospitals, skilled nursing facilities, and home health agencies) are typically subject to this fee. However, individual practitioners and small physician group practices are generally exempt.
- **Fee Waivers**: Providers may request a waiver if they can demonstrate hardship. If the provider has paid the application fee to Medicare or another state's Medicaid, the provider should choose the appropriate Application Fee option.
- **Consequences of Non-Payment**: Failure to pay the required application fee, unless exempt, may result in the denial of a provider's Medicaid enrollment application.

The enrollment application fee for institutional providers for the 2025 calendar year is $730. 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 can be found at https://medicaid.ms.gov/provider-enrollment-application-fee/.

3. Provider Screening and Risk Levels

Medicaid providers are subject to screening based on the level of risk they pose to the program. CMS classifies providers into three risk categories—**limited, moderate,** and **high**—each with corresponding screening requirements:

- **Limited Risk**: Providers such as physicians and clinics undergo basic screening, including license verification, and database checks.

Continued

surgical centers, independent diagnostic testing facilities (IDTF), physical therapists enrolling as individual or group practices may require additional screening, such as on-site visits.

- **High Risk**: Providers such as skilled nursing facilities, home health agencies, and durable medical equipment (DME) suppliers must pass stringent checks, including fingerprint-based criminal background checks and on-site inspections.

The Mississippi Division of Medicaid is responsible for performing these screenings as part of the enrollment process.

4. Federal and State Exclusion Screening

Providers must pass exclusion screening to ensure they are not barred from participating in Medicaid. This includes checking the **Office of Inspector General (OIG)'s List of Excluded Individuals/Entities (LEIE)** and the **System for Award Management (SAM)** database.

- **Exclusion Consequences**: Providers excluded from federal healthcare programs are prohibited from enrolling or participating in Medicaid. Providers who fail to disclose exclusions risk severe penalties, including recoupment of payments and civil fines.

5. Service Location Enrollment

Billing providers must enroll each service location where Medicaid beneficiaries receive services whereas non-billing providers must affiliate to a billing provider at all locations where they render services to Medicaid beneficiaries. This ensures that all practice locations comply with Medicaid requirements and are licensed appropriately.

- Multiple Locations: If your billing provider practice has multiple locations, each location must be enrolled separately. The billing provider must list the correct service location when submitting claims to Medicaid.
- Individual providers (non-billing) must be affiliated with every service location of a group or practice where services are rendered.

While providers have the ability to add multiple servicing addresses on as single enrollment application, the portal has the ability for a provider to copy a previously submitted application eliminating the need to re-enter data multiple times. Using the copy previously submitted application process will copy all data from the previous application except the address and attachments. Once copied, the data in the new application is editable prior to submission. The provider will need to key the address information, make any changes based on variations across practice locations, and upload any necessary attachments. Incomplete documentation will lead to processing delays while the necessary documentation is requested from the provider. The Copy an Existing Provider Enrollment Application Job Aid provides a step-by-step guide for using this functionality.

6. Licensure and Credentialing

Under the guidelines of 42 CFR § 455.412, the Mississippi Division of Medicaid (DOM) is required to have current licenses in the provider file for both fee-for-service, MississippiCAN, and CHIP providers. Providers must submit and verify all relevant licensure and certifications as part of their enrollment application as well as submit updated licenses to DOM to maintain their enrollment status as licenses are renewed. This includes:

- Professional licenses (e.g., for physicians, nurses, dentists).
- Certification of compliance with state and federal regulations.
- Evidence of participation in any necessary accreditation programs.

Continued

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). The CVO will perform recredentialing for both current providers and new providers at least every three (3) years unless the provider is credentialed by a DOM-approved Delegated Credentialing Entity. Providers identified for recredentialing 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 in MESA and a link will be available in the portal to start the process. It is crucial to submit the recredentialing application by the submission date in the notification letter to allow processing time before the deadline.

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 and service location address will need to submit the recredentialing application which will pick up and credential all the taxonomies at that location under that tax ID. If recredentialing is either denied or not completed by the recredential due date, all the facility enrollments at that location under that tax ID that was due for recredentialing will no longer be eligible to participate in Managed Care; however, FFS eligibility may not be impacted.

Individual providers with multiple provider IDs sharing the same NPI 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, the provider will no longer be eligible to participate in Managed Care; however, FFS eligibility may not be impacted.

If the recredentialing is denied or not completed by the recredentialing due date and the provider has FFS eligibility on the provider file, the provider will then need to log into the provider's portal account and click on the "Add Programs" link under the Provider Section of the Home Page to complete and submit the Add Programs for the MSCAN and/or MSCHIP programs that were terminated. Resources for the Add Programs process are located under General on the DOM website at www.medicaid.ms.gov/mesa-portal-for-providers/.

7. Provider Disclosure of Ownership

Ownership disclosure helps Medicaid agencies identify and prevent fraud by ensuring transparency in the provider's operations. Medicaid providers are required, in accordance with 42 CFR 455.104, to disclose information about ownership and control. This includes any person or entity with a 5% or greater ownership interest in the provider, as well as managing employees and anyone with operational control over the practice.

8. Revalidation

In accordance with 42 C.F.R. § 455.414 of the Affordable Care Act (ACA), all state Medicaid agencies must revalidate provider enrollments at least every five years. This ensures that the provider's credentials, ownership, and other information remain up to date.

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Providers will receive a notice when it's time to revalidate. Providers can revalidate through the MESA Provider Portal using a step-by-step process. It is crucial to submit the revalidation by the submission date in the notification letter to allow processing time before the deadline. Failure to complete revalidation by the deadline will result in termination requiring the provider to reapply.

Maintaining Compliance After Enrollment

After enrollment, providers are responsible for maintaining compliance with Medicaid program rules, including but not limited to:

- Ensuring the accuracy of claims submissions, including the correct NPI and service location.
- Reporting any changes of provider information, including ownership, licensure, or service locations, to the state Medicaid agency within the required timeframes.
- Participating in regular revalidation and recredentialing efforts and responding promptly to any requests for information from the Medicaid agency.

Conclusion

Enrolling in Mississippi Medicaid requires careful attention to federal and state regulations. By ensuring compliance with the key requirements outlined above, both billing and non-billing performing providers can maintain their eligibility to participate in Medicaid and continue delivering services to beneficiaries. Providers should stay informed about changes to Medicaid policies and work closely with DOM to ensure their continued participation in the program.

PROVIDER COMPLIANCE

Provider Recredentialing Mississippi Medicaid Managed Care Programs

All providers participating in MississippiCAN or the Children's Health Insurance Program (CHIP) are required to be credentialed by the Mississippi Division of Medicaid. Failure to complete credentialing/recredentialing will result in termination from these programs and will require reenrollment. There are a significant number of providers currently due for recredentialing that need to complete the process. Providers terminated for failing to recredential may reenroll for Medicaid's managed care programs (MSCAN/CHIP) through the MESA Provider Portal.

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 recredentialing 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 in 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 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 and claims can no longer be paid. A new application for each taxonomy at that service location will be required to re-enroll in the Mississippi Medicaid program.

