Attention: RHC & FQHC Providers  11/15/2019  3:13 pm
Effective December 1, 2019, the Mississippi Division of Medicaid (DOM) will no longer allow Rural Health Clinics (RHCs) and Federal Qualified Health Centers (FQHCs) to bill CPT code 99211 for services rendered. There will be no recoupment of any payments from RHCs and FQHCs for services billed using CPT code 99211 for dates of service prior to December 1, 2019. Please contact the Mississippi Division of Medicaid at 601-359-6150 if you have any questions.

ATTENTION:  Durable Medical Equipment (DME) Providers - Reminder regarding coverage of gloves and disposable wipes  10/11/2019

Gloves
The Mississippi Division of Medicaid (DOM) does not cover gloves provided solely for the convenience of the beneficiary or family, or the convenience of any health care provider; as outlined in Mississippi Administrative Code Title 23: Medicaid Part 200, Rule 5.1: Medically Necessary. DOM reimburses for gloves in accordance with Mississippi Administrative Code Title 23: Medicaid Part 209 Durable Medical Equipment and Medical Supplies, when they are medially necessary and considered standard care for the treatment of a beneficiary’s medical condition and dispensed in quantities that meet a beneficiary’s medical needs without excessive utilization.

Providers should refer to the following DME Administrative Code sections, regarding inclusion of gloves:

Title 23: Medicaid Part 209 Durable Medical Equipment and Medical Supplies
 D. Dressing (Bandaging) Supplies (page 76)
 F. Enteral Feeding (page 76)
 J. Insulin Pump Supplies (page 78)
 L. IV Supplies (page 78)
 S. Suction Pump Supplies -Respiratory and Gastric (page 80)
 T. Drug Infusion Catheter (page 81)
 U. External Drug Infusion Pump (page 82)
 X. Tracheostomy Supplies (page 82)
 Y. Urinary Catheters (page 83)

Disposable Wipes and Washcloths
Incontinence wipes/washcloths do not meet the definition of a medically necessary medical supply and therefore are not reimbursable by the Division of Medicaid

Please contact the Mississippi Division of Medicaid at 601-359-6150, if there are questions.
Attention All Providers! 10/09/2019 11:55 pm
Effective October 1, 2019, the Mississippi Division of Medicaid (DOM) will require prior authorization (PA) of certain Physician Administered Drugs (PADs) billed through the Medical Benefit. DOM covers PADs in accordance with Mississippi Administrative Code Title 23, Part 203, Chapter 2, found on DOM’s public website. [https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-203.pdf](https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-203.pdf)

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Physician Administered Drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1428</td>
<td>Exondys 51 (eteplirsen)</td>
</tr>
<tr>
<td>Q2042</td>
<td>Kymriah (tisagenlecleucel)</td>
</tr>
<tr>
<td>J3398</td>
<td>Luxturna (voretigene neparvovec-zyyl)</td>
</tr>
<tr>
<td>J2326</td>
<td>Spinraza (nusinersen)</td>
</tr>
<tr>
<td>Q2041</td>
<td>Yescarta (xicabtagene ciloleucel)</td>
</tr>
<tr>
<td>J3590*</td>
<td>Zolgensma (onasemnogene abeparvovec-xioi)</td>
</tr>
</tbody>
</table>

*Zolgensma does not have an established HCPCS code*

Failure to obtain authorization will result in denial of payment. The National Drug Code (NDC) number of the drug being administered should be submitted along with its corresponding Healthcare Common Procedure Coding System (HCPCS) Code. Please refer to the PAD fee schedule located on DOM’s public website for PADs requiring a PA [https://medicaid.ms.gov/providers/fee-schedules-and-rates/](https://medicaid.ms.gov/providers/fee-schedules-and-rates/).

Providers must obtain authorization, for fee-for-service (FFS) beneficiaries, from DOM’s Utilization Management and Quality Improvement Organization (UM/QIO). DOM contracts with Alliant Health Solutions, as the UM/QIO vendor. Please refer to Alliant Health Solutions’ provider portal at: [https://ms.allianthealth.org/](https://ms.allianthealth.org/), or call Alliant directly at 1-888-224-3067.

Providers should contact Magnolia Health, Molina Healthcare or United Healthcare Community Plan, for beneficiaries enrolled in Mississippi Coordinated Access Network (MSCAN), for specific authorization and documentation requirements.
Attention All Providers - Medically Unlikely Edits (MUE) Changes  04/01/2018-07/01/2018  09/30/2019  10:01 a.m.

The Division of Medicaid will reprocess claims for dates of service April 1, 2018 through July 1, 2018 due to changes in NCCI's Medically Unlikely Edits (MUE) for CPT codes 88291, 20936, 97169, 97170, 97171, and 97172. The mass adjustment will appear on your remittance advice dated September 30, 2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-844-3222.

Attention Dental Providers - Rate Changes for D7260, D7285, D7286, D7350, D7411, D7520, D7911, D7912 effective 03/01/2019  09/30/2019  10:06 a.m.

The Division of Medicaid will reprocess claims with CDT codes D7260, D7285, D7286, D7350, D7411, D7520, D7911, D7912 for dates of service March 1, 2019 through June 3, 2019. The mass adjustment will appear on your remittance advice dated September 30, 2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
On Nov. 1, the Mississippi Division of Medicaid (DOM) will implement new three-year contracts for the Children’s Health Insurance Program (CHIP).

Although DOM’s coordinated care program, MississippiCAN, includes three coordinated care organizations (CCOs), CHIP will continue to be administered by two vendors because it has a smaller number of members. A little over 46,000 Mississippi children are currently enrolled in CHIP. However, providers should be aware that there is one important change: Molina Healthcare will replace Magnolia Health as one of the two CCOs. UnitedHealthcare Community Plan will continue to serve as the other CHIP vendor. This only applies to CHIP; all three plans will continue to participate in MississippiCAN.

The new CHIP contracts with Molina Healthcare and UnitedHealthcare Community Plan will become operational on Nov. 1, 2019. CHIP beneficiaries currently enrolled with the outgoing CHIP CCO, Magnolia Health Plan, will receive a letter giving them the opportunity to choose between Molina Healthcare and UnitedHealthcare Community Plan. If a CHIP beneficiary does not respond, they will be assigned to Molina Healthcare.

All CHIP beneficiaries can select which plan they want during annual open enrollment which will be held in October through December with an effective date of Jan. 1, 2020. As always, DOM encourages providers to enroll in all Mississippi Medicaid programs and wants providers to be aware that Molina Healthcare will be providing CHIP services come Nov. 1, 2019. For more information about CHIP, visit our website at https://medicaid.ms.gov/programs/childrens-health-insurance-program-chip/.

**NOTICE TO PHARMACY PROVIDERS ONLY**
(DME or Pharmacy Disease Management Providers ARE NOT included)
08/23/19 5:15pm

There will be a point of sale (POS) system outage on Saturday, Aug 24th from 11:00PM CT until Sunday, Aug 25th 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a “System Unavailable” message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.
Attention All Providers!  08/20/19  3:03 pm


Attention Nursing Facilities!  08/20/19  3:05 pm

Effective October 1, 2019, CMS will retire the Medicare Prospective Payment Systems (PPS) 14-day, 30-day, 60-day, 90-day, and Medicare PPS unscheduled assessments. The Mississippi Division of Medicaid (DOM) will not require the submission of the Optional State Assessment (OSA) October 1, 2019.

Attention DME Providers – DOM Coverage of Incontinence Garments
- UPDATE  08/20/2019  3:17 pm

Effective August 1, 2019, Mississippi Division of Medicaid (DOM) coverage of incontinence garments will include the following updates:

- HCPCS code T4525 - age range updated to 0 - 999
- HCPCS code T4544 - for all eligible beneficiaries and should be utilized for billing beginning with dates of service on or after 8/1/2019.
- HCPCS code T4543 - reimbursement will change from ‘priced by prior authorization’ to a reimbursement rate of $1.00 per unit.

Failure to obtain prior authorization of all incontinence garments will result in denial of payment. The updated Medical Supply fee schedule will be available on 8/1/2019 at: https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

As a reminder, DOM covers up to six (6) units of incontinence garments per day, for a maximum of thirty-one (31) days per month, for beneficiaries aged three (3) and above only when certified as medically necessary and prior authorized by the Division of Medicaid or designee. Failure to obtain prior authorization will result in denial of payment. One (1) unit is equal to one (1) diaper or one (1) pull-on or one (1) underpad. The six (6) units can consist of any combination of diapers, pull-ons and/or underpads.

Beneficiaries eligible for certain Home and Community Based Services (HCBS) waivers may receive additional units through those benefits, if medically necessary and prior approved. If applicable, DME providers would receive authorization to provide those additional units from waiver case managers.
NOTICE TO PHARMACY PROVIDERS ONLY
(DME or Pharmacy Disease Management Providers ARE NOT included)
08/09/19 2:26pm

There will be a point of sale (POS) system outage on Saturday, Aug 10th from 11:00PM CT until Sunday, Aug 11th 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a “System Unavailable” message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

ATTENTION: Maternity Providers 08/02/19 1:14 pm

The Division of Medicaid will reprocess claims for dates of service October 1, 2015 through March 12, 2018 which denied due to edit 0750- -FPL-BENEFICIARY HAS PRIMARY INSURANCE C VERAGE RESUBMIT WITH TPL EOB. This mass adjustment will appear on your remittance advice dated August 5,2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers - 97760 Max Unit Change 08/02/19 1:19 pm

The Division of Medicaid will reprocess claims for dates of service July 1, 2015 through September 6, 2017 due to changes in max units on CPT code 97760. The mass adjustment will appear on your remittance advice dated August 5, 2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION ALL PROVIDERS - Autism Spectrum Disorder Fee Update 08/02/19 1:24 pm

The Mississippi Division of Medicaid will reprocess claims billed for dates of service 07/01/2018 through July 18, 2018. The mass adjustment will appear on your remittance advice dated August 5, 2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-844-3222.
**NOTICE TO PHARMACY PROVIDERS ONLY**
**(DME or Pharmacy Disease Management Providers ARE NOT included)**

07/26/19  10:48 am

There will be a point of sale (POS) system outage on Saturday, Jul 27th from 11:00PM CT until Sunday, Jul 28th 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a “System Unavailable” message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

**ATTENTION ALL PROVIDERS - System changes to allow vaccine codes to be billed with 90471**  07/19/19  9:37 am

The Division of Medicaid will reprocess claims with exception code 6558 to allow certain vaccine codes to be billed with CPT code 90471 for dates of service January 1, 2018 through January 1, 2019. The mass adjustment will appear on your remittance advice dated 7/22/2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

**NOTICE TO PHARMACY PROVIDERS ONLY**
**(DME or Pharmacy Disease Management Providers ARE NOT included)**

07/19/19  9:37 am

There will be a point of sale (POS) system outage on Saturday, Jul 20th from 11:00PM CT until Sunday, Jul 21st 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a “System Unavailable” message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

**NOTICE TO PHARMACY PROVIDERS ONLY**
**(DME or Pharmacy Disease Management Providers ARE NOT included)**

07/12/19  2:09 pm

There will be a point of sale (POS) system outage on Saturday, Jul 13th from 11:00PM CT until Sunday, Jul 14th 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a “System Unavailable” message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.
Attention All DME Providers – DOM Coverage of Incontinence Garments  07/01/2019  9:53 am

Effective July 1, 2019, the Mississippi Division of Medicaid (DOM) will reimburse certain HCPCS codes for pull-on incontinence garments for all eligible beneficiaries. DOM covers up to six (6) units of incontinence garments per day, for a maximum of thirty-one (31) days per month, for beneficiaries aged three (3) and above only when certified as medically necessary and prior authorized by the Division of Medicaid or designee. Failure to obtain prior authorization will result in denial of payment. One (1) unit is equal to one (1) diaper or one (1) pull-on or one (1) underpad. The six (6) units can consist of any combination of diapers, pull-ons and/or underpads. The new procedure codes should be utilized for billing beginning with dates of service on or after 7/1/2019.

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<tr>
<th>HCPCS Code</th>
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<tr>
<td>T4526</td>
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<td>T4534</td>
<td>$0.65</td>
</tr>
</tbody>
</table>

Providers can find the complete Administrative Code Filing for Part 209: Durable Medical Equipment (DME) on the Administrative Code final file page. The Medical Supply fee schedule will be available on 7/1/2019 at: https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

Beneficiaries eligible for certain Home and Community Based Services (HCBS) waivers may receive additional units through those benefits if medically necessary and prior approved. If applicable, DME providers would receive authorization to provide those additional units from waiver case managers.

Attention Providers: Accepting Medicare Advantage Part C Secondary Claims Electronically Effective July 1, 2019 - Register for webinar now!!

06/26/19  4:12 pm

Effective July 1, 2019, Medicaid providers will be able to submit electronic claims for dual eligible beneficiaries with Medicare Advantage Part C coverage. The Division of Medicaid and Conduent expect this change to be very beneficial for Medicaid providers. Please review the "What's New" article located on the home page of the Envision Web portal for more details. A webinar will be offered on Tuesday, July 2, 2019 and slots are limited. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Alliant Health Solutions to replace eQHealth Solutions as Medicaid UM/QIO vendor 06/19/19 10:30 am

Beginning Aug. 1, 2019, Alliant Health Solutions will begin performing prior authorization reviews as the Mississippi Division of Medicaid (DOM) transitions to a new Utilization Management/Quality Improvement Organization (UM/QIO) vendor. Alliant was awarded the new UM/QIO contract earlier this year, and will replace the current vendor, eQHealth Solutions, to review and process prior authorizations for fee-for-service Medicaid.

Alliant has already begun reaching out to providers with important enrollment information, and DOM urges providers to read these communications carefully. Both DOM and Alliant will provide more information and updates as they become available. Additionally, instructions and educational materials will be developed and shared through a variety of communications avenues to ensure no provider lacks access to necessary resources.

Prior authorizations for beneficiaries enrolled in MississippiCAN will continue to be handled by the respective coordinated care organizations.

All prior authorization reviews in process before Aug. 1 will be completed by eQHealth as part of the transition to Alliant. Therefore any requests submitted on or before July 31 will be handled by eQHealth and providers will submit related inquiries, requested information and documentation to eQHealth during the month of August. This UM/QIO transition applies to all prior authorization services currently reviewed by eQHealth with the exception of advanced imaging services, which will continue to be handled by eQHealth.

For information on service authorization processes and provider education opportunities, please visit Alliant’s Mississippi Medicaid portal at https://ms.allianthealth.org.

If you have questions about the UM/QIO transition, please contact Alliant through one of the following:

- Website: Alliant Health Solutions Mississippi portal https://ms.allianthealth.org/
- Phone: (888) 224-3067
- Email: mspaportal@allianthealth.org

NOTICE TO PHARMACY PROVIDERS ONLY
(DME or Pharmacy Disease Management Providers ARE NOT included) 06/19/19 10:28 am

There will be a point of sale (POS) system outages on Saturday, Jun 22nd from 11:00PM CT until Sunday, Jun 23rd 4:00AM CT, and also on Saturday, Jun 29th from 11:00PM CT until Sunday, Jun 30th 4:00AM CT to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a “System Unavailable” message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.
NOTICE TO PHARMACY PROVIDERS ONLY
(DME or Pharmacy Disease Management Providers ARE NOT included)  05/31/19  11:28 am

There will be a point of sale (POS) system outage on Saturday, Jun 1st from 11:00PM CT until Sunday, Jun 2nd 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a “System Unavailable” message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

Attention: Nursing Facilities  05/24/19  8:54 am

Effective June 1, 2019, pursuant to its authority under Attachment 4.19-D to the State Plan, Sections 1-7, Subsection B, paragraphs 17 and 18, the Division of Medicaid will assess and impose a sanction against any nursing facility that submits untimely, inaccurate or false information related to resident assessments in order to increase reimbursement above what is allowed under the State Plan. You may read more about this policy on our website at the following link: https://medicaid.ms.gov/wp-content/uploads/2019/05/Case-Mix-Sanction-Policy-for-Inaccurate-Assessments.pdf. Any questions regarding this policy may be directed to the Office of Program Integrity at 601-576-4162.

Attention Family Planning Waiver Providers  05/24/19  8:56 am

Effective April 1, 2019, the Division of Medicaid (DOM) no longer reimburses for CPT code 99211 (Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care profession. Usually the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services) under the Family Planning Waiver (FPW). All FPW visits should include at a minimal, an evaluation of the participant’s contraceptive program, renewal or change of the contraceptive prescription or supplies, and counseling and education.

FPW participants are allowed four (4) visits a year for family planning and family planning related services, which includes one annual/initial visit and three (3) subsequent visits. Participants cannot exceed a total of four (4) visits per calendar year (Jan. 1 – Dec. 31). FPW initial/annual visits should be billed with the appropriate preventive medicine code (99384, 99385, 99386, 99394, 99395, or 99396) and follow-up visits should be billed with the appropriate evaluation and management code (99201-99205 or 99213-99215).

If you have any questions, please contact the Office of Medical Services at (601) 359-6150.
Attention All DME Providers  05/09/19  11:06 a.m.
The Mississippi Division of Medicaid (DOM) does not currently cover pull-ups for non-EPSDT eligible beneficiaries. DOM is in the process of revising this policy to include coverage of pull-ups effective July 1, 2019. In the interim, coverage of incontinence garments for non-EPSDT eligible beneficiaries is limited to diapers and under pads only. Durable medical equipment (DME) suppliers providing pull-ups and billing DOM for diapers must cease and desist immediately. DME suppliers must follow all rules, regulations, and appropriate billing practices for the provision of DME, including incontinence garments.

HOSPITAL INPATIENT APR-DRG ALERT –
July 1, 2019 Updates  05/03/19 1:19pm

The Mississippi Division of Medicaid (DOM) 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, 2019:

The following APR-DRG parameters will be updated:
- Base Payment – will change from $6,585 to $6,731
- Neonate policy adjustor – will change from 1.40 to 1.25
- Pediatric mental health policy adjustor – will change from 2.00 to 1.85
- Adult mental health policy adjustor – will change from 1.60 to 1.50
- DRG Cost Outlier Threshold – will change from $45,000 to $48,500
- DRG Day Outlier per diem – will change from $450 to $675

DOM estimates the overall impact of the above changes will be a savings of $26,282 in state and federal funds.

Due to significant changes in the clinical logic and relative weights from version 35 to version 36 of the 3M APR-DRG grouper, DOM will not update to version 36 on July 1, 2019. The changes to the logic and weights in version 36 would have a substantial impact on hospital reimbursement; as a result DOM has decided to remain on version 35 of the APR-DRG grouper and weights for an extra year in order to study how best to adapt to the new logic and weights. DOM will begin educating hospitals on the potential impacts on reimbursement resulting from version 36 during the APR-DRG training sessions for the July 1, 2019 updates. Additional claims analysis will then be performed using the version 37 grouper when it becomes available, to determine changes in APR-DRG parameters that will be necessary for the July 1, 2020 APR-DRG updates.

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, 2019.

Training will be scheduled with dates to be provided. Hospitals will be notified via e-mail and the DOM website www.medicaid.ms.gov.
Attention: DME Providers  05/03/19  12:57pm

The Division of Medicaid will reprocess DME claims with dates of receipt between January 28, 2019 and February 3, 2019. The mass adjustment will appear on your remittance advice dated May 06, 2019. Providers must correct and resubmit such claims to comply with the required inclusion of NPI/Prov ID for Ordering physicians. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

NOTICE TO PHARMACY PROVIDERS ONLY  05/03/19  12:57 pm
(DME or Pharmacy Disease Management Providers ARE NOT included)

There will be a point of sale (POS) system outage on Saturday, May 18th from 11:00PM CT until Sunday, May 19th 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a “System Unavailable” message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

ATTENTION ALL PROVIDERS– 2018 CPT Code Update
Rate Corrections!!!  03/08/19  1:12 pm

The Mississippi Division of Medicaid will reprocess claims for dates of service January 1, 2018 through January 25, 2018. The mass adjustment will appear on your remittance advice dated March 11, 2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-844-3222.

ATTENTION ALL PROVIDERS!!!!  01/18/19  11:32 am

Change in rate for 4/01/2018 for HCPCS code J7307, Etonogestrel (contraceptive) implant system, including implant and supplies.

The Mississippi Division of Medicaid will reprocess claims for dates of service April 1, 2018 through July 13, 2018. The mass adjustment will appear on your remittance advice dated January 21, 2019. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-844-3222.
ATTENTION OUTPATIENT HOSPITAL PROVIDERS!!!!!!
01/16/19  7:40 pm
Under some circumstances, it is necessary to perform dental procedures in an outpatient hospital setting. The Division of Medicaid (DOM) covers medically necessary dental treatment in the outpatient hospital setting when all the following are met:

1. Quality, safe, and effective treatment cannot be provided in an office setting,
2. Is not medically necessary for inpatient hospitalization, and
3. Prior authorized by the Division of Medicaid or designee.

DOM will implement a billing policy change effective March 2019 for all dental services rendered in an outpatient hospital setting and billed on a UB-04 claim which:

1. Requires prior authorization to be obtained by the dentist (Failure to obtain prior authorization will result in denial of payment),
2. Each unit must be billed on a separate line, and
3. Multiple discounting will apply.

ATTENTION DENTAL PROVIDERS!!!!!!  01/16/19  7:39 pm
Certain dental services do not require prior authorization in the office setting; please refer to the dental provider fee schedule located at medicaid.ms.gov/providers/fee-schedules-and-rates/#. Under some circumstances, it is necessary to perform dental procedures in an outpatient hospital setting. The Division of Medicaid (DOM) covers medically necessary dental treatment in the outpatient hospital setting when all the following are met:

1. Quality, safe, and effective treatment cannot be provided in an office setting,
2. Is not medically necessary for inpatient hospitalization, and
3. Prior authorized by the Division of Medicaid or designee.

DOM will implement a billing policy change effective March 2019 for all dental services rendered in an outpatient hospital setting which requires:

1. The dentist to obtain a prior authorization from the Division of Medicaid or designee for dental services rendered in an outpatient hospital setting, and
2. The treatment authorization number (TAN) and Place of Treatment on the American Dental Association (ADA) Claim form.
2019 Code Changes for Mental Health Providers
01/07/19 4:38 pm

The 2019 CPT code changes include discontinued codes for Autism Spectrum Disorder (ASD) services and Psychological, Neuropsychological, and Developmental Testing. The new procedure codes should be utilized for billing beginning with dates of service on or after 01/01/2019.

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<tr>
<th>Autism Spectrum Disorder (ASD)</th>
<th>Psychological, Neuropsychological and Developmental Testing</th>
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<td>0359T</td>
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New fee schedules for mental health program areas are posted under the provider tab on the DOM website and accessible through the following link:

https://medicaid.ms.gov/providers/fee-schedules-and-rates/#

If you have any questions, please contact the Office of Mental Health at 601 359 9545.

Attention All Providers!!!  12/28/18 4:08pm

The Division of Medicaid will reprocess claims for dates of service January 1, 2018 through January 8, 2018 due to changes on the NCCI 2018 151 quarter update. The mass adjustment will appear on your remittance advice dated December 31, 2018. No further action on the part of the provider is needed.

If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention Outpatient Hospital Providers!!! 12/28/18 4:07pm

The Division of Medicaid will reprocess claims for dates of service January 1, 2015 through January 03, 2018. The mass adjustment will appear on your remittance advice dated December 31, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers!!! 12/28/18 4:06pm

The Division of Medicaid will reprocess claims for dates of service October 1, 2017 through January 2, 2018 due to changes for the October 2017 Physician Administered Drug Fee Update. The mass adjustment will appear on your remittance advice dated December 31, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers!!! 12/28/18 4:04pm

**Influenza Vaccine 90674 added to Edit 6558 to allow payment.**

The Division of Medicaid will reprocess claims for dates of service January 1, 2017 through March 5, 2018. The mass adjustment will appear on your remittance advice dated December 31, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Outpatient Hospital Providers!!! 12/28/18 4:02pm

The Division of Medicaid (DOM) has completed system changes for the new fee updates for SFY19 Outpatient Prospective Payment System (OPPS) and the removal of 5% reimbursement reduction. DOM will reprocess outpatient hospital claims with dates of service July 1, 2018, through October 22, 2018, for these system changes. The mass adjustment will appear on your December 31, 2018 Remittance Advice. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Providers 12/28/18 4:00pm

The Division of Medicaid will reprocess claims for dates of service January 1, 2011 through October 19, 2017. The mass adjustment will appear on your remittance advice dated December 31, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

**CPT Codes 90460, 90461, 90473, 90474, 90644, 90647, 90648, 90655, 90657, 90662 and 90673.**
Attention All Fee-for-Service Home Health Providers: Discontinuation of Home Health Type of Bill 33X  
12/28/18 10:51 am

The Mississippi Division of Medicaid will deny claims submitted with Type of Bill (TOB) 033X for home health services rendered on or after January 28, 2019. Please refer to the current Uniform Billing Editor for guidance regarding TOB codes used for home health claims.

Attention All Providers!!!  12/21/18 4:04pm
OCTOBER 2017 PHYSICIAN ADMINISTERED DRUG FEE UPDATE

The Division of Medicaid will reprocess claims for dates of service October 1, 2017 through January 2, 2018 due to changes for the October 2017 Physician Administered Drug Fee Update. The mass adjustment will appear on your remittance advice dated December 24, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers!!!  12/21/18 4:02pm
NCCI 2018 1st QUARTER UPDATE

The Division of Medicaid will reprocess claims for dates of service January 1, 2018 through January 8, 2018 due to changes on the NCCI 2018 151 quarter update. The mass adjustment will appear on your remittance advice dated December 24, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Providers  12/21/18 4:00pm
S9470 Nutritional Counseling, Dietitian Visit Max age changed from 20 to 55

The Division of Medicaid will reprocess claims for dates of service January 1, 2015 through January 03, 2018. The mass adjustment will appear on your remittance advice dated December 24, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers!!!  11/02/18 10:00am

Fee-For-Service, MississippiCAN & CHIP

2018 Fall Workshops are coming your way!!!

The Division of Medicaid, in conjunction with its contractors Conduent, eQHealth and the MSCAN plans – Magnolia Health, Molina Healthcare and UnitedHealthcare Community Plan, will conduct Provider Workshops November 27, 2018 through December 12, 2018, at varied location across the state. The purpose of these two-day Workshops is to provide updates and changes related to Medicaid and MSCAN. Office directors, office managers, coders and billing staff are encouraged to attend.

HELP US HELP YOU!

Please bring copies of claims and any issues your facility is experiencing to the Workshops. There will be a “Help Desk” available.

The following topics will be covered:

- MississippiCAN & CHIP Upcoming Changes
- Prior Authorization
- Retro Review
- Claims Review
- Dental
- Vision
- Non-Emergency Transportation
- Home Health & Wavier Services
- Durable Medical Equipment
- Hospital Services
- Newborn Services
- Third Party Liability
- Special Investigation Unit & Program Integrity
- HIPAA

See additional information on following page
RSVP SPACE IS LIMITED!
Complete your RSVP information below

| Date Attending Workshop(s): |  |
| Facility Name and Provider ID: |  |
| Number of Attendees from Facility: |  |
| Email and Contact Telephone Number: |  |

Please forward all RSVP replies to:
DOM Office Provider and Beneficiary Relations
Email: ProviderWkspReply@medicaid.ms.gov
Fax: 601-359-4185

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<thead>
<tr>
<th>Dates</th>
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<tr>
<td>Tuesday November 27, 2018</td>
<td>Natchez Convention Center</td>
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<tr>
<td>Wednesday November 28, 2018</td>
<td>211 Main Street</td>
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<tr>
<td></td>
<td>Natchez, MS 39120</td>
</tr>
<tr>
<td>Monday December 3, 2018</td>
<td>Embassy Suites by Hilton</td>
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<td>Tuesday December 4, 2018</td>
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<td>Ridgeland, MS 39157</td>
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<td>Landers Center</td>
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<td>Friday December 7, 2018</td>
<td>4560 Venture Drive</td>
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<td></td>
<td>Southaven, MS 38671</td>
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<tr>
<td>Tuesday December 11, 2018</td>
<td>Northeast Conference Center</td>
</tr>
<tr>
<td>Wednesday December 12, 2018</td>
<td>111 US Hwy 11 and 80</td>
</tr>
<tr>
<td></td>
<td>Meridian, MS 39301</td>
</tr>
</tbody>
</table>
New Billing Requirements Regarding Medicare Advantage Plan/Traditional Medicare EOBs 10/19/18 1:40 pm

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

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

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

Attention: Outpatient Hospital Providers 10/05/18 2:20 pm

The Division of Medicaid (DOM) has updated the new fees for SFY19 Outpatient Prospective Payment System (OPPS) fee schedule, effective July 1, 2018. The OPPS fee schedule can be found at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.

Additionally, Senate Bill 2836 excluded outpatient hospital services from the 5% reimbursement reduction effective July 1, 2018. DOM’s Fiscal Agent is working to successfully update the MMIS claims processing system for the removal of the 5% reduction. DOM anticipates the 5% reduction change in MMIS claims processing system to be completed by October 22, 2018.

Once the 5% reduction system changes are complete, a Mass Adjustment for all outpatient hospital claims, previously submitted for dates of service on or after July 1, 2018, will be completed for the SFY19 OPPS fee updates and the removal of the 5% reduction. No further action on the part of the provider is needed. Please watch Late Breaking News for information on the date these corrected claims will appear on your remittance advice. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

DOM appreciates your patience during this process.
Mandatory Billing Policy Change for 340B Purchased Drugs Takes Effect November 1, 2018

Effective November 1, 2018, the Division of Medicaid (DOM) is implementing a mandatory billing policy whereby providers must identify 340B purchased drugs on claims. This billing policy is in response to the Centers for Medicare and Medicaid Services (CMS) requirement that DOM define its policies and oversight activities related to 340B purchased drugs as outlined in CMS State Release No. 161, dated Oct. 26, 2012. Providers can find the complete Administrative Code Filing on the Administrative Code final file page.

NOTE: This represents a mandatory change to DOM billing policy only and will not impact 340B reimbursement.

The 340B program is a Drug Pricing Program established by the Veterans Health Care Act of 1992, which limits the cost of covered outpatient drugs to certain federal grantees including, but not limited to federally-qualified health center look-alikes, and qualified hospitals. These providers are allowed to purchase, dispense and/or administer pharmaceuticals at significantly discounted prices. The significant discount applied to the cost of these drugs makes them ineligible for the Medicaid drug rebate. State Medicaid programs are mandated to ensure that rebates are not claimed on these drugs thereby preventing duplicate discounts for these drugs.

In early 2017, DOM mailed attestation packets to covered entities, requiring that they opt-in (bill 340B purchased drugs to Medicaid) or opt-out (not bill Medicaid for any 340B purchased drugs). Providers who opt-in must bill the appropriate codes on a claim billed with a 340B purchased drug.

Billing Guidelines for 340B covered entities who have opted in:

- **Medical claims:** On CMS 1500 Health Insurance Claim Form or Uniform Billing (UB04) Form, a “UD” modifier is required to identify a 340B purchased drug in addition to the corresponding Healthcare Common Procedure Coding System (HCPCS) and National Drug Code (NDC).
- **Pharmacy point of sale claims billed electronically in the D.0 format:** The ingredient cost must be billed to DOM at the actual acquisition cost (AAC). This AAC is defined as the price at which the covered entity has paid the wholesaler or manufacturer for the covered outpatient drug.
  * The AAC must be submitted in field #409-D9, field name “ingredient cost submitted”. The professional dispensing fee must be submitted in field # 412-DC, field name “dispensing fee submitted”.
  * Enter “08” in field 423-DN, the Basis of Cost Determination field, and “20” in field 420-DK, the Submission Clarification Code.
Effective for dates of service (DOS) on and after October 1, 2018, the Division of Medicaid will reimburse seventy percent (70%) of the Medicare fee schedule for chiropractic services as required by the Mississippi State Plan.

Please see the below reminders regarding adult day care services billed under the S5100 procedure code for Elderly & Disabled Waiver participants.

For dates of service on or after November 1, 2017, the rate for Adult Day Care was changed to $3.88 per 15 minute unit for the duration of time the services were provided. Services will be reimbursed by DOM the lessor of the total amount of the 15 minute increment units billed or the maximum daily rate of $62.08. Providers should bill the number of actual units provided for each day. The system will pay the claims appropriately, but if the total unit rate exceeds the daily maximum, the line will be automatically adjusted to the daily maximum and a change reason code of ‘LC - LTC Provider Cutback Amount’ will be posted.

Services for the month cannot be billed until the first (1st) day of the month following the month in which services were rendered (i.e. April services cannot be billed until May 1). Claims will receive the following denial edit if this requirement is not met: Edit 0158 – BILLING DATE BEFORE LDOS

All services for the month must be billed on a single claim with individual lines for each date of service to accurately capture units provided each day. Claims for dates of service after September 4, 2018 will receive the following denial edit if this requirement is not met: Edit 1328 - LTC CAP LIMIT SPAN DOS

The duration of the service time should begin upon the person’s entry in the facility and end upon their departure, and does not include transportation time.

If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Effective January 1, 2018, the Division of Medicaid (DOM) required Family Planning Waiver (FPW) initial and annual visits to be billed with the appropriate preventive medicine CPT codes 99384, 99385, 99386, 99394, 99395, or 99396. DOM will reprocess FPW claims which denied incorrectly due to edit 3196 (annual physical assessment/exam to be performed by EPSDT Provider) for dates of service on or after January 1, 2018 for preventive medicine CPT codes 99384, 99385, 99394 and 99395. Providers should continue to bill the appropriate preventive medicine CPT codes for FPW services. The mass adjustment will appear on a future remittance advice and no further action on the part of the provider is needed. If you have any questions, please contact the Office of Medical Services at 601-359-6150.

Stimulant Prescriptions and Prescribing-Guideline Requirements 08/08/2018 8:37 am

Effective October 1, 2018 and in accordance with recommendations from the Drug Utilization Board, the Mississippi Division of Medicaid (DOM) will implement prescribing-guideline clinical edits for stimulant drugs most commonly used to treat attention deficit hyperactivity disorder (ADHD)/attention deficit disorder (ADD) in children and adults. The electronic edit requires the presence of at least one (1) Food and Drug Administration (FDA)-approved indication or compendia-supported indication for each stimulant product prescribed. A list of FDA-approved or compendia-supported indications covered by DOM, along with corresponding ICD-10 codes, can be found on the DOM’s Pharmacy Resource website page located at: https://medicaid.ms.gov/wp-content/uploads/2018/07/Stimulant-Approved-Indications-Coverage.pdf.

In order for a prescription claim to be electronically approved, the diagnosis must be:

- present in the patient’s medical paid claims history within the past 24 months of the prescription fill,

  OR

- written on the prescription by the prescriber and submitted by the pharmacist on the prescription claim.

Providers should be aware the new clinical edit is being implemented and taking effect Oct. 1, 2018, so that they may plan appropriately for uninterrupted care of their patients. For questions or more information, please contact the Office of Pharmacy at 601-359-5253, Option 4.
Updated Provider Enrollment Application
07/11/18  3:00 pm

On May 7, 2018, the Division of Medicaid (DOM) rolled out its Updated Mississippi Medicaid Provider Enrollment Application that has been revised to collect additional information required for enrollments.

Effective July 29, 2018, Conduent will return any applications that are not completed on the revised Mississippi Medicaid Enrollment Application. The provider will be required to complete and resubmit the updated application packet located at https://www.ms-medicaid.com/msenvision/downloadenrollPackage.do.

Providers with questions or needing additional information about the updated enrollment application should contact Provider Enrollment at (800) 884-3222.

ATTENTION ALL PHYSICIANS
07/09/18  12:41 pm

Effective July 1, 2018, the Mississippi Division of Medicaid (DOM) will reimburse professional claim lines billed with Place of Service Code 19 (Outpatient Hospital-Off Campus) at 90% of the Medicare Physician Fee Schedule Site of Service Payment Differential as currently reimbursed with Place of Service codes 21 (Inpatient Hospital), 22 (Outpatient Hospital-On Campus), and 23 (Emergency Room-Hospital). If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Providers
06/29/18  12:07 pm

In accordance with Section 6507 of the Patient Protection and Affordable Care Act, the Mississippi Division of Medicaid utilizes National Correct Coding Initiative (NCCI) methodologies in claims processing. Providers must report services in accordance with Medicaid NCCI guidance. Effective, July 1, 2018, the maximum units for certain Current Dental Terminology codes (CDT) will be updated for the Dental Fees – Outpatient Hospital fee schedule located at https://medicaid.ms.gov/providers/fee-schedules-and-rates/.
Attention All Providers!!! MississippiCAN & CHIP
06/28/18  8:51 am

2018 Workshops are coming your way!!!

The Division of Medicaid, in conjunction with its contractors – Conduent, eQHealth and the MSCAN plans – Magnolia Health, Molina Healthcare and UnitedHealthcare Community Plan, will conduct Provider Workshops July 25, 2018 through September 12, 2018, at varied location across the state. The purpose of these two-day Workshops is to provide updates and changes related to Medicaid and MSCAN. Office directors, office managers, coders and billing staff are encouraged to attend.

HELP US HELP YOU!

Please bring copies of claims and any issues your facility is experiencing to the Workshops. There will be a “Help Desk” available.

The following topics will be covered:

- MississippiCAN & CHIP Upcoming Changes
- Prior Authorization
- Retro Review
- Claims Review
- Dental
- Vision
- Non-Emergency Transportation
- Home Health & Wavier Services
- Durable Medical Equipment
- Hospital Services
- Newborn Services
- Third Party Liability
- Special Investigation Unit & Program Integrity
- HIPAA

Continued on next page
**WHAT’S NEW?**

**RSVP SPACE IS LIMITED!**
Complete your RSVP information below

<table>
<thead>
<tr>
<th>Date Attending Workshop(s):</th>
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<tbody>
<tr>
<td>Facility Name and Provider ID:</td>
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<td>Number of Attendees from Facility:</td>
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<tr>
<td>Email and Contact Telephone Number:</td>
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</tbody>
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Please forward all RSVP replies to:
Division of Medicaid Provider and Beneficiary Relations
**Email:** ProviderWkspReply@medicaid.ms.gov
**Fax:** 601-359-4185

*Continued on next page*
## Workshop Agenda

### Day 1

<table>
<thead>
<tr>
<th>Time</th>
<th>Discussion Topics</th>
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<tbody>
<tr>
<td>9:00 a.m.</td>
<td>Welcome &amp; Introductions</td>
</tr>
<tr>
<td>9:30 a.m.</td>
<td>Medicaid &amp; CCO Overview</td>
</tr>
<tr>
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<td>Upcoming Changes, Provider Enrollment, Credentialing</td>
</tr>
<tr>
<td>10:30 a.m.</td>
<td>Prior Authorizations</td>
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<tr>
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<td>Retro Reviews</td>
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<tr>
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<td>Claims Review</td>
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<tr>
<td>12:30 p.m.</td>
<td><em><strong>LUNCH BREAK</strong></em></td>
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<tr>
<td>1:30 p.m.</td>
<td>Dental Services</td>
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<td>Vision Services</td>
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<td>Non-Emergency Transportation</td>
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<tr>
<td>2:30 p.m.</td>
<td>Home Health &amp; Wavier Services</td>
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<td>Durable Medical Equipment</td>
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### Day 2

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<tr>
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</tr>
<tr>
<td>1:30 p.m.</td>
<td>Hospital Services</td>
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<td>Newborn Services</td>
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<tr>
<td>2:30 p.m.</td>
<td>Third Party Liability Program Integrity</td>
</tr>
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<td>Special Investigation Unit</td>
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On November 8, 2017 the Mississippi Division of Medicaid (DOM) released public notice of Medicaid State Plan (SPA) 17-0015 Durable Medical Equipment (DME) and Medical Supply Reimbursement. The Centers for Medicare and Medicaid Services (CMS) approved SPA 17-0015 on December 14, 2017 with an effective date of November 9, 2017.

SPA 17-0015 states that “[w]hen it is determined by DOM, based on documentation, that the DMEPOS fee is insufficient for the Mississippi Medicaid population or could result in a potential access issue, then a fee will be calculated using market research from the area.” As a result, DOM will modify rates for Healthcare Common Procedure Coding System (HCPCS) codes A4221, A4222, A4253, A4256, A4258 and A4259 to reflect market research from the area. DOM will reprocess claims for dates of service on or after November 9, 2017 which were billed using the aforementioned codes. No further action on the part of the provider is needed. If you have any questions, please contact the Office of Medical Services at 601-359-6150.

<table>
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<tr>
<td>A4259</td>
<td>$8.17</td>
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The Mississippi Division of Medicaid (DOM) 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, 2018:

1) DOM will adopt V.35 of the 3M Health Information Systems APR-DRG Grouper and Hospital-Specific Relative Value (HSRV) weights.

DOM will update the existing methodology used to assign pediatric and adult policy adjustors which is based on principal diagnosis codes and the age of the beneficiary. The new methodology will use the APR-DRG assigned to the stay and the age of the beneficiary to assign a pediatric or adult Medicaid Care Category (as established by DOM.) The Medicaid Care Category will be used to assign a policy adjustor to the inpatient stay.