Individual providers with multiple provider IDs sharing the same NPI 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, and

PROVIDER COMPLIANCE

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claims can no longer be paid. A new application for each service location will be required to re-enroll in the Mississippi Medicaid program.

To prepare for recredentialing, all Medicaid providers should take the following steps immediately:

- Each enrolled provider must register for access to the MESA Provider Portal to recredential electronically. This will streamline the process and allow providers to enter their own information. Providers can register now by going to https://portal.ms-medicaid-mesa.com/ and clicking the "Register Now" link.
- In addition to the notices mailed by Gainwell Technologies, providers can refer to DOM's website where we are posting the "Provider Six Month Recredentialing Due List" at https://medicaid.ms.gov/. This listing will be updated monthly.
- Review the Provider Recredentialing Presentation found under "MESA Tips" at https://medicaid.ms.gov/mesa-portal-for-providers/ which is a PowerPoint that includes a recredentialing walk through and tips for providers.
- Providers should verify that the address information on file is correct. The notifications will be mailed to the "Mail To" address on their file. To ensure each individual provider receives a notification, please validate your addresses on file, and correct them if necessary.
- If changes are needed, complete the Provider Change of Address form, located under Provider Forms at https://medicaid.ms.gov/resources/forms/.
- The Provider Change of Address form must be completed, signed by the individual provider or authorized official if enrolled provider is a business, and submitted to the Provider Enrollment Department of Gainwell Technologies via secure correspondence in the MESA Provider Portal, fax, or mail. The following correspondence information is provided:
  - Provider Services Fax Number:

    (866) 644-6148

    Attention: Provider Enrollment
  - Provider Services Mailing Address:

    Provider Enrollment/MississippiCAN/ MSCHIP

    PO Box 23078

    Jackson, MS 39225

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 https://medicaid.ms.gov/wp-content/uploads/2024/03/Provider-Field-Representatives-1.pdf.

PROVIDER COMPLIANCE

Provider Revalidation

Provider Revalidation

Effective October 1, 2023, DOM resumed provider revalidation.

Background: On May 11, 2023, the Health and Human Services Commission (HHSC) ended the extended revalidation dates for Medicaid providers that were implemented during the COVID-19 public health emergency (PHE). Following this, the Mississippi Division of Medicaid reinstated the revalidation process starting October 1, 2023. This requires all Mississippi Medicaid providers to verify the information in their provider files. According to 42 C.F.R. § 455.414 of the Affordable Care Act (ACA), all state Medicaid agencies must revalidate provider enrollments at least every five years.

Revalidation Requirements:

- Providers must verify or revalidate their current information.
- Providers must complete and sign a new Provider Disclosure form and a new Provider Agreement.
- The state will conduct a full screening according to the provider's risk level in compliance with 42 C.F.R. Part 455, Subparts B & E.
- Providers must comply with any state requests during the revalidation process within the specified timeframe.

Notification Process: Starting October 2023, notification letters were mailed to providers enrolled with Medicaid for five years or more. Revalidation notices will be issued on a staggered schedule until all providers due for revalidation have been notified. These letters will include instructions for completing the revalidation and the due date. Providers may need to submit additional documentation and/or meet other screening requirements, such as providing fingerprints or undergoing a site visit conducted by Medicaid's fiscal agent.

Application Fee: Certain providers must pay an enrollment application fee. For a list of institutional providers required to pay the fee, visit Provider Enrollment Application Fee. Providers who have already paid the application fee to Medicare or another state's CHIP or Medicaid program for the same provider type are exempt and should select the appropriate option when completing the revalidation application.

Revalidation Submission: Providers can revalidate through the MESA Provider Portal using a step-by-step process. It is crucial to submit the revalidation by the submission date in the notification letter to allow processing time before the deadline. Failure to complete revalidation by the deadline will result in termination requiring the provider to reapply.

Preparation Steps:

1. **Register for MESA Provider Portal Access:** All enrolled providers must register to revalidate electronically. Visit MESA Provider Portal and click "Register Now."
2. **Refer to DOM's Website:** Check the "Provider Six Month Revalidation Due List" at DOM's website. This list is updated monthly.
3. **Review Revalidation Presentation:** The Provider Revalidation Presentation, available under "MESA Tips" at MESA Portal for Providers, offers a walkthrough and tips for providers.

PROVIDER COMPLIANCE

Continued

4. **Verify Address Information and Submit Change of Address, if needed:** Login to the MESA Provider Portal, navigate to the Characteristics area and ensure the "Mail To" address on file is correct. If updates are needed, edit the address and save.

Assistance: For help, contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or refer to the Provider Field Representative list on Medicaid's website, which includes email addresses and phone numbers for each representative. This list is available at https://medicaid.ms.gov/wp-content/uploads/2024/03/Provider-Field-Representatives-1.pdf.

New Email Address for Provider Document Submission

A new email address has been created for submission of supporting documents related to provider enrollment applications, revalidations, and recredentialing. If a Gainwell Provider Enrollment Analyst requests missing or corrected documents via email or by a Return-To-Provider (RTP) letter, please send them to the new email address: ms_pe_docs@gainwelltechnologies.com. This will ensure the provider enrollment team receives your documents should you encounter issues uploading them through the web portal.

Remember to include the Application Tracking Number (ATN) in the subject line of your email.

Note: This email address is for supporting documents only. For provider and claim inquiries, continue to use the email address of ms_provider.inquiry@mygainwell.onmicrosoft.com.

We Want Your Feedback: Help Us Improve the MESA Portal Claims Submission Process

At the Mississippi Division of Medicaid (DOM), we are committed to ensuring that the claims submission process is efficient, user-friendly, and meets the needs of our providers. To achieve this, we need your valuable input. We want to hear about your experiences with the claim's submission functionality of the MESA portal. Whether you use the portal regularly or rely on paper submission, your feedback is essential in identifying challenges and areas for improvement.

Your insights will help us:

- Understand the pain points your face when using the portal.
- Prioritize updates and changes to enhance your experience.
- Streamline the process to save you time and effort.

Please share your feedback and suggestions by emailing us at ProviderFeedback@medicaid.ms.gov. Be as specific as possible, and feel free to include examples of issues or ideas for improvement. Your input will directly influence future enhancements, and together we can make the MESA portal work better for everyone.

Thank you for partnering with us to improve the claims submission experience for all Medicaid providers!

PROVIDER COMPLIANCE

New Taxonomies for Provider Enrollment

Effective **July 1, 2024**, Mississippi Medicaid has introduced an additional 123 eligible taxonomies to better align with the services rendered and billed by providers. These taxonomies are now available for selection during enrollment through the MESA Web Portal. A complete list of all eligible taxonomies for Mississippi Medicaid enrollment can be found at: https://medicaid.ms.gov/wp-content/uploads/2024/10/MESA-Taxonomies-Listing-as-of-7-11-2024.xlsx.

Since these taxonomies were not previously available, **currently enrolled providers** may request an update to their existing taxonomy code if they wish to align with one of the new eligible taxonomies.