Charge cap: If the sum of the APR-DRG base payment including effects of policy adjustors, APR-DRG cost outlier payment, APR-DRG day outlier payment, and transfer and/or prorated adjustments, if applicable, is more than the total billed charges on the claim, the total APR-DRG payment amount, net of medical education payments, will be limited to the total billed charges.

The following APR-DRG parameters will be updated:
- Base Payment – will change from $6,415 to $6,585
- Neonate policy adjustor – will change from 1.45 to 1.40
- DRG Cost Outlier Threshold – will change from $50,000 to $45,000
- DRG Cost Outlier Marginal Cost Percentage – will change from 50% to 60%

DOM estimates the overall impact of the above changes will be a savings of $165,620 in state and federal funds.

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, 2018.
Attention Qualified Providers who need to attest/re-attest to receive increased primary care services payments.  Updated 05/07/18  12:26pm

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers at 100% of the Medicare Physician Fee Schedule for certain primary care Evaluation and Management (E&M) and Vaccine Administration codes. Qualified providers who attest to a specialty designation in family medicine, general internal medicine, obstetric/gynecologic medicine, pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), the American Congress of Obstetricians and Gynecologists (ACOG), and the American Osteopathic Association (AOA) may be eligible for increased payment of certain primary care E&M and Vaccine Administration codes.

Effective July 1, 2018, reimbursement of certain primary care services provided by eligible providers will be at 100% of the Medicare Physician Fee Schedule, which is updated July 1 of each year and takes effect January 1. To receive the increased payment for dates of service beginning 7/1/2018, eligible providers must send a completed and signed 7/1/2018 – 6/30/2021 Self-Attestation Statement form to Conduent Provider Enrollment by 6/30/2018 through one of the following means:

- Email: msinquiries@conduent.com
- Fax: 888-495-8169
- Postal mail: P.O. Box 23078, Jackson, MS 39225

Providers must notify Conduent of any change(s) to their completed 7/1/2018 – 6/30/2021 Self-Attestation Statement form. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at https://www.ms-medicaid.com/msenvision/.

Additional information can be found on the DOM website (www.medicaid.ms.gov) and Envision Web Portal (www.ms-medicaid.com/msenvision/), including the PCP Self-Attestation General Instructions and the 7/1/2018 – 6/30/2021 Self-Attestation Statement form, or it can be requested by contacting the Conduent Call Center at 800-884-3222.
Attention Family Planning Waiver Providers!

04/26/2018 1:15pm

The Family Planning Waiver (FPW) standard terms and conditions (STCs) approved by the Centers for Medicare and Medicaid (CMS) effective January 1, 2018 through December 31, 2027, requires the Division of Medicaid (DOM) to report clinical breast exams. As defined by the Centers for Disease Control and Prevention (CDC), a clinical breast exam is an examination by a doctor or nurse, who uses his or her hands to feel for lumps or other changes. A clinical breast exam should be performed during the initial and annual FPW visits.

In an effort to distinguish between the initial/annual visits and follow up visits, effective January 1, 2018, DOM will require FPW initial/annual visits be billed with the appropriate preventive medicine code (99384, 99385, 99386, 99394, 99395, or 99396). Follow-up FPW visits should continue to be billed with the appropriate evaluation and management codes (99201-99205 or 99211-99215).

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

ATTENTION ALL PROVIDERS - ONLY MEDICAL SUPPLIES, EQUIPMENT AND APPLIANCES ORDERED BY A PHYSICIAN ARE COVERED AND REIMBURSED UNDER THE MEDICAID PROGRAM 04/26/18 1:18 pm

In accordance with 42 C.F.R. § 440.70, only medical supplies, equipment and appliances ordered by a physician are covered and reimbursed under the Medicaid program. As a result of discussions with the Centers for Medicare and Medicaid Services (CMS) regarding proposed State Plan Amendment (SPA) 17-0001 Home Health Services, the Division of Medicaid was instructed by CMS to remove the current SPA language which allows non-physician practitioners to order medical supplies, equipment and appliances. Therefore, effective September 1, 2018, the Division of Medicaid will no longer cover medical supplies, equipment and appliances ordered by non-physician practitioners. Durable Medical Equipment (DME) providers are required to specify the ordering physician’s National Provider Identifier (NPI) on any claim for payment to maintain compliance with C.F.R. § 455.440.

For more information regarding the ordering requirements of medical supplies, equipment and appliances, please contact the Office of Medical Services (601) 359-6150.
Attention Pharmacy Providers!  Revised on 04/23/2018 12:25pm

The Division of Medicaid will reprocess 59 Pharmacy Fee For Service claims with Dates of Service from 07/17/2017 to 01/05/2018 for the 17 NDCs listed below, due to a file load error. These claims will be mass adjusted during the week of 4/23/2018 and will be reflected on the Remittance Advice dated 4/30/2018.

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<th>Brand Name</th>
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<td>ACETAMINOPHEN</td>
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<td>ACETAMINOPHEN 325 MG/10.15</td>
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<td>00121197100</td>
<td>ACETAMINOPHEN 650 MG/20.3 M</td>
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<td>00074433902</td>
<td>HUMIRA 40 MG/0.8 ML PEN</td>
<td>ADALIMUMAB</td>
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<td>00074379902</td>
<td>HUMIRA 40 MG/0.8 ML SYRINGE</td>
<td>ADALIMUMAB</td>
</tr>
<tr>
<td>00074433906</td>
<td>HUMIRA PEN CROHN-UC-HS STAR</td>
<td>ADALIMUMAB</td>
</tr>
<tr>
<td>00074433907</td>
<td>HUMIRA PEN PSORIASIS-UVEITI</td>
<td>ADALIMUMAB</td>
</tr>
<tr>
<td>00115164301</td>
<td>NITROFURANTOIN MCR 50 MG CA</td>
<td>NITROFURANTOIN MACROCRYSTAL</td>
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<tr>
<td>00023530105</td>
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<td>CYCLOSPORINE</td>
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<tr>
<td>00023916305</td>
<td>RESTASIS MULTIDOSE 0.05% EY</td>
<td>CYCLOSPORINE</td>
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<tr>
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<td>PRAMLINTIDE ACETATE</td>
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<tr>
<td>000780488515</td>
<td>TEKTURNA 150 MG TABLET</td>
<td>ALISKIREN HEMIFUMARATE</td>
</tr>
<tr>
<td>00078048615</td>
<td>TEKTURNA 300 MG TABLET</td>
<td>ALISKIREN HEMIFUMARATE</td>
</tr>
<tr>
<td>00078052115</td>
<td>TEKTURNA HCT 150-12.5 MG TA</td>
<td>ALISKIREN/ HYDROCHLOROTHIAZIDE</td>
</tr>
<tr>
<td>00078052215</td>
<td>TEKTURNA HCT 150-25 MG TABL</td>
<td>ALISKIREN/ HYDROCHLOROTHIAZIDE</td>
</tr>
<tr>
<td>00078052315</td>
<td>TEKTURNA HCT 300-12.5 MG TA</td>
<td>ALISKIREN/ HYDROCHLOROTHIAZIDE</td>
</tr>
<tr>
<td>00078052415</td>
<td>TEKTURNA HCT 300-25 MG TABL</td>
<td>ALISKIREN/ HYDROCHLOROTHIAZIDE</td>
</tr>
</tbody>
</table>
Attention Providers! 04/06/18
The Division of Medicaid will reprocess claims for dates of service October 01, 2017 through January 30, 2018 which were billed using the codes J0585, J0586, J0587, and/or J0588. The mass adjustment will appear on your remittance advice dated 04/09/2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION ALL PROVIDERS
SY2018 PHYSICIAN FEE UPDATE 04/06/18 11:09 am
The Division of Medicaid has completed the SFY2018 Physician Fee Update effective July 1, 2017. Claims for dates of service on or after July 1, 2017 through August 21, 2017 will be reprocessed. No further action on the part of the provider is needed. These reprocessed claims will appear on your 4/09/2018 remittance advice. If you have any questions, please contact Conduent Provider and Beneficiary services at 800-884-3222.

Attention All Providers 03/23/18 12:42 p.m.
The March 2018 issue of the provider bulletin has been published and is posted to the Envision web portal and on DOM’s website (http://medicaid.ms.gov). DOM providers may download the bulletin by visiting the Envision web portal at https://www.ms-medicaid.com.

Providers now have the option to subscribe (for FREE) and receive the provider bulletin via hard copy print (through postal mail), e-newsletter or both by visiting DOM’s website at https://medicaid.ms.gov; click on Providers, Resources, then Forms. The completed subscription form should be faxed to the Office of provider Beneficiary Relations at 601 359-4185.

Attention: Qualified Medicare Beneficiary (QMB) Providers

2017 QMB Claim Error Claim Resubmission may be required

The Centers for Medicare and Medicaid Services (CMS) modified the Medicare Remittance Advice (Medicare RA) for Qualified Medicare Beneficiary (QMB) claims processed on or after October 2, 2017, to indicate the QMB status of patients that also reflect a zero cost-sharing patient liability.

Continued on next page
However, the Medicare RA changes caused unforeseen issues affecting the processing of QMB cost-sharing claims directly submitted by providers to state Medicaid agencies, including the MS Division of Medicaid (DOM). To address these issues, CMS temporarily suspended the Medicare RA system changes for QMB claims and reverted to the previous display of beneficiary responsibility on the Medicare RA December 8, 2017.

CMS is working to remediate these issues with the goal of reintroducing QMB information in the Medicare RA without disrupting claims processing in 2018.

In order for DOM to process affected QMB claims previously denied or processed incorrectly due to the RA changes for claims processed between October 2, 2017 and December 7, 2017, affected providers should execute the following:

Get the corrected Medicare RA from CMS.

If DOM already paid the claim with the wrong amount (this amount could equate to $0.00 or $XX.XX), provider should void and replace the claim with the corrected patient liability amount based on the corrected Medicare RA.

If a provider has a rejected claim based on the patient liability amount, affected providers should resubmit the claim with revised patient liability amount from the Medicare RA.

For more information, please visit the following webpages:


**ATTENTION: HOSPITAL PROVIDERS**

(02/23/18) 4:19 p.m.

**V.35 HCAC Utility**

For last dates of service on or after October 1, 2017, the Health Care Acquired Conditions (HCAC) utility used to process hospital inpatient claims has been updated to V.35. A Mass Adjustment is being completed for all Hospital inpatient claims previously paid under V.34 of the HCAC utility for last dates of service October 1, 2017 through November 5, 2017, the V.35 implementation date.
ATTENTION: MATERNITY PROVIDERS  
(02/23/18) 4:21 p.m.

The Division of Medicaid will reprocess claims for dates of service October 1, 2015 through October 12, 2017 which denied due to edit 0750-TPL BENEFICIARY HAS PRIMARY INSURANCE COVERAGE - RESUBMIT WITH TPL EOB. This mass adjustment will appear on your remittance dated February 26, 2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary services at 800-884-3222.

ATTENTION ALL PROVIDERS  
October 2017 HCPCS Code Update  
(02/23/18) 4:15 p.m.

The Division of Medicaid will reprocess claims for dates of service October 1, 2017 through December 7, 2017 which were billed using the codes listed in the table below. The mass adjustment will appear on your remittance advice dated February 26, 2018. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Code</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>C9491</td>
<td>C9492</td>
<td>C9493</td>
<td>C9494</td>
</tr>
</tbody>
</table>

ATTENTION ALL HOSPITAL PROVIDERS  
(02/23/18) 4:09 p.m.

The Medicaid Management Information System has been updated to add a date span for capturing the annual changes for POA Exempt diagnosis codes in order to ensure proper payment of hospital inpatient claims. The update was implemented April 18, 2017. A Mass Adjustment is being completed for all related Hospital inpatient claims with last dates of service on or after October 1, 2016, which were processed through April 1, 2017.

Updated Provider Enrollment Application Coming Soon!  
Revised on 02/27/2018 2:00pm- (02/01/18) 1:30 p.m.

On May 07, 2018, the Division of Medicaid (DOM) will roll out its Updated Mississippi Medicaid Provider Enrollment Application that has been revised to collect additional information required for enrollments. It is also anticipated that the updated enrollment application will be more efficient by:

- Employing a user-friendly format to streamline information entry and
- Eliminating entry of duplicate information
Any online applications that were started and saved via the web portal must be completed and submitted before May 7, 2018. Saved web applications which are not submitted by May 7, 2018, will be cancelled and a new application must be submitted.

Watch for upcoming communications on the DOM website and the Mississippi Envision Web Portal. Providers with questions or needing additional information about the updated enrollment application should contact Provider Enrollment at (800) 884-3222.

Attention Professional Services Providers  
(01/26/18) 1:00 p.m.

SFY2018 CPT CODE UPDATE  
The Division of Medicaid has corrected errors in the professional services rates posted for the 2018 CPT Code Update. Claims beginning with dates of service 1/1/2018 will be reprocessed for the codes listed below. No further action on the part of the provider is needed. Please watch Late Breaking News for information on the date these corrected claims will appear on your remittance advice. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

00731 00732 00811 00812 00813 15730 15733 19294 20939 31241 31253 31257 31259 31298 32994 33927 33928 33929 34701 34702 34703 34704 34705 34706 34707 34708 34709 34710 34711 34712 34713 34714 34715 34716 36465 36466 36482 36483 38222 38573 43286 43287 43288 55874 58575 64912 64913 71045 71046 71047 71048 74018 74019 74021 81108 81109 81110 81111 81112 81120 81121 81283 81334 81335 81346 81361 81448 81520 81521 86794 87634 87662 93793 94617 94618 95249 96573 96574 97763 99483 99492 99493 99494 99484

January 2018 Code and Fee Updates are Delayed  
(01/12/18) 10:00 a.m.

The Division of Medicaid will be delayed in completing the annual and quarterly code and fee updates indicated below which are effective January 1. Once the code and fee updates have been completed, the Division of Medicaid will reprocess impacted claims. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Physician Administered Drug (PAD) Fee Update  
Healthcare Common Procedure Coding System (HCPCS) Code Update
Allergen Immunotherapy and Antigen Preparation—NCCI Medically Unlikely Edits

(01/10/18) 9:10 a.m.

In accordance with Section 6507 of the Patient Protection and Affordable Care Act, the Division of Medicaid utilizes National Correct Coding Initiative (NCCI) methodologies in claims processing. Effective July 1, 2016, the Medically Unlikely Edits (MUEs) for CPT 95165 changed to 30 units of service. Specific information on Allergen Immunotherapy and Antigen Preparation may be found in the NCCI Policy Manual in Chapter 11, Sections K.3, K.4, and V.3.

Information on NCCI in Medicaid is located at https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html. Providers are encouraged to review the Medicaid NCCI Change Report posted on this webpage regularly to identify changes which may impact claims processing.

Medicaid Provider Bulletin Transition

(01/08/18) 11:40 a.m.

Effective January 2018, the Mississippi Division of Medicaid (DOM) will no longer auto-mail the quarterly publications of the provider bulletin. Providers may still download the bulletin by visiting the Envision web portal at https://www.ms-medicaid.com.

Providers also have the option to subscribe (for FREE) and receive the provider bulletin via hard copy print (through postal mail), e-newsletter or both by visiting DOM’s website at https://medicaid.ms.gov; click on Providers, Resources, then Forms. The completed subscription form should be faxed to the Office of provider Beneficiary Relations at 601 359-4185.
Notice to Pharmacy Providers- this includes Provider types: H01, H02, H04, H07 and ZP0.
(01/05/18) 2:10 p.m.

Effective January 8, 2018 Remittance Advice. This notice affects Pharmacies with Expired Licenses on 12/31/2017 and received claims that were returned as paid for dates of service on or after 1/1/2018. Claims that paid for a pharmacy with an expired license and Medicaid ID will not be pulled into the January 8, 2018 Remittance Advice. They will be reprocessed the week of January 8th, and show up on the January 15, 2018 Remittance Advice. PLEASE BE ADVISED: after the grace period extension to Jan 31, 2018, claims for pharmacies who have still not renewed WILL DENY.

Attention All Elderly and Disabled (E&D) Waiver Case Management Providers
(12/12/17) 4:40 p.m.

RATE CHANGE!
For dates of service on or after November 1, 2017, the rate for Case Management (T2022) has been changed to $180.68 per month. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.

Attention All Elderly and Disabled (E&D) Waiver Adult Day Care Providers
(12/12/17) 4:40 p.m.

RATE CHANGE!
For dates of service on or after November 1, 2017, the rate for Adult Day Care has been changed to $3.88 per 15 minute unit for the duration of time the services were provided. Services will be reimbursed by DOM the lessor of the total amount of the 15 minute increment units billed or the maximum daily rate of $62.08. The requirement for a person to attend the ADC for a minimum of four (4) hours per day has been removed. These changes optimize autonomy and independence in choices for ADC attendance.

Also, please note that the procedure code for Adult Day Care has been changed from S5102 to S5100. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.
Attention All Elderly and Disabled (E&D) Waiver Personal Care Service Providers
(12/12/17) 4:40 p.m.

RATE CHANGE!
For dates of service on or after July 1, 2017, the rate for Personal Care Services (T1019) has been changed to $4.41 per 15 minute unit. A Mass Adjustment is being completed for all Personal Care Service claims previously submitted at the old rate for dates of service on or after July 1, 2017. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.

Attention All Elderly and Disabled (E&D) Waiver In-Home Respite Providers
(12/12/17) 4:40 p.m.

RATE CHANGE!
For dates of service on or after July 1, 2017, the rate for In-Home Respite (S5150) has been changed to $4.41 per 15 minute unit. A Mass Adjustment is being completed for all In-Home Respite claims previously submitted at the old rate for dates of service on or after July 1, 2017. As a reminder, Elderly and Disabled Waiver services must always be billed with a U1 modifier.

Attention All Providers
(12/07/17) 4:40 p.m.

CPT Code 62319 and 62326
The Division Of Medicaid will reprocess claims for dates of service January 1, 2017 through May 17, 2017 which were billed using the codes 62319 and 62326. The mass adjustment will appear on your remittance advice dates 12/11/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers
(12/01/17) 9:00 a.m.

Various CPT Code Updates
The Division Of Medicaid will reprocess claims for dates of service January 1, 2016 through March 6, 2017 which were billed using the CPT codes listed in the table below. The mass adjustment will appear on your remittance advice dates 12/04/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>CPT Code</th>
<th>CPT Code</th>
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<td>73501</td>
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<tr>
<td>73522</td>
<td>73523</td>
<td>73551</td>
<td>73552</td>
</tr>
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</table>

Attention All Providers
(12/01/17) 9:00 a.m.

Immunotherapy Code Updates
The Division Of Medicaid will reprocess claims for dates of service July 1, 2016 through May 22, 2017 which were billed using the codes listed in the table below. The mass adjustment will appear on your remittance advice dates 12/04/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

<table>
<thead>
<tr>
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<th></th>
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<td>95017</td>
<td>95027</td>
<td>95052</td>
<td>95149</td>
<td>95180</td>
</tr>
</tbody>
</table>

Attention All Providers
(12/01/17) 9:00 a.m.

CPT Code 90686 and 90688
The Division Of Medicaid will reprocess claims for dates of service November 18, 2016 through June 20, 2017 which were billed using the codes 90686 and 90688. The mass adjustment will appear on your remittance advice dates 12/04/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention Telehealth Providers
(12/01/17) 9:00 a.m.

Place Of Service (POS) 02

The Division of Medicaid will reprocess claims for dates of service January 01, 2017 through May 19, 2017 which were billed using place of service (POS) code 02. The mass adjustment will appear on your remittance advice dated 12/04/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

2018 New Bed Values for Nursing Facilities, ICF-IIDs, PRTFs, and NSFDs
(11/29/17) 2:25 p.m.

The new bed values for 2018 for nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs), psychiatric residential treatment facilities (PRTFs) and Nursing Facilities for the Severely Disabled (NFSDs) have been determined by using the R.S. Means Historical Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

<table>
<thead>
<tr>
<th>Facility Class</th>
<th>2018 New Bed Value</th>
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<tbody>
<tr>
<td>Nursing Facility</td>
<td>$92,875</td>
</tr>
<tr>
<td>ICF-IID</td>
<td>$111,450</td>
</tr>
<tr>
<td>PRTF</td>
<td>$111,450</td>
</tr>
<tr>
<td>NFSD</td>
<td>$162,531</td>
</tr>
</tbody>
</table>
Attention Maternity Providers
(10/19/17) 2:04 p.m.