HOW TO REQUEST A TAXONOMY CODE UPDATE

Providers can submit taxonomy change requests through the following secure methods:

1. Online – MESA Provider Portal
    - Access the "Secure Correspondence" link on the MESA Provider Portal: https://medicaid.ms.gov/mesa-portal-for-providers.
    - For requests involving multiple Medicaid IDs, please attach a spreadsheet listing each update as a separate row.
    - Note: Preferred method for tracking purposes.
2. Fax
    - **Fax Number:** (866) 644-6148
    - **Attention:** Provider Enrollment
3. Mail
    - **Mailing Address:** Provider Enrollment, P.O. Box 23078, Jackson, MS 39225

When submitting your request, **please include the 9-digit Medicaid ID** and the **new taxonomy code** you are requesting.

Important:
The requested taxonomy code **must match the taxonomy reported in the NPPES NPI Registry** to ensure accuracy and compliance.

If you have any questions or need further assistance, please contact the Provider and Beneficiary Services Call Center at (800) 884-3222 or refer to the Provider Field Representative list on Medicaid's website, which includes email addresses and phone numbers for each representative. This list is available at https://medicaid.ms.gov/wp-content/uploads/2024/03/Provider-Field-Representatives-1.pdf.

Requesting an Administrative Review

In accordance with DOM's Administrative Code, Part 200, Rule 1.8, providers have 90 calendar days to request an Administrative Review from the date of the denial when the Division of Medicaid adjusts claims after timely filing and timely processing deadlines have passed. This process allows the provider an opportunity to submit a corrected claim for processing following a DOM mass adjustment, if the agency grants the request to override timely filing. To access the online submission process, please visit DOM's website where the Timely Filing Review Request Form is linked under Resources or use this link - Timely Filing Review Request.

PROVIDER COMPLIANCE

Expired Provider License Updates Required

It is imperative for providers to promptly provide their updated licensure information to Medicaid, as failure to do so will result in the closure of their Medicaid provider number and interruption of claim payments.

Who is impacted?
Under the guidelines of 42 CFR § 455.412, the Mississippi Division of Medicaid (DOM) is required to have current licenses in the provider file for both fee-for-service/MississippiCAN providers and CHIP providers.

When should licenses be updated?
As a part of this process, providers whose licenses have expired or are expiring will be notified via mailed notifications from Gainwell Technologies. We also encourage providers to consult DOM's official website, where the Provider Six-Month License Due List is available at https://medicaid.ms.gov/. This list will be refreshed monthly to ensure the latest information is accessible.

How can a provider submit the updated license?
To facilitate the submission of licensure information, Gainwell Technologies' Provider Enrollment Department offers multiple secure channels, including the MESA Provider Portal, fax, or mail. Here are the details for each method:

Online: MESA Provider Portal: https://medicaid.ms.gov/mesa-portal-for-providers (via the Secure Correspondence link)

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

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

Can a provider be reinstated if a provider fails to send in the updated license timely?
Complying with the provisions outlined in the Mississippi Administrative Code Part 200, Chapter 4, Rule 4.5 (B) (C), DOM will reinstate closed provider numbers due to license expiration, retroactive to the date of license renewal, provided the closure duration is under one (1) year and the provider is not past due for revalidation or recredentialing. For this to happen, the provider must furnish a current license copy and rectify any changed or inaccurate information. If a Medicaid provider number has been closed due to license expiration for a period exceeding one (1) year, re-enrollment as a Medicaid provider will be necessary.

For any assistance required between 8 a.m. and 5 p.m. CST, providers can contact the Provider and Beneficiary Services Call Center at (800) 884-3222.

PROVIDER COMPLIANCE

Letters Available in Provider Portal

Effective immediately, providers will be able to view copies of letters received by mail directly in the Provider Portal. Access to these letters will be determined by the status of the application and the age of the letter. Please refer to the following instructions for guidance on how to access letters within the Provider Portal. At this time, providers will continue to receive letters via mail, in addition to having the ability to view them online.

Accessing Letters for Enrolled Providers

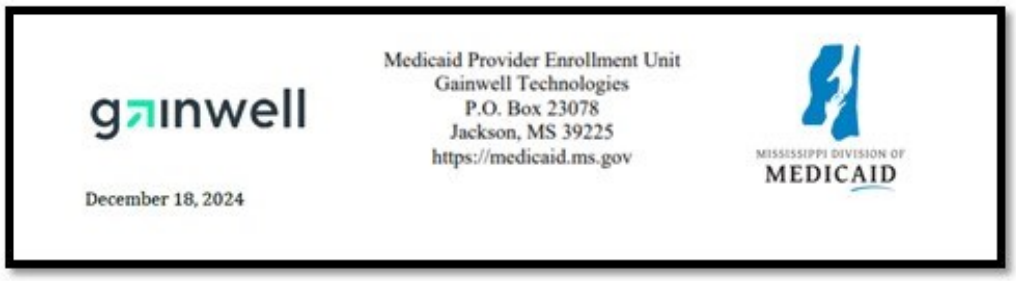
Once logged in, enrolled providers can access recent letters directly from the Provider Portal dashboard. Letters sent within the past 90 days will be available in a new section titled **View Letters**, located under the "Secure Correspondence" link on the right side of the page. A notification will appear below this link when new letters are available.

By clicking the "View Letters" link, providers can view letters generated in the last 90 days. Unviewed letters will be displayed in bold with a "New" status.

PROVIDER COMPLIANCE

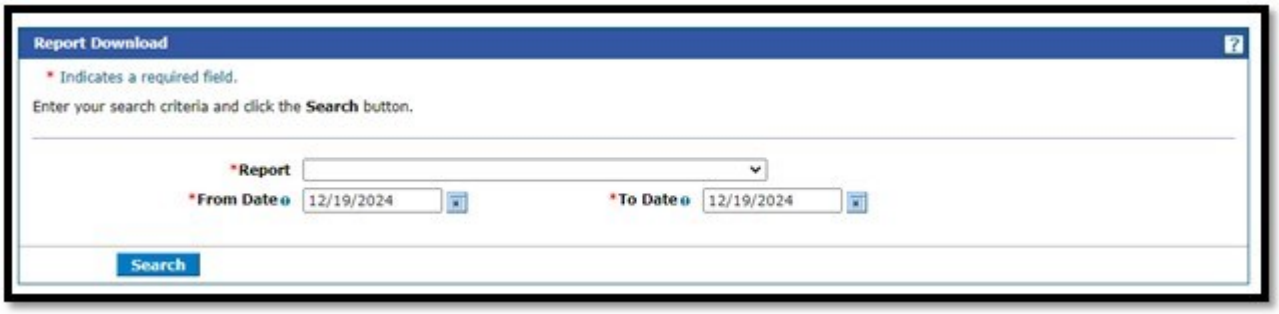
Continued

To view a letter, click Download. The letter will download and open in a PDF viewer.



After being viewed, the letter's status will change to "Viewed," and it will no longer appear in bold. These letters will remain accessible for 90 days.

Letters older than 90 days can be accessed via the Resources Tab through the Report Download functionality. Select the letter name from the Report dropdown menu and specify the desired date range.



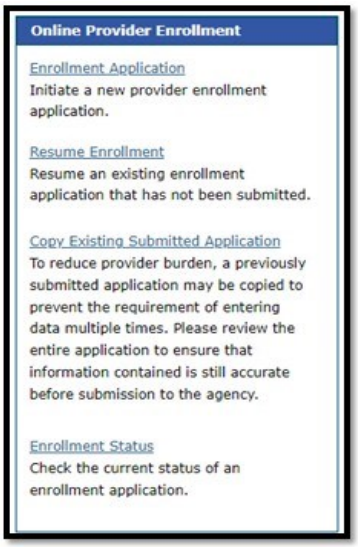
Note: This same functionality is available to Medicaid beneficiaries within the Medicaid Member Portal.

PROVIDER COMPLIANCE

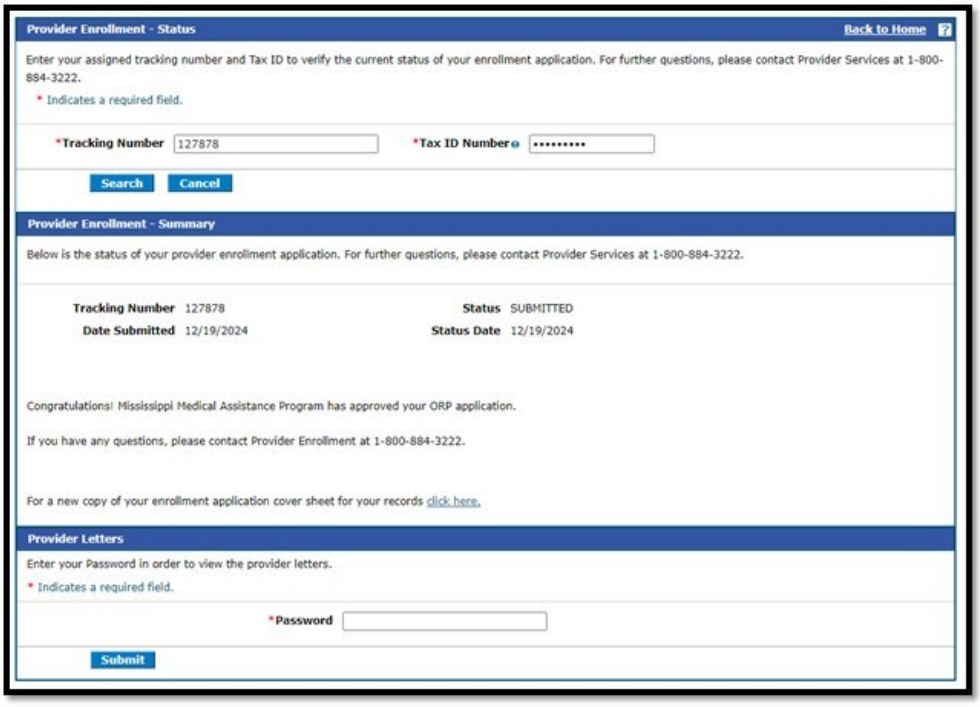
Continued

Accessing Letters for Applying Providers

Letters associated with enrollment applications can be accessed through the Enrollment Status search.



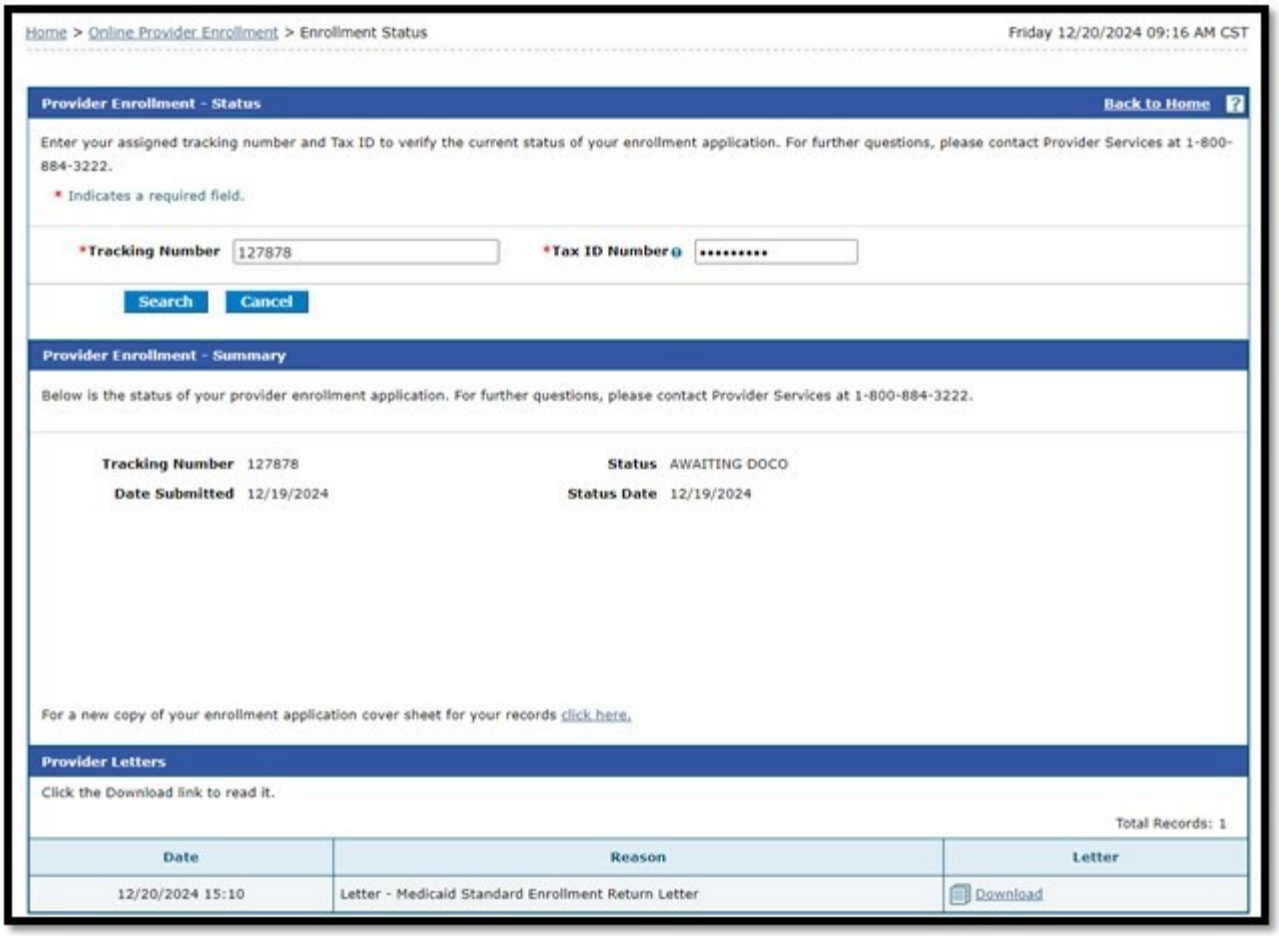
To view a letter related to a submitted application, enter the Tracking Number, Tax ID Number. Once the status is displayed, a new area titled Provider Letters will appear if the application has been submitted.