Effective July 1, 2017, Mississippi Division of Medicaid (DOM) received Centers for Medicare and Medicaid Services (CMS) approval of State Plan Amendment (SPA) 17-0003 Screening, Brief Intervention, and Referral to Treatment (SBIRT). As a result, DOM covers early intervention services for pregnant women with nondependent substance use to prevent problematic substance use disorders.

SBIRT is an early intervention approach that targets pregnant women with nondependent substance use to provide effective strategies for intervention prior to the need for more extensive or specialized treatment.

SBIRT services must include:

1. Screening for risky substance use behaviors using evidence based standardize assessments or validated screening tools,
2. Brief intervention of a pregnant woman showing risky substance use behaviors in a short conversation, providing feedback and advice, and
3. Referral to treatment for brief therapy or additional treatment to a pregnant woman whose assessments or screenings indicate a need for additional services.

DOM covers one (1) SBIRT service per pregnancy when performed by one (1) of the following licensed practitioners:

1. Physician,
2. Nurse Practitioner,
3. Certified Nurse Midwife,
4. Physician Assistant,
5. Licensed Clinical Social Worker,
6. Licensed Professional Counselor, or
7. Clinical Psychologist.

SBIRT services should be billed with HCPCS code G0396 (Alcohol and/or substance (other than tobacco) abuse structured assessment, and brief intervention 15 - 30 min) or G0397 (Alcohol and/or substance (other than tobacco) abuse structured assessment >30 min) and is only allowed once per pregnancy.

For more information regarding SPA 17-0003 SBIRT, please refer to the DOM website at medicaid.ms.gov/about/state-plan/approved-state-plan-amendments/ or contact the Office of Medical Services at (601) 359-6150.
2017 Owner Salary Limits for Long-Term Care Facilities
(10/05/17) 8:30 a.m.

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities as owner’s salaries for 2017 are based on 150% of the average salaries paid to non-owner/administrators that receive payment for services related to patient care. The limits apply to all salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2017 are as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost for 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small Nursing Facilities (1 - 60 Beds)</td>
<td>$133,454</td>
</tr>
<tr>
<td>Large Nursing Facilities (61+ Beds)</td>
<td>$156,183</td>
</tr>
<tr>
<td>Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)</td>
<td>$133,688</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facilities (PRTF)</td>
<td>$136,665</td>
</tr>
</tbody>
</table>

Allowable Board of Directors Fees for Long-Term Care Facilities2017 Cost Reports
(10/05/17) 8:30 a.m.

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2017 cost reports filed by nursing facilities (NFs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and psychiatric residential treatment facilities (PRTFs) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for all Urban Consumers - All Items. The amounts listed below are the per-meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2017 are as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>Maximum Allowable Cost for 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 99 Beds</td>
<td>$ 4,121</td>
</tr>
<tr>
<td>100 – 199 Beds</td>
<td>$ 6,182</td>
</tr>
<tr>
<td>200 – 299 Beds</td>
<td>$ 8,242</td>
</tr>
<tr>
<td>300 – 499 Beds</td>
<td>$10,303</td>
</tr>
<tr>
<td>500 Beds or More</td>
<td>$12,363</td>
</tr>
</tbody>
</table>
Attention All Providers
(10/05/17) 8:30 a.m.

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), effective October 1, 2017, the Division of Medicaid will no longer require a secondary mental illness diagnosis when reimbursing for medically necessary services to treat a substance use disorder (SUD). This change does not affect normal prior authorization requirements.

The final rules under the MHPAEA can be found here:

For questions related to this change, contact the Office of Mental Health at 601-359-9545.

Attention All Elderly and Disabled (E&D) Waiver Home Delivered Meal (HDM) Providers
(9/29/17) 11:00 a.m.

RATE CHANGE!

For dates of service on or after April 1, 2017, the Home Delivered Meal (HDM) rate has been increased to $4.96 per unit. A Mass Adjustment is being completed for all Home Delivered Meal claims previously submitted at the old rate for dates of services after the April 1st start date. The procedure code HDM is S5170 and must always be billed with U1 modifier for services provided under the Elderly and Disabled Waiver.
Attention All Long-term Care Facilities’ Cost Report Preparers
(9/26/17) 3:55 p.m.

“Integrated” Cost Report Forms

DOM has uploaded to its website a new file for the filing of nursing facilities’ cost reports. This comprehensive file contains all of the current cost report forms needed for filing with the Division of Medicaid. The forms have been integrated, linked and are formula-driven for ease of use and reporting of costs and other data. The use of this new file and its forms should negate some of the errors and omissions that are occasionally found in cost report submissions. Providers and their cost report preparers are encouraged to utilize this file immediately to complete and submit their 2017 cost reports, as well as subsequent period reports.

The current website listing of each individual cost report form will be maintained for use if needed, especially when only completing and submitting certain amended forms and schedules for current and prior periods.

Please note that the new comprehensive file only combined the current cost report forms into a single file with identifying tabs, and did not make any substantive changes. This new file integrated and linked the cost report forms to one another, as well as inserted formulas, per the cost report instructions, into their applicable cells, columns and rows that were previously the responsibility of the preparers.

The cost report instructions for completing these new “integrated” forms remain the same as for the current individual ones.

If you have questions or concerns on the above, please contact T. J. Walker @ 601-359-6827, or T.J.Walker@medicaid.ms.gov.
Attention All Providers
(9/22/17) 11:00 a.m.

2016 CLIA Lab Classification and Certification Update

The Division of Medicaid will reprocess claims for dates of service January 1, 2015 through February 3, 2016 which were billed using codes. The mass adjustment will appear on your remittance advice dated 9/25/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

G0477 81162 81314 81490 81545 G0478 81170 81412 81493 81595 G0479 81218 81432 81525 88350 G0480 81219 81433 81528 0009M G0481 81272 81434 81535 0010M G0482 81273 81437 81536 G6037 G0483 81276 81438 81538 G6050 80081 81311 81442 81540 0103T


Attention All Providers  
(9/22/17) 11:00 a.m.

The Division of Medicaid will reprocess claims for dates of service January 1, 2017 through February 17, 2017 which were billed using CPT code 77065, 77066 and 77067. The mass adjustment will appear on your remittance advice dated 9/25/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Elderly and Disabled (E&D) Waiver Home Delivered Meal (HDM) Providers  
(8/30/17) 3:45 p.m.  

RATE CHANGE!

For dates of service on or after April 1, 2017, the Home Delivered Meal (HDM) rate has been increased to $4.96 per unit. A Mass Adjustment is being completed for all Home Delivered Meal claims previously submitted at the old rate for dates of services after the April 1st start date. The procedure code for HDM is S5170 and must always be billed with a U1 modifier for services provided under the Elderly and Disabled Waiver.

Attention All Vision Providers  
(8/25/17) 11:00 a.m.

The Division of Medicaid will reprocess claims for dates of service July 21, 2014 through January 19, 2017 which incorrectly applied a $3.00 copay to code 92341- FITTING OF SPECTACLES EXCEPT FOR APHAKIA; BIFOCAL. The mass adjustment will appear on your remittance advice dated 8/28/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All ID/DD Waiver Providers!
(8/24/17) 8:30 a.m.

Rate Changes

Effective 5/1/2017, Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver rate changes for the following procedure codes are complete.

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Procedure Code</th>
<th>Second Modifier</th>
<th>Updated Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior Support Evaluation &lt;6 hours</td>
<td>H002</td>
<td></td>
<td>$310.64 per evaluation</td>
</tr>
<tr>
<td>Behavior Support Evaluation &gt;6 hours</td>
<td>H0002</td>
<td>TF</td>
<td>$621.27 per evaluation</td>
</tr>
<tr>
<td>Behavior Support Specialist</td>
<td>H2019</td>
<td>HN</td>
<td>$12.70 per 15 minute unit</td>
</tr>
<tr>
<td>Behavior Support Consultant</td>
<td>H2019</td>
<td>HO</td>
<td>$18.14 per 15 minute unit</td>
</tr>
<tr>
<td>Community Respite</td>
<td>S5150</td>
<td></td>
<td>$2.63 per 15 minute unit</td>
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<tr>
<td>Crisis Intervention Daily</td>
<td>T2034</td>
<td></td>
<td>$525.41 per day</td>
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<tr>
<td>Crisis Intervention Hourly</td>
<td>S9484</td>
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<td>$27.68 per hour</td>
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<tr>
<td>Day Services Low Support Level (1, 2)</td>
<td>S5100</td>
<td></td>
<td>$3.78 per 15 minute unit</td>
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<tr>
<td>Day Services Medium Support Level (3)</td>
<td>S5100</td>
<td>TF</td>
<td>$4.10 per 15 minute unit</td>
</tr>
<tr>
<td>Day Services High Support Level</td>
<td>S5100</td>
<td>TG</td>
<td>$4.66 per 15 minute unit</td>
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<tr>
<td>Home and Community Supports, Short Term</td>
<td>S5125</td>
<td>TF</td>
<td>$6.18 per 15 minute unit</td>
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<tr>
<td>Home and Community Supports, Long Term</td>
<td>S5125</td>
<td>TG</td>
<td>$4.35 per 15 minute unit</td>
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<td>Host Home</td>
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<td>$95.38 per day</td>
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<td>In-Home Nursing Respite</td>
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<td>$8.93 per 15 minute unit</td>
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<td>$11.16 per 15 minute unit</td>
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<td>Prevocational Low Support Level (1,2)</td>
<td>T2015</td>
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<td>$13.28 per hour</td>
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<td>Prevocational High Support Level (4,5)</td>
<td>T2015</td>
<td>TG</td>
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<td>Support Coordination*</td>
<td>T2022</td>
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<td>$203.87 per month</td>
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<td>Supervised Living , 4 beds or fewer, Low Support (Level 1,2)</td>
<td>S5136</td>
<td>UQ</td>
<td>$184.89 per day</td>
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<td>Supervised Living , 5 or more beds, Low Support (Level 1,2)</td>
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<td>UR</td>
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<td>Supervised Living , Medical Group Home</td>
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<td>Supervised Living , Behavioral Health Home</td>
<td>S5136</td>
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<td>$465.96 per day</td>
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<td>Supported Employment ,Job Development</td>
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<td>$8.80 per 15 minute unit</td>
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<tr>
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<td>Supported Employment 2 Person</td>
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<td>$5.22 per 15 minute unit</td>
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<td>Supported Living Intermittent, 3 person</td>
<td>S5135</td>
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<td>Transition Assistance</td>
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*Support Coordination 2nd Level with Second Modifier of TF has been discontinued.*

Modifier U3 must be added to every procedure code.

A mass adjustment will be made to address these changes for claims billed with dates of service on or after May 1, 2017. If your claims do not appear in the mass adjustment, you will need to adjust the claims. New and Tiered Service includes Supervised Living, Shared Supported Living, In-Home Respite, Supported Employment – Job Maintenance, and Crisis Intervention – 15 minute. Updates to the Medicaid Management Information System (MMIS) to add these new services and tiered rates are forthcoming and providers will be notified upon completion. Due to the timeframe it will take to implement the new and tiered rates, providers may continue to bill the current procedure codes and adjust their claims once MMIS is updated or providers may hold their claims until the process is complete.
Fee Schedule Updates for Mental Health Providers
(8/21/17) 3:50 p.m.

2017 Annual Fee Updates

Effective 7/1/2017, the Division of Medicaid (DOM) revised reimbursement rates for mental health providers as required by State law and the State Plan. New fee schedules for mental health program areas are posted under the provider tab on the DOM website and accessible through the following links:

Community/Private Mental Health Centers:

Psychiatry:

Therapeutic and Evaluative Services for Expanded EPSDT (T&E):

Please refer to the most current CPT Code Book for the appropriate procedure code(s) for services provided.

You may contact Jessica Bunch or Penny Torrey-Burns at 601-359-9545 with any questions.

Attention All Providers
(7/28/17) 10:00 a.m.

CPT Code 81211 and 81213
The Division of Medicaid will reprocess claims for dates of service March 1, 2016 through January 12, 2017 which were billed using Code 81211 and 81213. The mass adjustment will appear on your remittance advice dated 7/31/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers
(7/28/17) 10:00 a.m.

Various SFY2017 Casting Code Fee Update
The Division of Medicaid will reprocess claims for dates of service July 1, 2016 through July 20, 2016 which were billed using HCPCS Codes listed below. The mass adjustment will appear on your remittance advice dated 7/31/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

'Q4001', 'Q4002', 'Q4003', 'Q4004', 'Q4005', 'Q4006', 'Q4007', 'Q4008', 'Q4009', 'Q4010', 'Q4011', 'Q4012', 'Q4013', 'Q4014', 'Q4015', 'Q4016', 'Q4017', 'Q4018', 'Q4019', 'Q4020', 'Q4021', 'Q4022', 'Q4023', 'Q4024', 'Q4025', 'Q4026', 'Q4027', 'Q4028', 'Q4029', 'Q4030', 'Q4031', 'Q4032', 'Q4033', 'Q4034', 'Q4035', 'Q4036', 'Q4037', 'Q4038', 'Q4039', 'Q4040', 'Q4041', 'Q4042', 'Q4043', 'Q4044', 'Q4045', 'Q4046', 'Q4047', 'Q4048', and 'Q4049'.

Attention All Providers
(7/14/17) 10:00 a.m.

Various HCPCS Codes
The Division of Medicaid will reprocess claims for dates of service January 1, 2017 through March 29, 2017 which were billed using HCPCS Codes listed below. The mass adjustment will appear on your remittance advice dated 7/31/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

HCPCS Codes
A9587, A9588, C9140, J0883, J2182, J2786, J7175, J7202, J7207, J7209, J7322, J7342, and J8670.

Attention All Providers
(7/14/17) 10:00 a.m.

HCPCS Code J1050
The Division of Medicaid will reprocess claims for dates of service January 1, 2017 through January 17, 2017 which were billed using HCPCS Code J1050. The mass adjustment will appear on your remittance advice dated 7/14/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers  
(7/14/17) 10:00 a.m.

The Division of Medicaid will reprocess Healthier MS Waiver (HMW) claims which denied incorrectly due to edit 3955 (Service Not Covered for Beneficiary) for dates of service on or after July 24, 2015 through September 12, 2016 for podiatry, eyeglasses, dental and chiropractic services. The mass adjustment will appear on your remittance advice dated 7/14/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: EPSDT Providers  
(7/10/17) 9:00 a.m.

The American Academy of Pediatrics (AAP) released Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents, 4th, Edition. A summary of the changes can be found at brightfutures.aap.org/about/Pages/About.aspx. To comply with Bright Futures recommendations, effective August 1, 2017 the Division of Medicaid (DOM) will no longer reimburse a separate fee for adolescent counseling when billed on the same date of service (DOS) as a wellness visit (99381-99385 and 99391-99395). Adolescent counseling is included in anticipatory guidance during the preventive medicine visit. Providers may bill adolescent counseling as a separate reimbursable service with evaluation and management codes 99201-99215. Providers may utilize the adolescent counseling form on the DOM website medicaid.ms.gov but the form is not required.

Effective January 1, 2017, DOM reimburses a separate fee in addition to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) periodic screenings for maternal depression screening. DOM is in the process of updating Mississippi Administrative Code Title 23, Part 223 and Provider Reference Guide to reflect the changes. If you have any questions, please contact DOM Office of Medical Services at (601) 359-6150.

Resources:
Fee Schedule medicaid.ms.gov/wp-content/uploads/2014/03/EPSDT.pdf
Attention Autism Spectrum Disorder Service Providers
(7/05/17) 2:50 p.m.

On May 24, 2017, the Centers for Medicare & Medicaid Services (CMS) approved Mississippi State Plan Amendment (SPA) 16-0020 Autism Spectrum Disorder (ASD) to allow the Mississippi Division of Medicaid (DOM) to cover ASD services for Early, Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries with an ASD diagnosis when medically necessary, prior authorized and provided by certain providers operating within their scope of practice, effective January 1, 2017.

The SPA can be found on DOM’s website under approved State Plan Amendments located at medicaid.ms.gov/about/state-plan/approved-state-plan-amendments/.

ENROLLMENT
For more information on how to enroll as a Medicaid provider, contact Conduent at 800-884-3222 or go online to ms-medicaid.com/msenvision/index.do. Under the Provider tab, click on Provider Enrollment and select to either enroll online or download an enrollment packet.

You must be an enrolled Medicaid provider prior to enrollment with a coordinated care organization (CCO). For more information on how to enroll as a MississippiCAN provider, contact each CCO at:

**Magnolia Health Plan**
Phone: (866) 912-6285
Online: magnoliahealthplan.com/providers/become-a-provider.html

**United Healthcare**
Phone: (877) 743-8734
Online: uhc.com/provider

ELIGIBILITY
Eligibility can be determined through the use of either of the following services:
- Automated Voice Response System (AVRS) at 1-866-597-2675
- Provider/Beneficiary Services Call Center at 1-800-884-3222
- Envision Web Portal at ms-medicaid.com

Eligibility and service standards should be verified each time a service is rendered.

PRIOR AUTHORIZATION
- To submit a prior authorization for beneficiaries enrolled in fee for service, contact eQHealth Solutions (eQHS) at (866) 740-2221 or online using the eQHealth Suite at ms.eqhs.org/Home.aspx.
- To obtain more information on how to submit a prior authorization for beneficiaries
• To obtain more information on how to submit a prior authorization for beneficiaries enrolled with Magnolia Health Plan, contact Cenpatico at (866) 912-6285.
• To obtain more information on how to submit a prior authorization for beneficiaries enrolled with United Healthcare, contact Optum at (877) 743-8734.

CLAIMS SUBMISSION
• To submit a claim for beneficiaries enrolled in fee for service, access the Envision Web Portal at ms-medicaid.com/msenvision/index.do.
• To obtain more information on how to submit a claim for beneficiaries enrolled with Magnolia Health Plan, contact Cenpatico at (866) 912-6285.
• To obtain more information on how to submit a claim for beneficiaries enrolled with United Healthcare, contact Optum at (877) 743-8734.

Billing for these services can begin immediately and are covered for dates of service on or after January 1, 2017. DOM fee schedules are located on the DOM website at medicaid.ms.gov/providers/fee-schedules-and-rates/.

Providers are encouraged to monitor the website for updates and announcements regarding ASD services. Frequently Asked Questions for ASD services are located on DOM’s website at medicaid.ms.gov/programs/mental-health/.

For further questions, contact DOM’s Office of Mental Health at (601) 359-9545.

Attention All Providers
(7/03/17) 9:00 a.m.

HCPCS Code J0585
The Division of Medicaid will reprocess claims for dates of service July 1, 2015 through March 22, 2017 which were billed using HCPCS Code J0585. The mass adjustment will appear on your remittance advice dated 6/30/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Hospice Providers; Update from August 2016 Notice
(6/22/17) 4:45 p.m.

DOM’s Fiscal Agent has successfully updated the Medicaid MMIS claims processing system for Routine Home Care level of Hospice services. As of July 1, 2016, current Hospice claim payments should reflect the new methodology. Payment of the Service Intensity Add-on rate for the last seven days of life will not be paid until additional information is provided.

See Late Breaking News, https://www.ms-medicaid.com/msenvision/index.do, for the additional SIA billing requirements.

DOM anticipates proceeding with the mass adjustment to re-process Routine Home Care level claims for dates of service January 1 through June 30, 2016 during the month of June (2017). The mass adjustment will adjust those claims that were paid at the higher “T1” rate for day 61 and after instead of the lower “T2” rate. In most cases, this will result in a recoupment of funds. Providers will need to resubmit SIA claims with the required additional coding in order to be reimbursed the SIA.
Attention Hospice Providers; Update from August 2016 Notice
(6/15/17) 10:15 a.m.

DOM’s fiscal agent, Conduent Government Healthcare Solutions, has successfully updated the Medicaid MMIS claims processing system to process payment for Routine Home Care (Revenue 0651) level of Hospice services, as required by CMS’s methodology change. As of July 1, 2016, current Hospice claim payments should reflect the Tier-1 (T1) and Tier-2 (T2) Routine Home Care Rates. The (T1) higher rate is for the first 60 days of services and the lower rate (T2) is for days 61 and thereafter. Payment of the Service Intensity Add-on (SIA) rate for the last seven (7) days of life, which meet the registered nurse or social worker requirements, will not be paid until the following additional information is provided.

Reimbursement for the SIA component will require providers to identify on their claim when Registered Nurse (RN) or Social Worker (SW) services are provided. For RN services, providers will use 0559 Revenue Code and G0299 Procedure Code, along with the number of units provided. For this combination, one (1) unit is fifteen (15) minutes. For SW services, providers will use 0561 Revenue Code and G0155 Procedure Code for clinical social work services. For non-clinical social work services, Providers will use 0569 Revenue Code and G0155 Procedure Code, along with the number of units provided. These combinations will also be calculated as one (1) unit per fifteen (15) minutes.