PROVIDER COMPLIANCE

Continued

Enter the Password for the application. All letters related to the application that have been mailed to the provider will be displayed.



For more information, 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/2024/03/Provider-Field-Representatives-1.pdf.

Provider Enrollment Application Fee Increased for 2025

The enrollment application fee for institutional providers for the 2025 calendar year has increased from $709 to $730. See the following announcement: https://www.federalregister.gov/documents/2024/12/02/2024-28127/medicare-medicaid-and-childrens-health-insurance-programs-provider-enrollment-application-fee-amount.

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)

PROVIDER COMPLIANCE

Continued

- 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	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)
261QR0400X	Clinic/Center – Rehabilitation
261QR0401X	Clinic/Center – Rehabilitation, Comprehensive Outpatient Rehabilitation Facility (CORF)
261QR1300X	Clinic/Center – Rural Health
273R00000X	Psychiatric Unit
273Y00000X	Rehabilitation Unit
282E00000X	Long Term Care Hospital
282N00000X	General Acute Care Hospital
282NC0060X	General Acute Care Hospital – Critical Access
282NC2000X	General Acute Care Hospital – Children

PROVIDER COMPLIANCE

Continued

TAXONOMY	TAXONOMY DESCRIPTION
282NR1301X	General Acute Care Hospital – Rural
282NW0100X	General Acute Care Hospital – Women
283Q00000X	Psychiatric Hospital
291U00000X	Clinical Medical Laboratory
292200000X	Dental Laboratory
293D00000X	Physiological Laboratory
314000000X	Skilled Nursing Facility
332B00000X	Durable Medical Equipment and Medical Supplies
332BC3200X	Durable Medical Equipment and Medical Supplies – Customized Equipment
332BP3500X	Durable Medical Equipment and Medical Supplies – Parenteral and Enteral Nutrition
332BX2000X	Durable Medical Equipment and Medical Supplies – Oxygen Equipment and Supplies
333600000X	Pharmacy
3336C0003X	Pharmacy – Community/Retail Pharmacy
3336H0001X	Pharmacy – Home Infusion Therapy Pharmacy
3336S0011X	Pharmacy – Specialty Pharmacy
335V00000X	Portable X-Ray Supplier
341600000X	Ambulance
3416L0300X	Ambulance – Land Transport

PROVIDER COMPLIANCE

Continued

Providers submitting their application fee should make their check out to the Mississippi Division of Medicaid, annotating on the check the Application Tracking Number (ATN) and mail to:

- Gainwell Technologies P.O. 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, 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/2024/03/Provider-Field-Representatives-1.pdf.

Important Updates from Telligen

- Providers are advised to include all relevant procedure codes for the specific review type when submitting authorization requests. All procedure codes for a review type should be submitted together if they are to be provided on the same date of service. Please note that MESA only allows one authorization number per claim, so it is essential to ensure that all relevant procedure codes for the specific review type are included in a single submission.
- Prior authorizations for medical services for members enrolled in MississippiCAN and CHIP will continue to be handled by the respective coordinated care organizations (CCOs). Pharmacy authorization requests are handled by Gainwell. Authorization requests submitted to Telligen for a MississippiCAN or CHIP member will receive a decision of Outcome Not Rendered (ONR).
- Monthly Qualitrac Training – Telligen offers monthly Qualitrac training sessions, open to all providers. This session serves as a general introduction to Qualitrac providing an overview of system navigation, authorization submission, and common troubleshooting steps. Attendees will gain a better understanding of documentation requirements, eligibility verification, and the appeals process. The session will also cover updates and enhancements in the Qualitrac provider portal to help ensure a smooth and efficient experience.
- DME providers are advised to ensure that the applicable procedure code is clearly identified on both the quote and/or MSRP when submitting authorization requests. This is crucial to ensure accurate pricing for PA-priced codes, avoid any delays or technical issues in processing, and help expedite approval.
- Care Management Referrals - Telligen, DOM's Utilization Management/Quality Improvement Organization (UM/QIO), offers a streamlined care management referral process to optimize patient care for fee for service members, focusing on chronic conditions or high-risk factors. Care management is available for beneficiaries with diagnoses such as Hepatitis, Hemophilia, HIV/AIDS, as well as pregnant or postpartum beneficiaries enrolled in fee-for-service (FFS) or the Disabled Children Living at Home (DCLH) category. Providers can submit referrals via the Care Management Referral Form found on

PROVIDER COMPLIANCE

Continued

Telligen's website, faxing completed forms to 1-800-520-6564. For more information or questions, contact Telligen at 1-866-938-5144.

Guidance for Retrospective Requests submitted to Telligen

The Mississippi Division of Medicaid (DOM) contracts with Telligen, as the Utilization Management/Quality Improvement Organization (UM/QIO) vendor, for fee-for-service Medicaid members. Prospective Reviews, also referred to as prior authorization or precertification, include the review of medical necessity for the performance of services or scheduled procedures ***before*** the service is rendered or ***before*** admission occurs. Concurrent Reviews are medical necessity decisions made while the patient is currently in an acute or post-acute setting or when an episode of care needs to continue beyond the initial authorization period.

In certain circumstances, **Retrospective Review** may be allowed, which may include but is not limited to the following:

- **Beneficiary receives retroactive eligibility** – Requests should be submitted as soon as possible but no later than 90 days of the system add date of the eligibility determination, in accordance with Administrative Code Part 200, Chapter 1, Rule 1.8.A.1.a. Administrative Code (ms.gov)
- **Advanced Imaging** – limited to medically urgent procedures done before authorization could be obtained. Requests should be submitted as soon as possible but no later than five (5) calendar days after the date of service.
- **Dental related requests** – when additional services occur during a dental procedure that were not included in the initial authorization. Requests should be submitted as soon as possible but no later than five (5) calendar days after the date of service.
- **Expanded Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Physician Office Visits for EPSDT-eligible members** – limited to physician office visits that exceed the annual visit limit of 16. Requests should be submitted as soon as possible but no later than thirty (30) calendar days after the date of service. When a submitted claim denies that exceeds this 30-day timeframe, the provider will need to include a copy of the denied claim or denial posted to the remittance advice, when requesting the authorization.
- **Managed Care Recoupments** – If a claim payment was recouped by a managed care organization due to a change in payor (CCO to fee-for-service), the provider has ninety (90) days from the date of recoupment to request an authorization from the UM/QIO. Documentation (remittance advice) of the recoupment must be included with the request including, but not limited to, the recoupment letter and previous authorization approval.
- **Inpatient admissions:**
  - Limited to emergent and urgent admissions and must be authorized on the next working day after admission, in accordance with Administrative Code Part 202, Chapter 1, Rule 1.3.A.1.a.