DOM anticipates proceeding with the mass adjustment to re-process Routine Home Care level claims for dates of service January 1 through June 30, 2016 during the month of June (2017). The mass adjustment will adjust those claims that were paid at the higher “T1” rate for day 61 and after instead of the lower “T2” rate. In most cases, this will result in a recoupment of funds ranging from $34.55 to $37.28, per day, per beneficiary, depending on the county in which services were provided. Providers will need to resubmit SIA claims with the required additional coding in order to be reimbursed the SIA rate for beneficiaries that expired and had the pre-requisite services during the last seven (7) days of life.

DOM appreciates your patience during this process, and we apologize for the inconvenience.

If you have rate questions, please contact T.J. Walker @ 601-359-6827, or T.J.Walker@medicaid.ms.gov. If you have any claims questions, please contact Jay Horton, 601-359-9544, or James.Horton@medicaid.ms.gov.
Attention All Providers  
(6/12/17) 9:00 a.m.

Mississippi Medicaid Provider Revalidation has begun! To facilitate the revalidation process, do not use any special characters (i.e. apostrophe, hyphen, etc.) in the naming convention/file name of the required PDF files (Provider Disclosure Form and the Medical Assistance Participation Agreement) when completing the Revalidation Form process on the Mississippi Envision web portal. Files uploaded with special characters in the file name will cause delays in revalidation processing. If you have any questions or experience this issue, please contact Conduent Provider Enrollment at 1-800-884-3222.

Attention Nursing Facility and Hospital Providers  
(6/5/17) 4:50 p.m.

The Division of Medicaid (DOM) is contracted with ASCEND to administer the Level II Pre-Admission Screening and Resident Review (PASRR). Ascend was purchased by MAXIMUS in 2016 and has transitioned from their current email addresses to accounts through the parent company, MAXIMUS. We want to be sure you continue receiving important policy updates, helpful tips, and educational tools geared toward explaining and simplifying the PASRR assessment process. Please make note of the change, including an email server change to @maximus.com.

Attention Providers  
(6/1/17) 3:00 p.m.

The Division of Medicaid (DOM), Office of Program Integrity has contracted with DataMetrix to administer the MS Medicaid Recovery Audit Contractor (RAC) program effective April 1, 2017. The RAC serves a critical role in the overall strategy of protecting the integrity of Medicaid funds from improper payments. DataMetrix is a twelve (12) year old company which specializes in Payment Integrity and Recovery. DataMetrix has experienced staff performing reviews, including: physicians, certified coders, statisticians and credentialed clinical reviewers.

All updates are outlined on the DOM website located at https://medicaid.ms.gov/providers/recovery-auditor-contractors/. Providers are encouraged to monitor the website for updates and announcements regarding the Mississippi Recovery Audit Contractor program. Providers can submit inquiries, complaints and other communications as it relates to the MS Medicaid RAC program to MSRAC@medicaid.ms.gov.
Upcoming Medicaid Revalidation Webinars!
Introductory and In-depth webinar materials now available on the Mississippi Envision Web Portal
(6/1/17) 3:00 p.m.

Mississippi Medicaid Provider Revalidation has begun! Introductory and In-depth webinars have been created as resources for providers to prepare for and complete the required revalidation.

Conduent will present the In Depth webinar via WebEx on the following days in June 2017:

Date - Thursday, June 8th – 10:00 a.m. and 2:00 pm
Date - Thursday, June 15th – 10:00 a.m. and 2:00 p.m.
Date - Wednesday, June 21st – 10:00 a.m. and 2:00 p.m.

If you would like to participate, please send an email with the selected day and time to msmedicaidlatebreakingnews@conduent.com. Also, please include the Medicaid provider number, contact phone number, and the attendee’s name. If multiple individuals will be calling in from one facility, please use one line in order to allow other interested parties an opportunity to participate in the webinar. The WebEx information will be provided by email 24 hours prior to the session requested. **Reminder, these sessions are conducted via telephone and computer access. There is no physical location.**

The webinars are also located on the MS Envision web portal located at [https://www.ms-medicaid.com](https://www.ms-medicaid.com). Select “Training Materials/CBT” from the Provider tab drop down menu or click the following links:

Provider Revalidation Introductory Training
In-depth Medicaid Provider Revalidation Training

We encourage providers to download and print this information to use as a guide when preparing for and completing the revalidation process. You may contact Conduent Provider Enrollment at 800-884-3222 if you have any questions.
Notice for 340B Pharmacy Providers  
(5/31/17) 9:05 a.m.

The Centers for Medicare and Medicaid Services (CMS) requires the Mississippi Division of Medicaid (DOM) to define its policies and oversight activities related to 340B purchased drugs as outlined in CMS state release No. 161, dated Oct. 26, 2012.

In February 2017, letters were mailed to all Medicaid providers identified as 340B covered entities. These letters contained the 340B Covered Entity Initial Attestation Enrollment Form and billing policy guidelines.

The form completion and submission deadline was extended for 340B Covered Entities from March 1, 2017 to May 1, 2017. Based upon provider feedback, the effective date for 340B billing policy implementation was extended from April 1, 2017 to July 1, 2017.

DOM encourages stakeholder feedback regarding 340B requirements and billing policy guidelines. In an effort to ensure clear and consistent communication regarding 340B attestation and billing policy, DOM will be posting a 340B Question and Answers document online at https://medicaid.ms.gov and hosting an informational conference call.

Please submit your comments and questions for inclusion in the 340B Q&A document to info@medicaid.ms.gov, by Monday, June 5, 2017.

Additional information about the 340B program may be found at the Medicaid website: https://medicaid.ms.gov/providers/pharmacy/340b-program/

Attention Physicians, Practitioners, and Clinics!  
(5/26/17) 11:05 a.m.

New Modifiers Effective: 1/1/2013 and 1/1/2016  
The Division of Medicaid will reprocess claims for dates of service January 01, 2013 through December 16, 2016 which were billed with following new modifiers: 33, CH, CI, CJ, CK, CL, CM, CN, CP, CT, DA, L1, PT, SZ, and ZA. The mass adjustment will appear on your remittance advice dated 5/29/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers
(5/26/17) 11:05 a.m.

CPT Code 95885 and 95886
The Division of Medicaid will reprocess claims for dates of service January 01, 2012 through August 19, 2016 which were billed using code 95885 and 95886. The mass adjustment will appear on your remittance advice dated 5/29/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

All Providers; Physician Fee Update
(5/26/17) 11:05 a.m.

The Division of Medicaid will reprocess claims for dates of service January 1, 2015 through May 26, 2015. The mass adjustment will appear on your remittance advice dated 5/29/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Outpatient Hospital Providers; Bilateral Surgical Procedure Billing—Outpatient Hospital Claims
(5/19/17) 10:05 a.m.

The Division of Medicaid will reprocess outpatient hospital claims for dates of service January 01, 2013 through December 9, 2014 which were billed with bilateral CPT codes. The mass adjustment will appear on your remittance advice dated 5/22/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Hospital Inpatient APR-DRG Alert – July 1, 2017

Updates
(5/01/17) 2:30 p.m.

The Mississippi Division of Medicaid (DOM) 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, 2017:

1. DOM will adopt V.34 of the 3M Health Information System APR-DRG Grouper.
2. DOM will adopt V.34 of the Health Care Acquired Conditions (HCAC) utility.
3. Low-side Outlier Payment Reduction – The APR DRG Base Payment may be reduced for low cost non-psych hospital inpatient stays when the DRG Base Payment exceeds the estimated cost of a stay.
4. Charge cap – The APR-DRG allowed amount, (the sum of the DRG Final Base Payment after low-side outlier payment reduction, plus DRG Cost Outlier payment, plus DRG Day Outlier payment), will be limited to the lower of the DRG Payment Amount or the total billed charges on the claim.
5. The following APR-DRG parameters will be updated:
   - Neonate policy adjustor – will be changed from 1.45 to 1.40
   - Low-side Outlier Threshold - $50,000
   - Low-side Outlier Marginal Cost Percent - 50%

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, 2017.

Training will be scheduled with dates to be provided. Hospitals will be notified via e-mail and the DOM website www.medicaid.ms.gov.
Attention All Providers

(4/28/17) 1:30 p.m.

The Division of Medicaid will reprocess claims for dates of service October 01, 2015 through July 20, 2016 billed with codes listed below. The mass adjustment will appear on your remittance advice dated 5/1/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

**Diagnosis Codes:**

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</table>
Attention All Providers
(4/28/17) 10:30 a.m.

The Division of Medicaid will reprocess claims for dates of service January 01, 2014 through March 21, 2016 which denied due to edit 3105 - ANNL PHYEXM NCOVRD FOR LTC, ETC. The mass adjustment will appear on your remittance advice dated 5/1/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Outpatient Hospital Providers
(4/28/17) 10:30 a.m.

Revenue Code 0515
The Division of Medicaid will reprocess claims for dates of service October 01, 2015 through October 03, 2016 which were billed with Revenue Code 0515. The mass adjustment will appear on your remittance advice dated 5/1/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: Qualified Obstetric/Gynecological Providers who need to attest/re-attest to receive increased primary care services payments
(4/27/17) 10:30 a.m.

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers at 100 percent (100%) of the Medicare Physician Fee Schedule for certain primary care Evaluation and Management (E&M) and Vaccine Administration codes. Effective July 1, 2016 and in accordance with House Bill (HB) 1560, DOM began reimbursing eligible obstetricians and gynecologists (OB/GYNs) at 100 percent (100%) of the Medicare Physician Fee Schedule for certain primary care services. Eligible OB/GYNs with a primary specialty/subspeciality designation in obstetric/gynecologic medicine must attest to one (1) of the following:

1) Physician is board certified by the American Congress of Obstetricians and Gynecologists (ACOG) as a specialist or subspecialist in obstetric/gynecologic medicine, or

2) Physician with a primary specialty/subspeciality designation in obstetric/gynecologic medicine and has furnished certain primary care E&M and Vaccine Administration codes that equal at least sixty percent (60%) of the Medicaid codes they have billed during the most recently
3) Physician, newly enrolled as a Medicaid provider, with a primary specialty/subspecialty designation in obstetric/gynecologic medicine and attests that certain primary care E&M and Vaccine Administration codes will equal at least sixty percent (60%) of the Medicaid codes they will bill during the attestation period, or

4) Non-physician practitioner providing primary care services in a Practice Agreement with a qualified physician enrolled for increased primary care services.

Pursuant to HB 1510, providers who self-attest to a specialty designation in obstetric/gynecologic medicine by ACOG will be eligible to continue receiving an increased payment for certain primary care services effective July 1, 2017. The DOM Primary Care Provider Fee Schedule is updated July 1 of each year based on 100 percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year.

To receive the increased payment for dates of service (DOS) beginning 7/1/2017, eligible providers must send a completed and signed 7/1/2017-6/30/2018 OB/GYN PCP Self-Attestation form to Conduent Provider Enrollment by 6/30/2017. Providers, whose forms are received after 5/31/2017, may experience a delay in the effective date of the increased payment. To receive the increased payment, eligible providers must send a completed and signed 7/1/2017-6/30/2018 OB/GYN PCP Self-Attestation form to Conduent Provider Enrollment through one of the following means:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: Conduent Provider Enrollment, P. O. Box 23078, Jackson, MS 39225

Qualified providers who attest to a specialty designation in family medicine, general internal medicine, pediatric medicine or a subspecialty recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), and the American Osteopathic Association (AOA) may be eligible for increased payment of certain primary care E&M and Vaccine Administration codes. Providers may submit a 7/1/2016-6/30/2018 Self-Attestation Statement form to Conduent Provider Enrollment and will be eligible to receive the increased payment effective the day the form is processed by Conduent.

Additional information can be found on the DOM website (www.medicaid.ms.gov), including the OB/GYN PCP Self-Attestation General Instructions, the 7/1/2017-6/30/2018 OB/GYN PCP Self-Attestation form, the PCP Self-Attestation General Instructions and the 7/1/2016-6/30/2018 Self-Attestation Statement form. Providers may also find this information on the Envision Web Portal (www.ms-medicaid.com/msenvision/) or it can be requested by calling the Conduent Call Center toll-free at 800-884-3222.
Attention: Nursing Facility Providers
(4/19/17) 10:40 a.m.

According to the Division of Medicaid Eligibility Determination Policy, Volume III, Section L page 12370, nursing facilities must submit the DOM-317 Exchange of Information between a nursing facility or hospital and Division of Medicaid Regional Office form at the time a resident is discharged from a nursing facility. Upon receipt of the DOM-317, the Regional Office staff will update the beneficiary case to reflect the discharge date. Delayed submission of the form may limit beneficiary access to medications and community services. Providers must submit the DOM-317 in a timely manner.

Attention: Nursing Home Claims: Revenue Code Change
(4/19/17) 10:40 a.m.

Effective July 1, 2017, revenue code 0181-“leave of absence-reserved” will no longer be accepted by DOM for hospital leave claims. Revenue code 0185-“leave of absence-nursing home (for hospitalization)” is required for all hospital leave claims. This change is being made to meet compliance of the National Uniform Billing Committee. If you have any questions, you may call LaShunda Woods at 601-359-5251.

MississippiCAN & CHIP Workshops Are Coming to Your Area!!!
(4/11/17) 9:30 a.m.

The Division of Medicaid Office of Coordinated Care, in conjunction with Magnolia Health Plan and UnitedHealthcare Community Plan, will conduct Provider Workshops beginning May 31, 2017 through September 6, 2017 at locations throughout the state. The workshops will be designed to address questions and concerns that are of most importance to the Medicaid Providers. Office directors, office managers, coders, and billing staff are encouraged to attend these workshops. For more specific information, including dates and locations, please visit the What’s New section of the Mississippi Envision Web Portal at https://www.ms-medicaid.com/msenvision/servlet/DocumentViewerServlet?docType=news&fileName=News2.pdf or the Mississippi Division of Medicaid’s website at www.medicaid.ms.gov/mscan/.
Attention All Providers
(3/31/17) 10:30 a.m.

The Division of Medicaid will reprocess claims for dates of service January 01, 2016 through June 30, 2016. The mass adjustment will appear on your remittance advice dated 4/3/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: Outpatient Hospital Providers
(3/31/17) 10:30 a.m.

The Division of Medicaid will reprocess claims for dates of service July 01, 2016 through July 25, 2016 which were billed with various CDT codes with incorrectly calculated fees. The mass adjustment will appear on your remittance advice dated 4/3/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Deadline extended for 340B Covered Entity Attestation Enrollment Form
(3/30/17) 9:00 a.m.

The deadline for 340B covered entities to complete the Initial 340B Covered Entity Attestation Enrollment Form and submit to Conduent has been extended to May 1, 2017.

Billing requirements defined in the cover letter and instructions of the Initial 340B Covered Entity Attestation Enrollment Form for providers who have elected to opt-in, will be effective on July 1, 2017.

Additional information about the 340B program may be found at https://medicaid.ms.gov/providers/pharmacy/340b-program/
Pharmacy Reimbursement changes will be implemented retrospectively upon CMS State Plan Amendment (SPA) approval

On February 1, 2016, the Centers for Medicare and Medicaid Services (CMS) published 42 CFR, Part 447: Medicaid Program Covered Outpatient Drugs with final comments (CMS-2345-FC). This rule addresses regulations pertaining to reimbursement for covered outpatient drugs in the Medicaid program. In accordance with this rule, all states must submit an amendment to its State Plan by June 30, 2017 to CMS with an effective date of no later than April 1, 2017, to be in compliance with the new reimbursement requirements.

The Mississippi Division of Medicaid (DOM) submitted State Plan Amendment (SPA) 17-0002 Pharmacy Reimbursement to the Centers for Medicare and Medicaid Services (CMS) on March 15, 2017.

Reimbursement changes will be implemented retrospectively upon CMS approval. Pharmacy POS claims with a date of service on or after April 1, 2017 will be mass adjusted according to the CMS’ approved reimbursement methodology. Pharmacy providers will be notified when CMS approves SPA 17-0002.

Attention All Providers!

HCPCS Codes B4034,B4035,B4036, B4081,B4082,B4083 and B4087

The Division of Medicaid will reprocess claims for dates of service July 01, 2016 through August 16, 2016 which were billed using codes B4034,B4035,B4036,B4081,B4082,B4083 and B4087. The mass adjustment will appear on your remittance advice dated 03/27/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers: Provider Revalidation Starts April 2017

(3/17/17) 12:30 p.m.

In April 2017, the Division of Medicaid (DOM) will begin implementing Federal Regulation 42 CFR §455.414 which requires state Medicaid agencies to revalidate the enrollment of all providers at least every five years. A rollout process will be used to notify providers enrolled in the Mississippi Medicaid Program five or more years of the revalidation requirement. Revalidation notifications will be issued on a staggered schedule until notices have been issued to all providers due for revalidation.

A revalidation letter will initiate the process with each provider. The letter will provide instructions for completing the revalidation and will indicate the due date. As part of the revalidation, the state must conduct a full screening appropriate to the provider’s risk level in compliance with 42 CFR 455 Subparts B & E and the provider must comply with any requests made by the state as part of the revalidation process within the specified timeframe. A complete revalidation must be submitted by the due date in the letter to prevent termination.

To prepare for revalidation, all providers should review the bullets below and complete the following steps immediately:

- The revalidation letter will be sent to the current “Mail Other” address noted on the provider file. If there is no “Mail Other” address noted on the provider file, the notification will be sent to the billing address. To ensure proper notification, please validate your addresses on file with the Division of Medicaid. If changes are needed, please complete the Change of Address form located at:


- The form must be completed and signed by the provider. The Change of Address form can be faxed to CONDUENT Provider Enrollment at (888) 495-8169.

- Providers must access their revalidation electronically through the Envision web portal. This will allow providers to enter their own information and will streamline the revalidation process. If the revalidating provider is not a registered user, the provider will need to register by going to www.ms-medicaid.com by clicking the “web registration” link to find the registration instructions for becoming a web portal user.

Enrollment must be terminated for any provider who does not comply with revalidation requirements. A new application will then be required for the provider to re-enroll in the Mississippi Medicaid program.
Watch for upcoming communications and webinar information on the DOM website and the Mississippi Envision Web Portal. Providers with questions or needing additional information about revalidation should contact Provider Enrollment at (800) 884-3222.

**Attention All Nursing Facility Providers**

(3/14/17) 9:15 a.m.

The Division of Medicaid and Mississippi State Department of Health Division of Licensure and Certification are hosting a free, one-day educational seminar for nursing home providers and other individuals or organizations interested in applying for a Civil Money Penalty grant. Several speakers experienced in the nursing home industry will share their expertise and perspectives on developing successful CMP grants. In addition, new and revised information on the grant application process will be discussed. Attendees will be able to speak with industry representatives on products and services devoted to improve care and quality of life for nursing home residents. The seminar will be May 3, 2017 from 8:30 a.m. until 4:30 p.m. at the University of Mississippi Medical Center Conference Center, Jackson Medical Mall, 350 W. Woodrow Wilson Drive, Jackson, MS. If your organization is seeking funding from the Centers for Medicare and Medicaid Services for a project benefiting nursing home residents, you are urged to attend this educational seminar.

The deadline for registration is April 26. You may register at the following link: [http://HealthyMs.com/register/cmp/](http://HealthyMs.com/register/cmp/).

For more information, please call 601-359-9529 or 601-359-5251.
Information on the “Present on Admission” (POA) Indicator Claim Exception Edit 0178- VALID POA REQUIRED
(3/10/17) 1:15 p.m.

The Mississippi Division of Medicaid and Conduent are aware of the issue where claims are denying for claim exception 0178- VALID POA REQUIRED. Currently, there is a system fix that is being analyzed and coded. Once the system fix is implemented, we will advise through Late Breaking News/RA banner messages and a mass adjustment will be completed. No further action on the part of the provider is needed.

Consent Form Status Inquiry now available on the Envision Web portal!
(3/10/17) 11:25 a.m.

Effective 03/15/2017, select providers (i.e. Physicians, Physician groups, Hospitals, Rural Health Clinics, Nurses, and Ambulatory Surgery Centers) can now check the status of submitted sterilization consent and hysterectomy acknowledgment forms via the Envision web portal. Providers should have the Security privilege checked for “Consent Form Status Inquiry” in security privileges by their respective Master Administrators. Providers must logon to the secure side of the web portal and select Provider menu- Inquiry Options-Consent Form Status Inquiry to access this function. Please be reminded that the consent and acknowledgment forms are initially reviewed independently. An approved consent form does not ensure payment. This functionality is only applicable to consents submitted for fee-for-service beneficiaries and does not apply to MSCAN beneficiaries. You may contact the Conduent Call Center at 1-800-884-3222 if you have questions.

Attention EPSDT Providers
(3/2/17) 4:15 p.m.

The Division of Medicaid will reprocess EPSDT claims which denied incorrectly due to edit 3700 (Procedure exceeds lifetime limit) or 3234 (Procedure code/ EPSDT age restriction) for paid dates on or after July 1, 2015 through July 4, 2016. The mass adjustment will appear on your remittance advice dated 03/06/2017. No further action on the part of the provider is needed. If you have any
EPSDT Provider Termination
(2/27/17) 8:50 a.m.

Effective November 1, 2015, Mississippi Division of Medicaid (DOM) received Centers for Medicare and Medicaid Services (CMS) approval of State Plan Amendment (SPA) 15-017 Early and Periodic Screening, Diagnosis and Treatment (EPSDT). SPA 15-017 requires DOM EPDST providers adhere to the American Academy of Pediatrics Bright Futures periodicity schedule for physical, mental, psychosocial and/or behavioral health, vision, hearing, adolescent, and developmental screening services.

Currently enrolled EPSDT providers were required to update their enrollment status by signing and completing the EPSDT Provider Agreement by November 30, 2016. Failure to send the completed and signed EPSDT Provider Agreement by November 30, 2016 results in provider disenrollment from the EPSDT program. Please note you are not being terminated as a Medicaid provider; however, effective March 1, 2017, claims submitted with CPT codes 99381-99395 will deny. If you would like to continue providing EPSDT screening services, please complete the EPSDT Provider Agreement located on the DOM website at www.medicaid.ms.gov.

Please contact the Office of Medical Services at (601) 359-6150 if you have any questions or need additional assistance.

Attention All Providers!
(2/10/17) 8:40 a.m.

CPT Codes 99238 and 99239
The Division of Medicaid will reprocess claims for dates of service October 1, 2015 through October 3, 2016 which were billed with CPT codes 99238 and 99239. The mass adjustment will appear on your remittance advice dated 02/13/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention: Physicians, Practitioners, and Vision/Hearing Providers

(1/30/17) 8:40 a.m.

CMS-1500 CLAIMS WITH TAXONOMY DENIALS FOR EDITS 3457 AND 3458

The Mississippi Division of Medicaid (DOM) is in the process of correcting the system issue for these Global Surgical Package edits and will reprocess claims once corrected. Any claims which correctly received the edit denial, will again deny when reprocessed causing overpayments to be recovered. This can be avoided by resubmitting a corrected claim by following the information below.

These taxonomy codes are needed to prevent a claim from denying with Edit 3456 GLOBAL PACKAGE APPLIES TO SERVICES REPORTED when multiple claims are billed for the same beneficiary, same billing provider, different rendering provider, and different specialty for either the same date of service or during the assigned post-operative period of a previous service. If the rendering providers are the same specialty, one of the claims will deny.

Edit 3457-GLOBAL PACKAGE CLAIM; RENDERING TAXONOMY CODE DOES NOT MATCH PROVIDER FILE
This edit posts when the taxonomy code billed for the line does not match one of the taxonomy codes listed in the rendering provider file. These two taxonomy codes must match for the claim to bypass this edit. Please verify what taxonomy code is listed in the provider file and use this code to correct the claim lines.

Edit 3458-GLOBAL PACKAGE CLAIM; RENDERING TAXONOMY CODE IS REQUIRED
This edit posts when a taxonomy code for the rendering provider was not billed on the claim line. Please verify what taxonomy code is listed in the rendering provider file and use this code to correct the claim lines.

Resubmit the corrected claim by following these steps:
• If the entire claim denied, the provider will resubmit the corrected claim for processing.
• If the claim partially paid, the provider will void the entire claim resubmit the corrected claim for processing.

If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers!
(1/27/17) 8:40 a.m.

CPT Codes 58300 and 11981
The Division of Medicaid will reprocess claims for dates of service July 1, 2016 thru November 7, 2016, which were billed with HCPCS codes 58300 and 11981. The mass adjustment will appear on your remittance advice dated 1/30/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention EPSDT Providers
(1/06/17) 8:40 a.m.

The Division of Medicaid will reprocess EPSDT claims which denied incorrectly due to edit 0367 (Procedure/servicing provider type conflict) for paid dates on or after November 1, 2015 thru October 17, 2016 for CPT code 96110 (Development screening) and for paid dates on or after July 1, 2015 thru October 17, 2016 for CPT code 96127 (Brief Emotional/Behavioral assessment, with scoring). The mass adjustment will appear on your remittance advice dated 1/9/2017. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers—DOM Coverage of PrEP
(1/03/17) 12:50 p.m.

The Division of Medicaid (DOM) covers HIV Pre-Exposure Prophylaxis (PrEP) for men and women as recommended by the Centers for Disease Control and Prevention (CDC). According to the CDC, “Pre-exposure prophylaxis, or PrEP, is a way for people who do not have HIV but who are at substantial risk of getting it to prevent HIV infection by taking a pill every day. The pill (brand name Truvada) contains two medicines (Emtricitabine and Tenofovir) that are used in combination with other medicines to treat HIV. When someone is exposed to HIV through sex or injection drug use, these medicines can work to keep the virus from establishing a permanent infection.”

If you have additional questions regarding coverage, please contact DOM Office of Medical Services at 601.359.6150.

Correction to Billing Reminders for Nursing Facility and ICF/IID residents
(1/03/17) 11:20 a.m.

The article below was published in the 2016 December Medicaid bulletin with the incorrect phone number. The phone number has been corrected and is listed below.

1. Disposable diapers and blue pads were listed as medical supplies to be included in the nursing facility and ICF/IID per diem as of January 2, 2015. Reference: Administrative Code, Part 207, Chapter 2, Rule 2.6, C.10 for Nursing Facility; Administrative Code, Part 207, Chapter 3, Rule 3.4: C.11 for ICF/IID.
2. Individuals residing in a nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) are exempt from payment of a co-payment. The co-payment exception code of “N” must be indicated on the claim. This exception code applies to facility charges, professional fees, and pharmaceuticals. Reference: Administrative Code, Part 200, Chapter 3: Beneficiary Information, Rule 3.7: Beneficiary Cost Sharing C.4. Nursing Facility.

If additional information is required, contact the Office of Long Term Care Institutional Division at 601-359-6141.
Using an older Operating System or Web Browser?
(12/22/16) 4:02 p.m.

Due to a recent announcement by Microsoft concerning a security flaw in SHA-1 SSL certificates, the Mississippi Envision Web Portal will be upgrading to a SHA-2 SSL certificate on the night of 12/29/2016. Users who are using older, unsupported web browsers and/or operating systems may not be able to access this site without upgrading. A list of SHA-2 compatible web browsers and operating systems can be found here: https://www.digicert.com/sha-2-compatibility.htm

Attention All Providers
(12/22/16) 3:43 p.m.

The Division of Medicaid will reprocess all claims submitted with CPT 82105 - ALPHA FETOPROTEIN; SERUM for dates of service beginning 11/1/2015 through 6/10/2016. The mass adjustment will appear on your remittance advice dated 12/26/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

2017 New Bed Values for Nursing Facilities, ICF-IIDs, PRTFs, and NSFDs
(12/12/16) 3:10 p.m.

The new bed values for 2017 for nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs), psychiatric residential treatment facilities (PRTFs) and Nursing Facilities for the Severely Disabled (NFSDs) have been determined by using the R.S. Means Historical Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

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Attention All Radiology Providers  
(12/8/16) 4:00 p.m.  

The Division of Medicaid will reprocess all Advanced Imaging claims for dates of service beginning 07/01/2013 through 06/20/2016 that were denied incorrectly with Claim Exception 0727 - PRIOR AUTHORIZATION NUMBER ON CLAIM BUT NOT ON FILE and/or 3341 - CLAIM REQUIRES PRIOR AUTHORIZATION OR APPROPRIATE MODIFIER. The mass adjustment will appear on your remittance advice dated 12/12/2016. No further action on the part of the provider is needed.

If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers—Additional Administered Drug Fee Updates  
(12/8/16) 4:00 p.m.  

The Division of Medicaid will reprocess claims which were billed with codes listed below for dates of service July 1, 2016 through August 22, 2016. The mass adjustment will appear on your remittance dated 12/12/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Codes  A4561, A4562, A9543, A9600, A9604, A9606, J0714, J1322, J1327, J1330, J1573, J1595, J1725, J1744, J1830, J2760, J3145, J3246, J3470, J7188, Q4101, Q4106, Q4131, Q5101, Q9950, S0189.

Attention All Providers—Physician Fee Updates  
(12/8/16) 4:00 p.m.  

The Division of Medicaid will reprocess claims for dates of service July 1, 2016 through July 21, 2016. The mass adjustment will appear on your remittance dated 12/12/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers
(10/21/16) 12:00 p.m.

DME/Medical Supply Fee Corrections The Division of Medicaid will reprocess claims which were billed with codes listed below for dates of service July 1, 2016 through July 15, 2016. The mass adjustment will appear on your remittance dated 10/24/2016. The new DME fee schedule is posted under the provider tab on our website or accessible through the following link http://www.medicaid.ms.gov/wpcontent/uploads/2015/07/DMEOrthoProsth.pdf. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.


Attention All Providers
(10/21/16) 12:00 p.m.

The Division of Medicaid will reprocess claims for dates of service July 1, 2016 through July 6, 2016 which were billed with impacted physician administered drug codes. The mass adjustment will appear on your remittance advice dated 10/24/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers
(10/21/16) 12:00 p.m.

Physician Fee Updates The Division of Medicaid will reprocess claims for dates of service beginning July 1, 2016 which were billed with impacted CPT/HCPCS on professional claims. The mass adjustment will appear on your remittance dated 10/24/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Hospital Administrators, CFOs, and Billers!
(10/19/16) 2:00 p.m.

Effective July 1, 2015, the Division of Medicaid (DOM) implemented Phase 2 of Outpatient Prospective Payment System (OPPS). Since implementation of Phase 2, certain hospital outpatient claims inappropriately denied for edit 0110-Date Bundling Not Allowed. DOM has implemented a systemic fix for edit 0110-Date Bundling Not Allowed. The affected claims with dates of service July 1, 2015 through August 21, 2016 will be adjusted to correct associated payment errors. Provider training workshops will be held regarding OPPS Date Bundling.

To register for training, please RSVP by emailing Provider Field Service Representative LaShundra Othello at Lashundra.Othello@conduent.com with the following information:

- Full name
- Title
- Facility name
- Contact phone number
- Number of participants

Training workshops will be conducted the following dates and times:

**Oct. 25** – North Mississippi: Southaven
Registration: 8:30 a.m. - 9 a.m.
Training: 9 a.m. – 12 p.m.
Hilton Garden Inn
6671 Towne Center Loop
Southaven, MS 38671

**Nov. 2** – South Mississippi: Biloxi/Gulfport
Registration: 8:30-9 a.m.
Training: 9 a.m. – 12 p.m.
Courtyard Marriot
1600 East Beach Boulevard
Gulfport, MS 39501

**Nov. 8** – Central Mississippi, Jackson
Registration: 8:30-9 a.m.
Training: 9 a.m. – 12 p.m.
Central High School Auditorium
359 North West Street
Jackson, MS 39201

Reference guides and other resources will be available on the DOM website as they become available. For more information about OPPS, visit [https://medicaid.ms.gov/providers/finance/](https://medicaid.ms.gov/providers/finance/).
Attention All Providers
(10/3/16) 12:30 p.m.

Effective for dates of services on and after October 1, 2016, the Mississippi Division of Medicaid (DOM) will cover the following procedure codes:

- **E2402** NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, STATIONARY OR PORTABLE
- **A6550** WOUND CARE SET, FOR NEGATIVE PRESSURE WOUND THERAPY ELECTRICAL PUMP, INCLUDES ALL SUPPLIES AND ACCESSORIES

This change will apply to all Medicaid beneficiaries. Additional information regarding coverage of these procedure codes can be found on the applicable Fee Schedule at [www.medicaid.ms.gov](http://www.medicaid.ms.gov).

If you have additional questions regarding this change, please contact the Office of Medical Services at 601-359-6150.
Attention All Providers
(9/30/16) 2:30 p.m.

**Code 76770**
The Division of Medicaid will reprocess claims for dates of service July 1, 2016 through July 12, 2016 which were billed with CPT code 76770. The mass adjustment will appear on your remittance advice dated 10/3/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers
(9/30/16) 2:30 p.m.

**HCPCS Code 99420**
The Division of Medicaid will reprocess claims for dates of service November 1, 2015 through June 28, 2016 which were billed with HCPCS code 99420. The mass adjustment will appear on your remittance advice dated 10/03/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers
(9/30/16) 2:30 p.m.

The Division of Medicaid will reprocess claims for dates of service July 1, 2016 through July 18, 2016 billed with procedure code 77427. The mass adjustment will appear on your remittance advice dated 10/03/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers
(9/30/16) 2:30 p.m.

**HCPCS Code 90791 and 90792**
The Division of Medicaid will reprocess claims for dates of service October 1, 2015 through June 30, 2016 which were billed with HCPCS code 90791 and 90792. The mass adjustment will appear on your remittance advice dated 10/03/2016. No further action on the part of the provider is needed. If
Attention All Providers
(9/30/16) 2:30 p.m.

The Division of Medicaid will reprocess claims for dates of service October 1, 2013 through July 15, 2016 which were denied with Claim Exception 0188 - PATIENT STATUS INVALID. The mass adjustment will appear on your remittance advice dated Oct 03, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Extension of deadline to submit EPSDT Provider Agreement
(9/29/16) 2:50 p.m.

EPSDT screening providers, currently enrolled in the program, must update their enrollment status by completing the EPSDT Provider Agreement. The EPSDT Provider Agreement is located on the Mississippi Envision website under “What’s New?” at www.ms-medicaid.com/msenvision/index.do and on the Division of Medicaid website under “Programs” at https://medicaid.ms.gov/resources/forms/. Providers must send the completed and signed EPSDT Provider Agreement by November 30, 2016 to:

Division of Medicaid-Office of Medical Services
550 High Street, Suite 1000, Jackson, MS 39202
or via fax to (601) 359-6147

Failure to send the completed and signed EPSDT Provider Agreement by November 30, 2016 may result in provider disenrollment from the EPSDT program.

Please contact the Office of Medical Services at (601) 359-6150 if you have any questions or need additional assistance.
Attention All Providers!
(9/16/16) 9:10 a.m.

**HCPCS Code G0277**

The Division of Medicaid will reprocess claims for dates of service January 1, 2015 through April 6, 2016 which were billed with HCPCS code G0277. The mass adjustment will appear on your remittance advice dated 9/19/2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Submission of Consent Forms for Beneficiaries
(9/8/16) 8:50 a.m.

As of December 1, 2015, MississippiCAN, Medicaid’s Managed Care Program is responsible for both, inpatient and professional service payments. It is imperative that providers verify the beneficiary’s eligibility before submitting consent forms to verify whether the beneficiary is enrolled in MississippiCAN or Fee-for-Service Medicaid.

If the beneficiary is enrolled in one of the MississippiCAN Coordinated Care Organizations (CCO), United Healthcare Community Plan or Magnolia Health, providers should follow the guidelines of the CCO for submitting consent forms as they will be responsible for payment of the services. No consent form should be sent to Conduent for beneficiaries that are enrolled in the MississippiCAN.

However, if the beneficiary is enrolled in Fee-for-Service (traditional) Medicaid, providers should continue to fax all consent forms to Conduent Medical Review at 1-888-495-8169.
Extension of deadline to submit EPSDT Provider Agreement
(9/1/16) 1:50 p.m.

EPSDT screening providers, currently enrolled in the program, must update their enrollment status by completing the EPSDT Provider Agreement. The EPSDT Provider Agreement is located on the Mississippi Envision website under “What’s New?” at www.ms-medicaid.com/msenvision/index.do and on the Division of Medicaid website under “Programs” at https://medicaid.ms.gov/resources/forms/. Providers must send the completed and signed EPSDT Provider Agreement by September 30, 2016 to:

Division of Medicaid-Office of Medical Services
550 High Street, Suite 1000, Jackson, MS 39202
or via fax to (601) 359-6147

Failure to send the completed and signed EPSDT Provider Agreement by September 30, 2016 may result in provider disenrollment from the EPSDT program.

Please contact the Office of Medical Services at (601) 359-6150 if you have any questions or need additional assistance.

Submission of Medicare Part C Claims on the Mississippi Envision Web Portal is Now Available!
(9/1/16) 9:35 a.m.

The Mississippi Envision Web Portal has now been updated to allow providers to submit Part C claims electronically. When entering claims via the Web Portal, providers will not only have the options to submit CMS 1500 and UB-04 claims, but will also have the option to submit “Medicare Part C Institutional” or “Medicare Part C Professional” claims. If entered correctly, these claims should suspend for review of the Explanation of Medicare Benefits (EOMB), edit 0610. NOTE: The EOMB must be uploaded and attached to the claim during the submission process. Please allow up to 30 days to have the claim reviewed and released for payment or denial.

If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Additional Coverage of Services for Beneficiaries Enrolled in Healthier Mississippi Waiver
(07/22/16) 2:27 p.m.

Effective July 24, 2015, Mississippi Division of Medicaid (DOM) received Centers for Medicare and Medicaid Services (CMS) approval to cover all State Plan services for beneficiaries enrolled in Category of Eligibility 045 - Healthier Mississippi Wavier (HMW) except the following services:

- Long-term care services,
- Swing Bed in a skilled nursing facility, and
- Maternity and newborn care.

Currently, the Mississippi Envision Web Portal does not reflect coverage of the following services:

- Chiropractic services,
- Dental services,
- Eyeglasses, and
- Podiatry services.

Providers must contact the Conduent Call Center toll-free at 800-884-3222 to verify beneficiary eligibility. Providers will be notified through Late Breaking News when the Envision Web Portal has been updated to reflect the change in coverage. DOM will reprocess claims which denied incorrectly due to edit 0370-SERVICE EXCLUDED-PLAD WAIVER and edit 3955-SERVICE NOT COVERED FOR BENE. Providers will be notified through Late Breaking News and on their remittance advice when claims are reprocessed.

Attention All Providers
(07/22/16) 8:56 a.m.

The Division of Medicaid will reprocess claims for dates of service January 1, 2016 through April 12, 2016 which billed Place Of service 19 (POS19) Off-Campus-Outpatient Hospital. The mass adjustment will appear on your remittance advice dates 07/25/2016. No further action on the part of the provider is needed. If you have questions, please contact Conduent provider and Beneficiary Services at 800-884-3222.
Hospice Providers Update
(07/21/16) 3:32 p.m.

DOM’s fiscal Agent, Conduent, has successfully updated the Medicaid MMIS claims processing system to process payment for Routine Home Care (Revenue 0651) level of Hospice services, as required by CMS’s methodology change. As of July 1, 2016, current Hospice claim payments should reflect the Tier-1 (T1) and Tier-2 (T2) Routine Home Care Rates. The (T1) higher rate is for the first 60 days of services and the lower rate (T2) is for days 61 and thereafter. Payment of the Service Intensity Add-on (SIA) rate for the last seven (7) days of life, which meet the registered nurse or social worker requirements, will not be paid until the following additional information is provided.

Reimbursement for the SIA component will require providers to identify on their claim when Registered Nurse (RN) or Social Worker (SW) services are provided. For RN services, providers will use 0559 Revenue Code and G0299 Procedure Code, along with the number of units provided. For this combination, one (1) unit is fifteen (15) minutes. For SW services, providers will use 0561 Revenue Code and G0155 Procedure Code for clinical social work services. For non-clinical social work services, Providers will use 0569 Revenue Code and G0155 Procedure Code, along with the number of units provided. These combinations will also be calculated as one (1) unit per fifteen (15) minutes.

In August, DOM anticipates a mass adjustment to re-process prior claims for dates of service January 1, 2016, through June 30, 2016 (start of the new methodology processing). The mass adjustment will correctly adjust those claims that were incorrectly paid at the higher “T1” rate for day 61 and after instead of the lower “T2” rate. In most cases, this will result in a recoupment of funds due Medicaid ranging from $34.55 to $37.28, per day, per beneficiary, depending on the county in which services were provided. Providers will need to resubmit SIA claims with the required additional coding in order to be reimbursed the SIA rate for beneficiaries that expired and had the pre-requisite services during the last seven (7) days of life.

DOM appreciates your patience during this process, and we apologize for the inconvenience.

If you have rate questions, please contact T.J. Walker @ 601-359-6827, or T.J.Walker@medicaid.ms.gov. If you have any claims questions, please contact Jay Horton, 601-359-9544, or James.Horton@medicaid.ms.gov.
Durable Medical Equipment (DME) Provider
Workshops 2016
(07/19/16) 12:21 p.m.