PROVIDER COMPLIANCE

Continued

- **Retrospective requests** are used after the fact, typically when a service has already been provided, or the patient has been discharged from inpatient care.
- **Concurrent reviews** are used while the patient is still receiving care, such as during an ongoing inpatient stay. If the patient has an approved authorization and the provider anticipates the need for extending the inpatient stay, a **continued stay request** should be submitted prior to the last approved date to get approval for the additional time.

Please refer to Telligen's website at https://msmedicaid.telligen.com/, or call Telligen directly at 1-855-625-7709 for assistance. To submit authorization requests, providers are encouraged to register for access to Telligen's provider portal, Qualitrac, by completing the Telligen Provider Portal Registration.

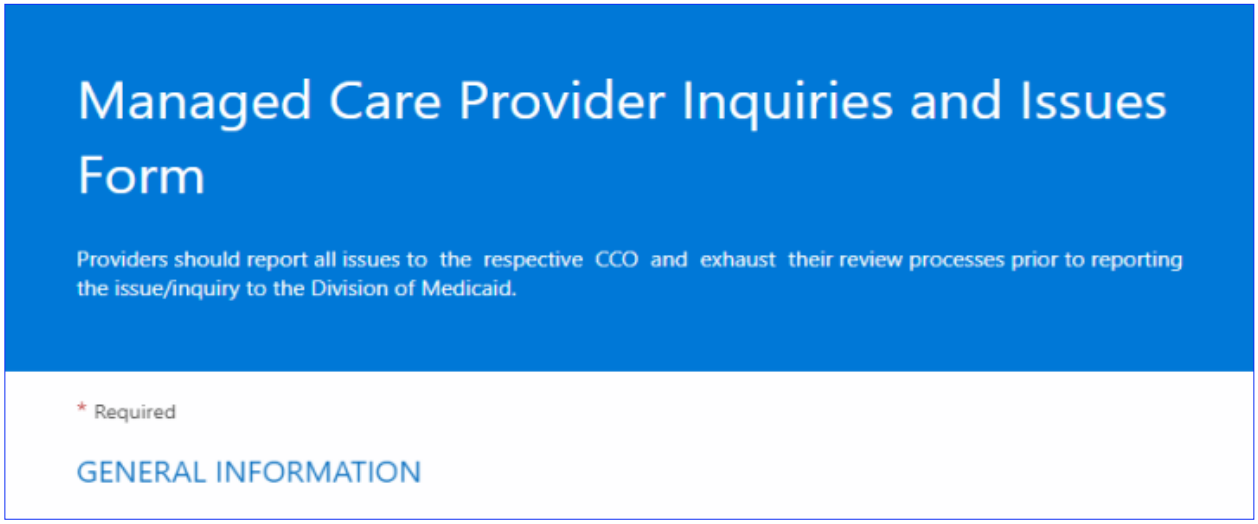
COORDINATED CARE NEWS

Managed Care Inquiries and Complaints

HELP US, HELP YOU

Please forward all provider issues and complaints related to Magnolia Health, UnitedHealthcare, and Molina Health Care:

https://forms.office.com/g/WXj92sN1MH



Please contact Office of Coordinated Care Provider Services at (601) 359-3789.

COORDINATED CARE NEWS

MAGNOLIA

Optum Audits

On February 15th Magnolia Health began using Optum's Comprehensive Payment Integrity (CPI) tool to perform additional prepayment claim reviews. As a result, providers may be asked for medical records and billing documents that support the charges billed.

Magnolia Health utilizes widely acknowledged national guidelines for billing practices and supports the concept of uniform billing for all payers. Prepayment claim reviews will look for overutilization of services or other practices that directly or indirectly result in unnecessary costs. A provider's order must be present in the medical record to support all charges, along with clinical documentation to support the diagnosis and services or supplies billed.

If selected for prepayment claim reviews, you will receive a request for medical records and provided instructions outlining how to submit medical records for review. Providers who do not submit the requested documentation may receive a technical denial, which will result in the claim being denied until the information required to adjudicate the claim is received.

If it is determined that a coding and/or payment adjustment is applicable, the provider will receive the appropriate claim adjudication. Providers retain their right to dispute results of reviews.

Magnolia Updates to the Outpatient Prior Authorization (PA) Form for MSCAN

Magnolia has updated the Outpatient Prior Authorization (PA) forms to improve the current process for providers by developing and implementing an optional supplemental page to request additional codes.

- The supplemental page will allow providers to request four or more CPT codes without manually writing on the PA form.
- Writing on the PA form in areas which are not designated for writing can cause errors. The supplemental page ensures providers' request for four or more CPT codes are managed appropriately.
- The supplemental page can be found on the Magnolia Health website under the following: For Provider > Provider Resources> Manual, Forms, and Resources>Prior Authorization.

Magnolia Updates to the Outpatient Prior Authorization (PA) Form for MSCAN

You may have recently received a letter from Magnolia Health Plan with information regarding an upcoming claims recoupment for project numbers 574360310 and/or 577431021related to members who were not eligible at the date of the service. **We plan to pause this recoupment and work with the Division of Medicaid to coordinate the recoupment and potential repayment of these claims under another payor**. There is no need for providers to appeal these claim recoupments.

We will also be including more information in our weekly Provider email blasts, so please watch for upcoming information.

To sign up for Magnolia's email blast, visit our website at www.magnoliahealthplan.com/providers/email-sign-up.html.

If you have any questions, or need additional information regarding this issue, please contact your provider relations representative, or Provider Services at 866.912.6285.

COORDINATED CARE NEWS

MAGNOLIA

March is Colorectal Cancer Awareness Month

Let's all pitch in to remind patients on the importance of screening for colon cancer!

Key tips

- Educate members on the importance of colorectal cancer screenings for early detection and the complete screening options available.
- Talk with patients about using home kits for colorectal cancer screening as an option.
- Educate patients on proper sample collection when distributing FIT or FOBT testing kits.
- Complete and document all screenings for patients, including date of service.
- Help patients schedule colonoscopy screening appointments.

Measure Info:

COLORECTAL CANCER SCREENING (COL)

The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.

- Please ensure that annual documentation in the member record clearly indicates colon cancer or colectomy, as *patients who have a history of colon cancer or who have had a total colectomy are exempt from this measure*.

DESCRIPTION	CODES
Colonoscopy	**CPT**: 44388 - 44392, 44394, 44401 - 44408, 45378 - 45382, 45384 – 45386, 45388 – 45393, 45398 **HCPCS:** G0105, G0121
CT Colonography	**CPT:** 74261 - 74263
FIT-DNA Lab Test	**CPT:** 81528
Flexible Sigmoidoscopy	**CPT:** 45330 - 45335, 45337,45338, 45340 – 45342, 45346, 45347, 45349, 45350 **HCPCS**: G0104
FOBT Lab Test	**CPT**: 82270, 82274 **HCPCS**: G0328
Colorectal Cancer	**ICD-10:** C18.0 - C18.9, C19, C20, C21.2, C21.8, C78.5, Z85.038, Z85.048
Total Colectomy	**CPT:** 44150 - 44153, 44155 - 44158, 44210 - 44212

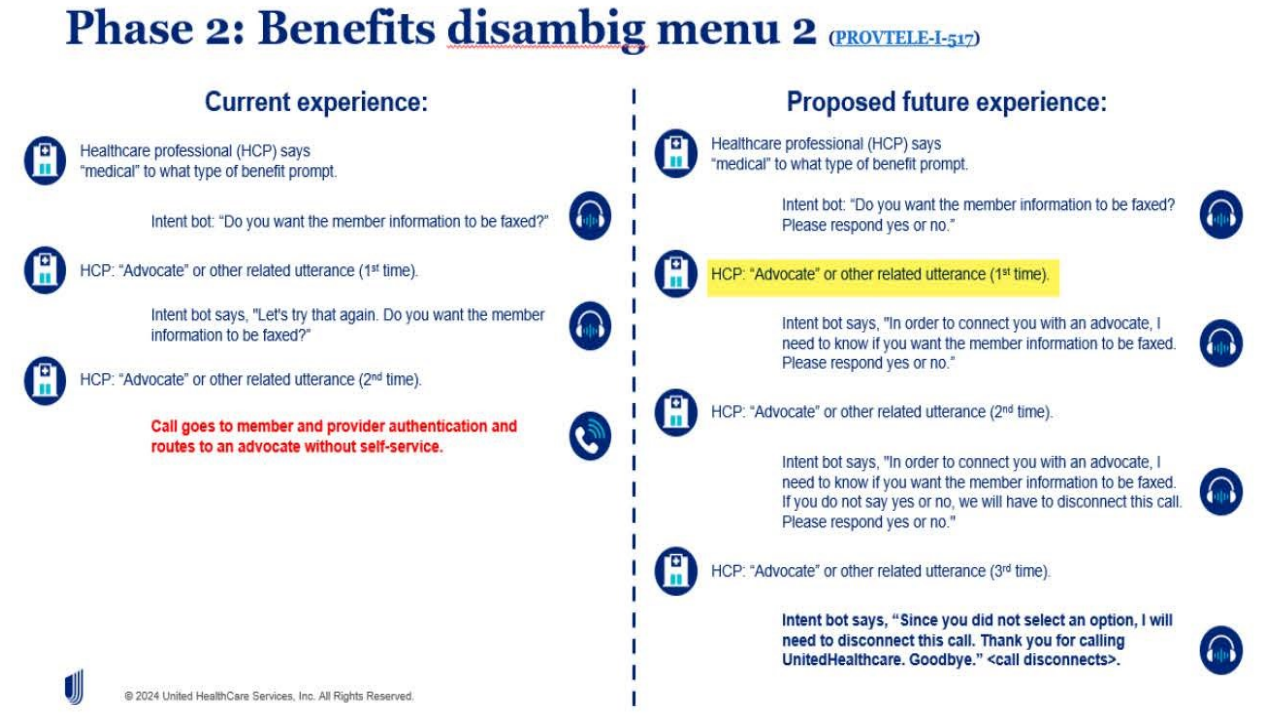
COORDINATED CARE NEWS

UNITED HEALTHCARE

United Healthcare

Upcoming Provider IVR Change

As our healthcare industry evolves, so does the world of artificial intelligence and the use of bots. Beginning at the end of March, our Internal Voice Recognition system (IVR) will include new requirements as an approach to mitigate privacy risks to our members personal health information.



COORDINATED CARE NEWS

UNITED HEALTHCARE

United Healthcare

March 01, 2025

Network News is going monthly

We're making a change to our email newsletter delivery schedule

Beginning April 1, 2025, you'll receive Network News monthly instead of bi-weekly. We're making this change based on your feedback expressing a preference for fewer emails, but more comprehensive updates. For urgent or timely updates, we will continue to provide notice to health care professionals outside of the regular Network News first-of-the-month email schedule.

Update your preferences within the email to receive only relevant content

To ensure that you receive only the most relevant content, it's important to update your preferences. By providing information about your state, role, specialty and interests, you can personalize the amount of news you receive.

Here are examples of the same email but with different preferences selected based on the user:

How to update your email preferences

Updating your preferences is quick and easy. Simply click on the "Email preferences" link in the email footer of any Network News email and fill out the necessary information.

Questions? We're here to help.

Connect with us through chat 24/7 in the **UnitedHealthcare Provider Portal.** For additional contact information, visit our **Contact us** page.

PCA-1-25-00382-POE-NN_02132025

COORDINATED CARE NEWS

UNITED HEALTHCARE

United Healthcare Community Plan

UnitedHealthcare Community Plan of Mississippi Medical Policy Update Bulletin *Quick View*: March 2025

A list of recently approved, revised, and/or retired Medical Policies and/or Medical Benefit Drug Policies is provided below for your reference. **For a comprehensive summary of the latest updates, refer to the Medical Policy Update Bulletin: March 2025.**

Medical Policy Updates

Policy Title	Status	Effective Date
Skin and Soft Tissue Substitutes (for Mississippi Only)	Revised	May 1, 2025
Sleep Studies	Updated	Mar. 1, 2025
Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions)	Revised	May 1, 2025

Medical Benefit Drug Policy Updates

Policy Title	Status	Effective Date
Antiemetics for Oncology	Revised	Apr. 1, 2025
Denosumab	Revised	Apr. 1, 2025
Elevidys™ (Delandistrogene Moxparvovec-Rokl)	Retired	Mar. 1, 2025
Evkeeza® (Evinacumab-Dgnb)	Revised	Apr. 1, 2025
Gene Therapies for Hemophilia B	Revised	Apr. 1, 2025
Immune Globulin (IVIG and SCIG)	Revised	Apr. 1, 2025
Leqvio® (Inclisiran) (for Mississippi Only)	Revised	Apr. 1, 2025
Maximum Dosage and Frequency	Revised	Apr. 1, 2025
Oncology Medication Clinical Coverage	Revised	Apr. 1, 2025
Ophthalmologic Vascular Endothelial Growth Factor (VEGF) Inhibitors	Revised	Apr. 1, 2025
Roctavian® (Valoctocogene Roxaparvovec-Rvox)	Revised	Apr. 1, 2025
Somatostatin Analogs	Revised	Apr. 1, 2025

COORDINATED CARE NEWS

UNITED HEALTHCARE

Continued

General Information

The inclusion of a health service (e.g., test, drug, device, or procedure) in this bulletin indicates only that UnitedHealthcare is adopting a new policy and/or updated, revised, replaced, or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the health service. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a health service must be determined in accordance with the member's benefit plan and any applicable federal or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Medical Policy Update Bulletin was developed to share important information regarding changes to our Community Plan of Mississippi Medical Policies and Medical Benefit Drug Policies. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

Policy Update Classifications

New

New clinical coverage criteria have been adopted for a health service (e.g., test, drug, device, or procedure)

Updated

An existing policy has been reviewed and changes have not been made to the clinical coverage criteria; however, items such as the clinical evidence, FDA information, and/or list(s) of applicable codes may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the clinical coverage criteria

Replaced

An existing policy has been replaced with a new or different policy

Retired

The health service(s) addressed in the policy are no longer being managed or are considered to be proven/medically necessary and are therefore not excluded as unproven/not medically necessary services, unless coverage guidelines or criteria are otherwise documented in another policy

The complete library of Medical Policies and Medical Benefit Drug Policies for UnitedHealthcare Community Plan of Mississippi is available at **UHCprovider.com/MS** > Medicaid (Community Plan) > Current Policies and Clinical Guidelines > Medical & Drug Policies.