The MS Division of Medicaid and Conduent State Healthcare, LLC will conduct provider workshops for billers at DME facilities in August 2016. The workshop will cover the following topics:

- MS Medicaid Policy
- Top Common Denials
- Web Portal Functionality & Registration
- Managed Care
- Program Integrity
- Claims Resolution
- When is an Invoice Required?
- Fee Schedules
- The Importance of Checking Eligibility
- Manually Priced Claims

For more information regarding dates, locations, and registration for DME provider workshops, please refer to the “What’s New” section of the Mississippi Envision Web Portal at https://www.ms-medicaid.com/msenvision/servlet/DocumentViewerServlet?docType=news&fileName=News3.pdf

Attention All Providers
(07/05/16) 11:42 a.m.

HCPCS Code J2426
The Division Of Medicaid will reprocess claims for dates of service October 1, 2015 through November 18, 2015 due to the addition of ICD-10 diagnosis restrictions to HCPCS codes J2426. The mass adjustment will appear on your remittance advice dated 07/18/2016. No further action on part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Provider Information regarding the Zika Virus
(07/14/16) 11:24 a.m.

June 1, 2016 the Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin informing Medicaid Agencies how Medicaid services can help states and territories prevent, detect, and respond to the Zika virus, including efforts to prevent the transmission and address health risks to beneficiaries. The Informational Bulletin may be found at https://www.medicaid.gov/federal-policy-guidance/downloads/cib060116.pdf

The Mississippi Division of Medicaid’s (DOM) Zika coverage related to the 6/1/2016 CMCS informational bulletin is as follows:

- **Prevention**
  - **Vaccine** – The Food and Drug Administration (FDA) has not approved a vaccine for Zika at this time. Should one become available and be FDA approved, DOM will cover the vaccine through State Plan benefits available to all beneficiaries.
  - **Insect Repellents** – Mosquito repellents applied to the skin can aid in preventing Zika virus infection. The Centers for Disease Control (CDC) recommends people use Environmental Protection Agency (EPA)-registered insect repellents with one of the following active ingredients: DEET, picaridin, IR3535, oil of lemon eucalyptus, or para-methane-diol.
  - Effective August 1, 2016, **DOM will cover mosquito repellents when prescribed by an enrolled Medicaid provider and billed by a Medicaid pharmacy provider.** DOM will maintain a list of covered insect repellents which have been assigned National Drug Code (NDC) numbers by national drug databases such as First Databank and Medispan. Please refer to DOM’s website at https://medicaid.ms.gov/providers/pharmacy/
  - Prescription claims for insect repellents **will not count toward the five (5) prescription monthly service limit**.
  - A maximum of **two (2) cans/bottles per month per beneficiary** will be allowed for **all beneficiaries aged 13 and over**.

- **Coverage** – Family Planning Service for Men and Women of Child Bearing Age or Women who are Pregnant
  - Family Planning Counseling – DOM currently covers this service for all beneficiaries through the Family Planning Waiver, Annual Wellness Exams and in accordance with the EPSDT Bright Futures Wellness periodicity guidelines.
  - Contraception – DOM covers all forms of contraceptives included in the bulletin (oral contraceptives, condoms, diaphragms, foams, gels, patches, rings, injections, tablets, emergency contraceptives and long acting reversible contraceptives) through the Family Planning Waiver. DOM covers all forms of contraceptives included in the waiver, except for condoms, for all beneficiaries regardless of category of eligibility (COE).
• Detection of Zika Infection

◊ Diagnostic Services – DOM covers all forms of diagnostic testing included in the bulletin (CT scans, MRIs, ultrasounds, blood tests, urine tests and genetic testing) for all beneficiaries, as medically necessary.

• Treatment

◊ Targeted Case Management Services – DOM covers targeted case management services for beneficiaries enrolled in certain waivers, the PHRM/ISS Program, the EI Program and through certain MSCAN programs.

◊ Physical Therapy and Related Services – DOM covers medically necessary physical, speech and occupational therapy services for all beneficiaries.

◊ Prescribed Drugs – DOM covers the drugs specifically mentioned in the letter, for all beneficiaries.

◊ Long Term Services and Supports – DOM covers medically necessary long-term rehabilitative services for all beneficiaries in institutional care and covers additional home and community based services through EPSDT benefits and the five HCBS waivers (AL, E&D, ID/DD, IL, TBI/SCI).

Attention All Elderly and Disabled (E&D) Waiver Adult Day Care (ADC) Providers
(07/14/16) 11:24 a.m.

RATE CHANGE!
For dates of service on or after July 1, 2016, the ADC rate is $61.82 per day. This is the maximum rate allowed under the current CMS approved Elderly and Disabled Waiver. The procedure code for ADC is S5102 and must be billed with a U1 modifier for services provided under the Elderly and Disabled Waiver.

Third Party Billing
(07/12/16) 4:25 p.m.

Did you know most third party billing questions or problems can be resolved by simply referring to the MS Administrative Code or the Provider Billing Handbook? This information is available on the Division of Medicaid’s website at https://medicaid.ms.gov/providers/. The support staff of the Office of Recovery is available to assist providers with any additional third party billing issues and can be reached at 1-800-421-2408.

Providers can also report third party insurance updates directly to the Third Party Recovery File Maintenance Unit via email at tplpolicyupdate@medicaid.ms.gov. Your email will be promptly handled within three to four business days.
Attention EPSDT Providers
(07/12/16) 11:08 a.m.

EPSDT screening providers, currently enrolled in the program, must update their enrollment status by completing the EPSDT Provider Agreement. The EPSDT Provider Agreement is located on the Mississippi Envision website under “What’s New?” at www.ms-medicaid.com/msenvision/index.do. Providers must send the completed and signed EPSDT Provider Agreement by August 30, 2016 to:

Division of Medicaid-Office of Medical Services
550 High Street, Suite 1000, Jackson, MS 39202
or via fax to (601) 359-6147

Failure to send the completed and signed EPSDT Provider Agreement may result in provider disenrollment from the EPSDT program. Please contact the Office of Medical Services at (601) 359-6150 if you have any questions or need additional assistance.

Billing Updates for Mental Health Providers
(07/11/16) 9:04 a.m.

2016 Annual Rate Updates
Effective 7/1/2016, the Division of Medicaid (DOM) has revised the rates for our providers based on 90% of the current Medicare rate, as defined in State Law. The new fee schedule for each mental health program area is posted under the provider tab on our website or accessible through the following links:

Community/Private Mental Health Centers:

Psychiatry:

Therapeutic and Evaluative Services for Expanded EPSDT (T&E):
TherapeuticEvaluativeMentalHealthChildren.pdf

Please refer to the most current CPT Code Book for the appropriate procedure code(s) for services provided. You may contact Kimberly Evans or Felita Bell at 601-359-9545, should you have
Extension of deadline to submit Self-Attestation Statement form for Qualified Providers who need to self-attest to receive increased primary care services payments
(07/01/16) 4:59 p.m.

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (PPACA), for an increased payment for certain Evaluation and Management (E&M) and Vaccine Administration codes. DOM is extending the deadline for eligible providers to submit their 7/1/2016-6/30/2018 Self-Attestation Statement form to Conduent. Effective July 1, 2016, reimbursement of certain primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule. The DOM Primary Care Provider Fee Schedule is updated July 1 of each year based on 100 percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year. To receive the increased payment for dates of service (DOS) beginning 7/1/2016, eligible providers must send a completed and signed 7/1/2016-6/30/2018 Self-Attestation Statement form to Conduent Provider Enrollment by 8/1/2016 through one of the following means:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: P. O. Box 23078, Jackson, MS 39225

Providers whose 7/1/2016-6/30/2018 Self-Attestation Statement forms are e-mailed, postmarked or faxed during the extension timeframe of 6/30/2016 – 8/1/2016, will experience a delay in the reimbursement of the increased payment, which will be retroactively adjusted. Providers must notify Conduent of any change(s) to their completed 7/1/2016-6/30/2018 Self-Attestation Statement form. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at https://www.ms-medicaid.com/msenvision/. You can locate the form on the DOM website under the Forms section and the Envision Web Portal, or request it by calling the Conduent Call Center toll-free at 800-884-3222.
Extension of deadline to submit Obstetrician/Gynecologist Self-Attestation Statement form for Qualified Obstetric/Gynecological Providers who need to self-attest to receive increased primary care services payments

(07/01/16) 4:59 p.m.

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (PPACA), for an increased payment for certain primary care Evaluation and Management (E&M) and Vaccine Administration codes. Pursuant to HB 1560, effective July 1, 2016 providers who self-attest to a specialty designation in obstetric/gynecologic medicine by the American Congress of Obstetricians and Gynecologists (ACOG) will be eligible for an increased payment for certain primary care services. DOM is extending the deadline for eligible providers to submit their 7/1/2016-6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement form to Conduent. Effective July 1, 2016, reimbursement of certain primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule. The Medicaid Primary Care Provider Fee Schedule is updated July 1 of each year based on one hundred percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year. To receive the increased payment for dates of service (DOS) beginning 7/1/2016, eligible Obstetric/Gynecological providers must send a completed and signed 7/1/2016–6/30/2017 OB/GYN Self-Attestation Statement form to Conduent Provider Enrollment by **8/1/2016** through one of the following means:

Email: msonquiries@conduent.com
Fax: 888-495-8169
Postal mail: P. O. Box 23078, Jackson, MS 39225

Providers whose 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement forms are e-mailed, postmarked or faxed during the extension timeframe of 6/30/2016 – 8/1/2016, will experience a delay in the reimbursement of the increased payment, which will be retroactively adjusted. Providers must notify Conduent of any change(s) to their completed 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement form. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at [https://www.ms-medicaid.com/msenvision/](https://www.ms-medicaid.com/msenvision/). You can locate the form on the DOM website under the Forms section and the Envision Web Portal,
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

Effective November 1, 2015, Mississippi Division of Medicaid (DOM) received Centers for Medicare and Medicaid Services (CMS) approval of State Plan Amendment (SPA) 15-017 Early and Periodic Screening, Diagnosis and Treatment (EPSDT). SPA 15-017 requires DOM EPDST providers adhere to the American Academy of Pediatrics Bright Futures periodicity schedule for physical, mental, psychosocial and/or behavioral health, vision, hearing, adolescent, and developmental screening services. SPA 15-017 also requires DOM EPSDT providers adhere to the requirements of the American Academy of Pediatric Dentistry (AAPD) for dental screening services.

EPSDT screenings must be provided by currently enrolled DOM EPSDT providers who have signed an EPSDT specific provider agreement. EPSDT providers may seek reimbursement for services rendered in accordance with the Bright Futures periodicity schedule for dates of service on and after November 01, 2015.

EPSDT screenings must include:

1. An initial or established age appropriate medical screening which must include, at a minimum:
   - A comprehensive health and developmental history including assessment of both physical and mental health development,
   - A comprehensive unclothed physical exam (which may be accomplished by examining each unclothed body system individually),
   - Appropriate immunizations according to the Advisory Committee for Immunization Practices (ACIP) and specific to age and health history,*
   - Laboratory tests adhering to the AAP Bright Futures periodicity schedule, sexual development and sexuality screening adhering to the AAP Bright Futures periodicity schedule, and
   - Health education, including anticipatory guidance

2. Adolescent counseling and risk factor reduction intervention to include diagnosis with referral to a Mississippi Medicaid enrolled provider for diagnosis and treatment for defects discovered.

3. Developmental screening or surveillance to include diagnosis with referral to a Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

4. Psychosocial/behavioral assessment to include referral to a Mississippi Medicaid provider for diagnosis and treatment for defects discovered.

5. Vision screening at a minimum to include diagnosis with referral to a Mississippi Medicaid optometry or ophthalmology provider for diagnosis and treatment for defects in vision, including eyeglasses.
6. Vision screening at a minimum to include diagnosis with referral to a Mississippi Medicaid optometry or ophthalmology provider for diagnosis and treatment for defects in vision, including eyeglasses.

7. Hearing screening at a minimum to include diagnosis with referral to a Mississippi Medicaid audiologist, otologist, otolaryngologist or other physician hearing specialists for diagnosis and treatment for defects in hearing including hearing aids.

8. Dental screening at a minimum to include diagnosis with referral to a Mississippi Medicaid dental provider for beneficiaries at or the eruption of the first tooth or by twelve (12) months of age for diagnosis and referral to a dentist for treatment and relief of pain and infections, restoration of teeth and maintenance of dental health.

DOM EPSDT providers must schedule and perform all age appropriate screenings and assessments in accordance with Mississippi Administrative Code Title 23, Part 223 Early and Periodic Screening, Diagnosis, and Treatment, which is currently under revision to align with the AAP Bright Futures.

DOM EPSDT providers must refer beneficiaries to other Mississippi Medicaid enrolled licensed practitioners for services necessary to correct or ameliorate physical, mental, psychosocial and/or behavioral health conditions discovered by the screening services, whether or not such services are covered under the Mississippi State Plan.

For more information regarding SPA 15-017 Early and Periodic Screening, Diagnosis and Treatment (EPSDT), please refer to the DOM website at https://medicaid.ms.gov/about/state-plan/approved-state-plan-amendments/ or contact the Office of Medical Services (601) 359-6150.

*DOM does not enroll providers in the VFC Program. To enroll in the VFC program, please contact the Mississippi Department of Health Immunizations at 1-601-576-7751.

**Mental Health Provider Enrollment Update**

(6/27/16) 11:16 a.m.

Effective January 1, 2016, Licensed Professional Counselors (LPCs) began enrolling as individual MS Division of Medicaid (DOM) providers. Effective July 1, 2016, MS Board Certified Behavior Analysts (BCBAs) may also submit applications to begin the enrollment process as Therapeutic and Evaluative Mental Health Services (T&E) providers. LPCs and BCBAs may be reimbursed for medically necessary T&E services provided to EPSDT-eligible Medicaid beneficiaries and rendered in accordance with their professional licensure and scope of practice. Providers should reference the DOM T&E billing guidelines for a list of reimbursable services and procedure codes. Additional T&E provider guidance is available for reference at https://medicaid.ms.gov/wp-content/uploads/2016/01/Provider-Guidance-Therapeutic-and-Evaluative-Mental-Health-Services.pdf.

Please direct questions regarding T&E services to Kimberly Evans or Charlene Toten at 601-359-9545.

The Envision website contains provider application instructions, documentation and forms required to enroll. Providers may start the enrollment process by completing the Mississippi Medicaid Provider Enrollment Application located at https://msmedicaid.acs-inc.com/msenvision/pef/Login.do.
Long Acting Reversible Contraceptives Inpatient Reimbursement

(6/23/16) 3:52 p.m.

Effective July 1, 2016, Mississippi Division of Medicaid will begin reimbursing hospitals outside of the All Patient Refined- Diagnosis Related Groups methodology (APR-DRG), for insertion of Long Acting Reversible Contraceptive (LARC) devices when the device is placed prior to discharge from a postpartum inpatient stay. To receive reimbursement, the hospital may submit a separate outpatient claim for the device and insertion listing only the correct Current Procedural Terminology (CPT) and/or Healthcare Common Procedural Coding System (HCPCS) code and National Drug Code (NDC). Reimbursement will be at the current outpatient prospective payment system (OPPS) rates for the date of service. All other services provided by the hospital must be billed on the inpatient claim and reimbursed at the appropriate APR-DRG rate.

LARCs inserted in an outpatient hospital or physician setting, will continue to receive reimbursement under applicable reimbursement methodologies, when billed using the correct CPT and/or HCPCS code and NDC.

**Inpatient LARC placement postpartum (supplied by HOSPITAL and prior to discharge)**
- The hospital may submit an outpatient claim for LARC devices placed during the postpartum inpatient stay, listing only the date of the insertion as the date of service.
- The claim should include only the LARC device and insertion billed under the applicable Revenue code(s) with the appropriate device CPT and/or HCPCS code and the NDC for the product supplied.
- Reimbursement for LARCs will be at the current outpatient prospective payment system (OPPS) rates for the date of service.
- All other services provided by the hospital must be billed on the inpatient claim and reimbursed at the appropriate APR-DRG rate.
- Any professional claims submitted should not duplicatively include a LARC device.

**Inpatient LARC placement postpartum (supplied by PHYSICIAN and prior to discharge)**
- The hospital will not be reimbursed for the LARC device when it is provided by the physician during the postpartum inpatient stay.
- All other services provided by the hospital must be billed on the inpatient hospital claim and reimbursement will be calculated at the appropriate APR-DRG rate.
- The physician will submit a CMS1500 professional claim for services provided and include the appropriate device HCPCS code, and the NDC for the product supplied.
- Reimbursement for the LARC will be the physician fee for the date of service billed.
The hospital may submit an outpatient claim for all services provided and include the LARC device billed under the appropriate Revenue code(s) with the appropriate device CPT and/or HCPCS code and the NDC for the product supplied.

- Reimbursement for LARCs will be at the current outpatient prospective payment system (OPPS) rates for the date of service.
- Any professional claims submitted should not duplicatively include a LARC device.

**Outpatient LARC placement (supplied by the PHYSICIAN)**

- The hospital will not be reimbursed for the LARC device when it is provided by the physician.
- All other services provided by the hospital must be billed on the outpatient hospital claim and will be reimbursed at the outpatient hospital rate for the date of service billed.
- The physician will submit a CMS-1500 professional claim for services provided and include the appropriate device HCPCS code and the NDC for the product supplied.
- Reimbursement for the LARC will be the physician fee for the date of service billed.

**The current reimbursement rates are:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Physician Fee</th>
<th>Outpatient Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>J7297</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 3 year duration</td>
<td>$750.00</td>
<td>$750.00</td>
</tr>
<tr>
<td>J7298</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52 mg, 5 year duration</td>
<td>$972.61</td>
<td>$972.61</td>
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<tr>
<td>J7300</td>
<td>Intrauterine copper contraceptive</td>
<td>$886.80</td>
<td>$886.80</td>
</tr>
<tr>
<td>J7301</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg</td>
<td>$780.38</td>
<td>$780.38</td>
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<tr>
<td>J7307</td>
<td>Etonogestrel (contraceptive) implant system, including implant and supplies</td>
<td>$925.82</td>
<td>$925.82</td>
</tr>
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</table>

**Attention Maternity Providers**

(6/22/16) 2:09 p.m.

The Division of Medicaid (DOM) covers inductions of labor or cesarean sections prior to one (1) week before the treating physician’s expected date of delivery when medically necessary in accordance with Part 222, Chapter 1, Rule 1.1 B. DOM does not cover non-medically necessary early elective deliveries. DOM defines an early elective delivery as delivery one (1) week prior to the treating physician’s expected date of delivery. An elective delivery performed after one (1) week prior to the treating physician’s expected date of delivery, is considered a covered service.

If you have any questions, please contact your Provider Representative or the Office of Medical Services at 601-359-6150.
The MS Division of Medicaid and Conduent State Healthcare, LLC will conduct provider workshops for billers at RHC and FQHC facilities.

The workshop will cover the following topics:

- MS Medicaid Policy
- Top Common Denials
- Web Portal Functionality
- Managed Care
- Program Integrity

The specific dates and locations of the workshops are as follows:

<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Location</th>
<th>Date/Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 21, 2016</td>
<td>Jackson Convention Complex</td>
<td>June 28, 2016</td>
<td>BancorpSouth Arena and Conference Center</td>
</tr>
<tr>
<td>9:00 a.m. – 4:00 p.m.</td>
<td>105 E. Pascagoula Street Jackson, MS 39201</td>
<td>9:00 a.m. – 4:00 p.m.</td>
<td>387 E Main Street, Tupelo, MS 38804</td>
</tr>
<tr>
<td>June 23, 2016</td>
<td>Hilton Garden Inn</td>
<td>June 29, 2016</td>
<td>The Alluvian Hotel</td>
</tr>
<tr>
<td>9:00 a.m. – 4:00 p.m.</td>
<td>133 Plaza Drive Hattiesburg, MS 39402</td>
<td>9:00 a.m. – 4:00 p.m.</td>
<td>318 Howard Street, Greenwood, MS 38930</td>
</tr>
</tbody>
</table>

Please complete the RSVP section and fax to: 601-206-3119
or email to: msmedicaidlatebreakingnews@conduent.com
Conduent State Healthcare, LLC
ATTN: Provider Field Services RHC and FQHC Workshops
Attention Provider Enrollment Credentialing Personnel
(6/1/16) 3:00 p.m.

Effective July 1, 2016, any providers enrolling or submitting a Change of Ownership (CHOW) application to Mississippi Medicaid will be required to submit the new Provider Disclosure Form as part of their application packet. All providers are required to disclose this information based on 42 CFR § 455.104. Applications received on and after July 1 that do not include a completed Provider Disclosure Form are incomplete and will be returned.
Physician visit limit lifted for dually-eligible beneficiaries
(5/26/16) 4:00 p.m.