UnitedHealthcare Community Plan of Mississippi Medical Policy Update Bulletin: March 2025

CALENDAR OF EVENTS

APRIL 2025

THURS., APR 3	EDI Cut Off – 5 p.m.
MON., APR 7	Checkwrite
THURS., APR 10	EDI Cut Off – 5 p.m.
MON., APR 14	Checkwrite
THURS., APR 17	EDI Cut Off – 5 p.m.
MON., APR 21	Checkwrite
THURS., APR 24	EDI Cut Off – 5 p.m.
MON., APR 28	Checkwrite

MAY 2025

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

JUNE 2025

MON., JUNE 2	Checkwrite
THURS., JUNE 5	EDI Cut Off – 5 p.m.
MON., JUNE 9	Checkwrite
THURS., JUNE 12	EDI Cut Off – 5 p.m.
MON., JUNE 16	Checkwrite
THURS., JUNE 19	EDI Cut Off – 5 p.m.
MON., JUNE 23	Checkwrite
THURS., JUNE 26	EDI Cut Off – 5 p.m.
MON., JUNE 30	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 26	**Memorial Day**
FRI., 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/

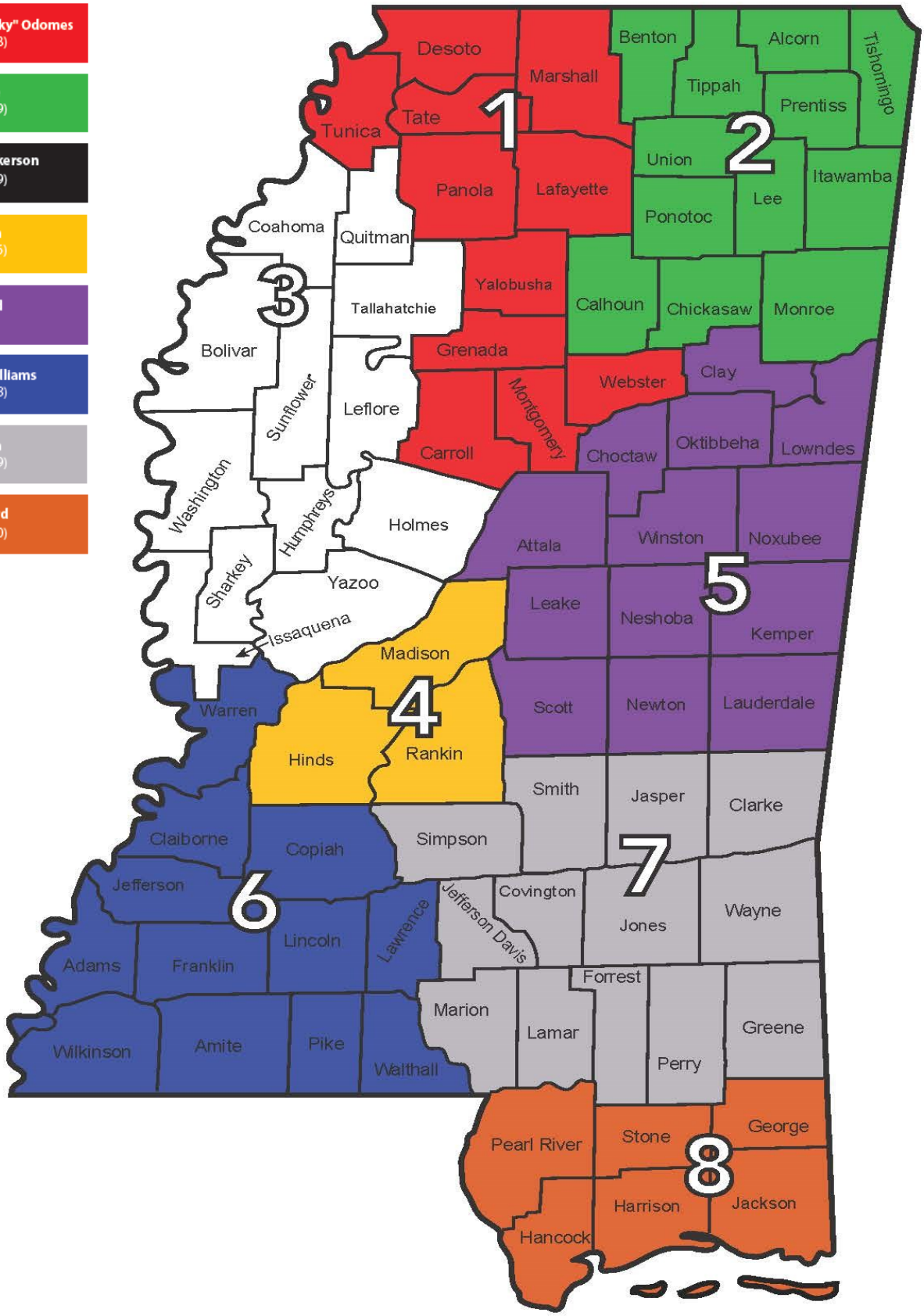
CONTACT INFORMATION

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

GAINWELL TECHNOLOGIES
P.O. BOX 23078
JACKSON, MS 39225
ms_provider.inquiry@mygainwell.onmicrosoft.com

PROVIDER FIELD REPRESENTATIVE REGIONAL

1	Claudia "Nicky" Odomes (601.345.3953)
2	Latrece Pace (601.345.3479)
3	Jasmine Wilkerson (601.345.2859)
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	LaKeida Ward (769.304.1100)



PROVIDER FIELD REPRESENTATIVES

PROVIDER FIELD REPRESENTATIVE AREAS BY COUNTY		
AREA 1 **Claudia (Nicky) Odomes** Claudia.Odomes@gainwelltechnologies.com 601-345-3953	**AREA 2** **Latrece Pace** Latrece.Pace@gainwelltechnologies.com 601-345-3479	**AREA 3** **Jasmine Wilkerson** Jasmine.Wilkerson@gainwelltechnologies.com 601-345-2859
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 **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	Claiborne
	Kemper	Copiah
	Lauderdale	Franklin
	Leake	Jefferson
	Lowndes	Lawrence
	Neshoba	Lincoln
	Newton	Pike
	Noxubee	Walthall
	Oktibbeha	Warren
	Scott	Wilkinson
	Winston	
AREA 7 **Erica Guyton** Erica.Guyton@gainwelltechnologies.com 601-345-3619		**AREA 8** **LaKeida Ward** Lakeida.Ward@gainwelltechnologies.com 769-304-1100
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	**Tiwana Jackson** Tiwana.Jackson@gainwelltechnologies.com 769-867-8761	