Effective May 1, 2016, the Medicaid-imposed 12 visit limit on physician visits is no longer applicable to individuals covered by both Medicare and Medicaid, who are eligible for Medicaid payment of crossover claims. These individuals are dually-eligible beneficiaries, who receive some type of health-care coverage from Medicare and Medicaid.

This change means that Medicaid providers may be reimbursed for physician visits deemed medically necessary, which exceed the previous 12 visit limit for dually-eligible beneficiaries.

Submitted claims may still deny until the appropriate system modifications are made. System modifications are tentatively scheduled to be implemented by July 1, 2016.

Providers currently seeking reimbursement for denied claims for visits which exceed the 12 visit limit for dually-eligible beneficiaries must follow the standard reconsideration process during this interim system modification period. The Claim Reconsideration Form is available on the Mississippi Division of Medicaid’s (DOM) website on the Forms webpage (http://medicaid.ms.gov/resources/forms/).

This change will apply to all claims previously denied for Claim Exception Code 3708, Physician Office Visit Service Limit Exceeded, and that fall within timely filing requirements as of the effective date of this change. Medicare crossover claims for coinsurance and/or deductibles must be filed with DOM within 180 days of the Medicare pay date. The 180-day filing limitation will be determined using the Medicare payment register date as the date of receipt by DOM. Claims filed after the 180-day timely filing limitation will be denied.

Please be advised that this change will not affect claims denied for Claim Exception Code 3708, Physician Office Visit Service Limit Exceeded, for individuals covered only by DOM.

If you have questions, please contact us toll-free at 800-421-2408 or 601-359-6050. Learn more about the Mississippi Division of Medicaid at http://medicaid.ms.gov.
Attention Inpatient Hospitals
(5/12/16) 4:40 p.m.

Incorrect Application of Policy Adjuster
The Division of Medicaid will reprocess Inpatient Hospital claims for dates of service October 1, 2015 through November 10, 2015 due to the incorrect application of Obstetric/Newborn Policy adjuster to claims billed with ICD10CM principle diagnosis codes between 022.8X2 - Z99.89. The mass adjustment will appear on your remittance advise dated May 16, 2016. No further action on part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary services at 800-884-3222.

Attention Nurse Practitioners
(5/12/16) 4:40 p.m.

The Division Of Medicaid will reprocess Nurse Practitioner claims for dates of service January 1, 2013 through June 08, 2015, at the Medicaid allowed Fee as required by State Plan Amendment (Attachment - 4.19-B, Page 6d). The mass adjustment will appear on your remittance advise dated May 16, 2016. No further action on the part of the provider is needed. If you have questions, please contact Conduent provider and beneficiary services at 800-884-3222.

Hospice Providers Update
(5/10/16) 4:19 p.m.

Due to programming challenges, the updates to the claims payment system for federally required rate changes have not been completed. Even though a reduction was to begin January 1, rates are currently being paid for Routine Home Care reimbursement at the higher rate for beneficiaries that have reached the 60 day limit for the first rate tier. The estimated overpayment for beneficiaries that have or will reach the day 61+ tier rate, range from $34.55 to $37.28, per day, per beneficiary, depending on the county in which services are provided. In addition, the SIA add-on payment is not currently being paid for eligible claims for the last seven days of life.

While there will not be any changes in the way providers submit their claims, there will be some additional information required when submitting claims to ensure proper processing. There will be forthcoming notification on the additional requirements for claim submission.

If you have rate questions, please contact T.J. Walker @ 601-359-6827, or T.J.Walker@medicaid.ms.gov. If you have any claims questions, please contact Jay Horton, 601-359-9544, or james.horton@medicaid.ms.gov.
Attention Qualified Providers who need to self-attest to receive increased primary care services payments
(5/9/16) 9:15 a.m.

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (PPACA), for an increased payment for certain Evaluation and Management (E&M) and Vaccine Administration codes. Effective July 1, 2016, reimbursement of certain primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule. The DOM Primary Care Provider Fee Schedule is updated July 1 of each year based on 100 percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year. To receive the increased payment for dates of service (DOS) beginning 7/1/2016, eligible providers must send a completed and signed 7/1/2016 – 6/30/2018 Self-Attestation Statement form to Conduent Provider Enrollment by 6/30/2016 through one of the following means:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: P. O. Box 23078, Jackson, MS 39225

Providers whose 7/1/2016-6/30/2018 Self-Attestation Statement forms are e-mailed, postmarked or faxed after 5/31/2016, may experience a delay in the effective date of the increased payment. Providers must notify Conduent of any change(s) to their completed 7/1/2016-6/30/2018 Self-Attestation Statement form. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at https://www.ms-medicaid.com/msenvision/. You can locate the form on the DOM website under the Forms section and the Envision Web Portal, or request it by calling the Conduent Call Center toll-free at 800-884-3222.

Attention Qualified Obstetric/Gynecological Providers who need to self-attest to receive increased primary care services payments
(5/9/16) 9:15 a.m.

Pursuant to Miss. Code Ann. §§ 43-13-117, 43-13-121, the Mississippi Division of Medicaid (DOM) was granted authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (PPACA), for an increased payment for certain primary care
Evaluation and Management (E&M) and Vaccine Administration codes. Pursuant to HB 1560, effective July 1, 2016 providers who self-attest to a specialty designation in obstetric/gynecologic medicine by the American Congress of Obstetricians and Gynecologists (ACOG) will be eligible for an increased payment for certain primary care services. Effective July 1, 2016, reimbursement of certain primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule. The Medicaid Primary Care Provider Fee Schedule is updated July 1 of each year based on one hundred percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year. To receive the increased payment for dates of service (DOS) beginning 7/1/2016, eligible Obstetric/Gynecological providers must send a completed and signed 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement form to Conduent Provider Enrollment by 6/30/2016 through one of the following means:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: P. O. Box 23078, Jackson, MS 39225

Providers whose 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement forms are e-mailed, postmarked or faxed after 5/31/2016, may experience a delay in the effective date of the increased payment. Providers must notify Conduent of any change(s) to their completed 7/1/2016–6/30/2017 Obstetrician/Gynecologist (OB/GYN) Self-Attestation Statement form. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at https://www.ms-medicaid.com/msenvision/. You can locate the form on the DOM website under the Forms section and the Envision Web Portal, or request it by calling the Conduent Call Center toll-free at 800-884-3222.
Attention All Advanced Imaging Providers
(4/22/16) 11:00 a.m.

Advanced Imaging Claims Denials
For dates of service beginning March 01, 2016, Division of Medicaid (DOM) identified that certain claims billed with advanced imaging CPT codes are denying incorrectly for edit 0727-Prior Authorization Number Not on File. DOM is working to correct this issue and claims will be reprocessed. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222 or DOM at 601-359-6150.

Attention All Providers
(4/22/16) 9:00 a.m.

CPT, CDT & HCPCS Code Corrections
The Division of Medicaid will reprocess claims for dates of service January 1, 2014 through September 28, 2015 which denied due to edit '0306 - EYEGlass OR DENTAL SERVICES NOT COVERED FOR BENEFICIARY' and '3955 - SERVICE NOT COVERED FOR BENEFICIARY'. This mass adjustment will appear on your remittance advise dated April 25, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers
(4/22/16) 9:00 a.m.

2016 CPT Lab Codes 0001M - 0010M
The Division Of Medicaid will reprocess claims for dates of service January 1, 2013 through February 8, 2016 which were billed for CPT Lab Codes 0001M - 0010M. The mass adjustment will appear on your remittance advise dated April 25, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers
(4/22/16) 9:00 a.m.

CPT, CDT & HCPCS Code Corrections
The Division of Medicaid will reprocess claims for dates of service January 1, 2014 through September 28, 2015 which denied due to edit '0306 - EYEGlasses OR DENTAL SERVICES NOT COVERED FOR BENEFICIARY' and '3955 - SERVICE NOT COVERED FOR BENEFICIARY'. This mass adjustment will appear on your remittance advise dated April 25, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Pharmacy Provider Notice
(4/18/16) 9:40 a.m.

For Fee for Service POS Claims
The DOM has implemented a systematic fix for PREFERRED BRAND drugs listed on the PDL which have been reimbursing with an ingredient cost based on the FUL price.

Pharmacists may enter a DAW of '9' on claims to override the FUL price on Preferred Brand drugs found on the PDL.

This fix is retroactive for claims with a Date of Service of 4/11/2016 and forward. Claims that paid incorrectly should be reversed and resubmitted with the original date of service (fill date).

For CAN claims
Pharmacist may call Magnolia or United Healthcare Help Desks for an override.
Attention All Providers
(4/15/16) 3:52 p.m.

2016 HCPCS and AMA Code Updates
The Division of Medicaid will reprocess claims for dates of service January 1, 2016 through January 15, 2016 due to a delay in annual code updates. The mass adjustment will appear on your remittance advice dated April 18, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Hospitals Providers
(4/8/16) 9:00 a.m.

The Division of Medicaid will reprocess paper claims that were denied incorrectly for Claim Exception 1816-PRINCIPAL SURGICAL PROCEDURE NOT ON DATA BASE’ for dates of service October 1, 2015 thru January 18, 2016. The mass adjustment will appear on your Remittance advice dated April 11, 2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention Outpatient Hospitals and Physician Providers
(4/8/16) 9:00 a.m.

Incorrect Denials on Non-Surgical CPT Codes.
The Division of Medicaid will reprocess outpatient hospital and physician claims for dates of service October 1, 2014 through December 15, 2014 due to incorrect posting of Edit 1003 NOT A BILATERAL CODE-NO MODIFIER 50 ALLOWED and edit 1004 MULTIPLE SURGERY APPLIES-MODIFIER 51 REQUIRED on non- surgical CPT Codes. The mass adjustment will appear on your Remittance advice dated April 11, 2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers  
(4/8/16) 9:00 a.m.

**CPT Codes 19302, 19304, 19305, 19306, 19307**
The Division of Medicaid will reprocess claims containing codes 19301, 19302, 19304, 19305, 19306, 19307 for dates of service January 1, 2007 through November 19, 2015 due to Gender changes on CPT Codes 19302, 19304, 19305, 19306, 19307. The mass adjustment will appear on your Remittance advice dated April 11, 2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

**Hospital Inpatient APR-DRG Alert– July 1, 2016**  
**Updates**  
(4/1/16) 8:25 a.m.

The Mississippi Division of Medicaid will adopt V.33 of the 3M Health Information System APR-DRG Grouper and V.33 of the Health Care Acquired Conditions (HCAC) utility for payment of hospital inpatient claims for discharges on and after July 1, 2016. APR-DRG parameters will not change effective for hospital inpatient discharges on and after July 1, 2016.

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, 2016.

Hospitals will be notified of all information related to these updates via e-mail, the DOM website [www.medicaid.ms.gov](http://www.medicaid.ms.gov), Late Breaking News, and RA Banner Messages.

**Attention: Pharmacy Providers**  
(3/23/16) 4:25 p.m.

In accordance with the Centers for Medicare and Medicaid Services (CMS) Final Rule, implemented at 42 CFR §447.514, the April 2016 revised federal upper limit (FUL) prices will be used in current pharmacy reimbursement methodology beginning on April 11, 2016. Find more information about the final rule on the CMS website: [https://www.medicaid.gov/Medicaid-CHIP-Program-Information/](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/)
Attention: Nursing Facility Providers  
(3/2/16) 9:30 a.m.

The Division of Medicaid and Mississippi State Department of Health Division of Licensure and Certification are hosting a free, one-day educational seminar for nursing home providers and other individuals or organizations interested in applying for a Civil Money Penalty grant. The seminar will be April 26, 2016 from 9:00 AM until 3:30pm. The seminar will be held at the University of Mississippi Medical Center Conference Center, Jackson Medical Mall, 350 W. Woodrow Wilson Drive, Jackson, MS. If your organization is seeking funding from Centers for Medicare and Medicaid Services for a project benefiting nursing home residents, please attend this educational seminar.

The deadline for registration is April 12. You may register at the following link: [http://healthyms.com/register/cmp/](http://healthyms.com/register/cmp/)

For more information, please call 601-359-9529 or 601-359-5251.

Provider Information for Leading Testing and Treatment  
(2/26/16) 9:15 a.m.

On Feb. 24, the City of Jackson issued a press release regarding elevated levels of lead in some home water samples serviced by the city water system. ([City of Jackson Meeting Additional Compliance Measures Related to Lead Exceedance](#))

To better assist our providers who serve our beneficiaries, the Mississippi Division of Medicaid (DOM) has listed specific instructions about billing and reimbursement related to lead testing and treatment. DOM covers CPT code 83655 (lead testing) outside of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) or wellness benefit for all beneficiaries when billed with a QW modifier. The ICD-10 code for contact with and (suspected) exposure to lead is Z77.011.

Claims for beneficiaries impacted by the recent Mississippi Department of Health announcement related to City of Jackson Public Water System should include ICD-10 code Z77.011, CPT code 83655 (with QW modifier) and an appropriate Evaluation and Management code, when lead testing is performed outside of the EPSDT or wellness benefit. All applicable Administrative Code, State Plan and provider policies apply.
Attention All Providers
(2/26/16) 8:52 a.m.

**CPT-HCPCS Radiology Code Fee Corrections**
The Division of Medicaid will reprocess claims for dates of service January 1, 2015 through February 20, 2015 due to CPT-HCPCS Radiology Code Fee Corrections. The mass adjustment will appear on your remittance advice dated February 29, 2016. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

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Attention All Providers
(2/19/16) 8:40 a.m.

**NCCI Edit 6560 Correction**
The Division of Medicaid will reprocess claims for dates of service April 1, 2011 through December 1, 2015 which denied due to edit 6560-NCCI Medically Unlikely Edits. The mass adjustment will appear on your remittance advice dated February 22, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

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Attention All Providers
(2/19/16) 8:40 a.m.

**End Date Corrections on Various Pricing Segments**
The Division of Medicaid will reprocess claims which were billed with the codes 76390, 27215, 27216, 27217, 27218, 58300, 97010, 97014, 92617, and 93641 for dates of service July 1, 2014 through June 30, 2015. The mass adjustment will appear on your remittance advice dated February 22, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers  
(2/19/16) 8:40 a.m.

CPT Code 73206 & 78102  
The Division of Medicaid will reprocess claims for dates of service July 1, 2015 through December 10, 2015 which billed newly opened CPT codes 78102 and 73206. The mass adjustment will appear on your remittance advice dated February 22, 2016. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Mental Health Provider Guidance  
(2/12/16) 9:00 a.m.

New guidance for providers of Therapeutic and Evaluative Mental Health Services for Expanded EPSDT is now available on the Division of Medicaid (DOM) website. This document contains helpful information about mental health services offered to DOM beneficiaries under the age of 21 and is accessible at the following link: http://www.medicaid.ms.gov/wp-content/uploads/2016/01/Provider-Guidance-Therapeutic-and-Evaluative-Mental-Health-Services.pdf

If you have any questions about this information, contact Kimberly Evans or Charlene Toten at 601-359-9545.

Attention All Providers  
(2/12/16) 9:00 a.m.

CPT Code 88342 Update  
The Division of Medicaid will reprocess claims which were billed with CPT code 88342 for dates of service January 1, 2015 through October 30, 2015. The mass adjustment will appear on your remittance advice dated February 15, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
**WHAT’S NEW?**

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**Attention All Providers**

(2/12/16) 9:00 a.m.

**Code Updates**

The Division of Medicaid will reprocess claims which were billed with codes 88342, 96040, 80440, 86152, 86153, J7303, and 88341 for dates of service January 1, 2013 through May 11, 2015. The mass adjustment will appear on your remittance advice dated February 15, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

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**Join Magnolia Health for a webinar on acute inpatient issues and the inpatient transition**

(2/8/16) 2:00 p.m.

Join Magnolia Health Plan Thursday, Feb. 11 for an educational webinar on acute inpatient issues and behavioral health.

**Webinar: Magnolia Health Inpatient and Behavioral Health Webinar**
**Date:** Thursday, Feb. 11
**Time:** 2:00 – 3:00 p.m. CDT
**Conference Number:** 1-855-351-5537
**Participant Code:** 5440205058
**To join the meeting:** [http://centene.adobeconnect.com/r2yr3d07ypb/](http://centene.adobeconnect.com/r2yr3d07ypb/)

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**Questions?**

Your questions and concerns are important to us. For that reason, we have established a dedicated email box for the inpatient transition. We encourage you to submit your questions about the inpatient transition and your inquiry will be addressed. Contact us by emailing [inpatient@medicaid.ms.gov](mailto:inpatient@medicaid.ms.gov).
Allowable Board of Directors Fees for Nursing Facilities, ICF-IID’s and PRTF’s 2015 Cost Reports
(2/5/16) 2:00 p.m.

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2015 cost reports filed by nursing facilities (NF’s), intermediate care facilities for individuals with intellectual disabilities (ICF-IID’s), and psychiatric residential treatment facilities (PRTF’s) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for all Urban Consumers - All Items. The amounts listed below are the per meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2015 are as follows

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost for 2015</th>
</tr>
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<tr>
<td>0 – 99 Beds</td>
<td>$4,015</td>
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<td>100 – 199 Beds</td>
<td>$6,022</td>
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<td>200 – 299 Beds</td>
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<td>500 Beds or More</td>
<td>$12,044</td>
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</tbody>
</table>

2016 New Bed Values for Nursing Facilities, ICF-IIDs, and PRTFs
(2/5/16) 2:00 p.m.

The new bed values for 2016 for nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF-IIDs) and psychiatric residential treatment facilities (PRTFs) have been determined by using the R.S. Means Historical Cost Index. These values are the basis for rental payments made under the fair rental system of property cost reimbursement for long-term care facilities.

<table>
<thead>
<tr>
<th>Facility Class</th>
<th>2016 New Bed Value</th>
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<tbody>
<tr>
<td>Nursing Facility</td>
<td>$91,462</td>
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<tr>
<td>ICF-IIDs</td>
<td>$109,754</td>
</tr>
<tr>
<td>PRTF</td>
<td>$109,754</td>
</tr>
</tbody>
</table>
2015 Owner Salary Limits for Long-Term Care Facilities
(2/5/16) 2:00 p.m.

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities as owner’s salaries for 2015 are based on 150% of the average salaries paid to non-owner/administrators that receive payment for services related to patient care. The limits apply to all salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2015 are as follows:

- Small Nursing Facilities (1-60 Beds): $128,285
- Large Nursing Facilities (61+ Beds): $150,977
- Intermediate Care Facilities for individuals with intellectual disabilities (ICF-IID): $140,820
- Psychiatric Residential Treatment Facilities (PRTF): $206,906

Attention All Providers
(2/5/16) 2:00 p.m.

CPT, CDT & HCPCS Code Corrections
The Division of Medicaid will reprocess claims which were billed with the codes listed below for dates of service January 1, 2015 through April 16, 2015. The mass adjustment will appear on your remittance advice date February 8, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

<table>
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<th>Change</th>
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<th>End Date</th>
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</table>
Attention All Providers  
(2/5/16) 2:00 p.m.

**CPT Codes 99406 & 99407**
The Division of Medicaid will reprocess claims for dates of service October 1, 2015 through November 2, 2015 which were billed with CPT codes 99406 & 99407. The mass adjustment will appear on your remittance advice dated February 8, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers  
(1/28/16) 4:15 p.m.

**CPT Codes 90685 and 90687**
The Division of Medicaid will reprocess outpatient hospital claims for dates of service July 1, 2014 through November 25, 2014 due to changes on CPT codes 90685 and 90687. The mass adjustment will appear on your remittance advice dated February 1, 2016. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers  
(1/28/16) 4:15 p.m.

**OCT 2014 PAD Fee Corrections**
The Division of Medicaid will reprocess claims for dates of service October 1, 2014 through May 12, 2015 due to multiple October 2014 Physician Administered Drug Fee corrections. The mass adjustment will appear on your remittance advice dated February 1, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers
(1/28/16) 4:15 p.m.

Various HCPCS Codes
The Division of Medicaid will reprocess claims billed with various HCPCS codes for dates of service January 1, 2015 through April 7, 2015. The mass adjustment will appear on your remittance advice dated February 1, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers
(1/28/16) 4:15 p.m.

Physician Administered Drug Fee Updates
The Division of Medicaid will reprocess claims for dates of service July 1, 2014 through January 27, 2015 due to Physician Administered Drug Fee updates. The mass adjustment will appear on your remittance advice dated February 1, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers
(1/28/16) 4:15 p.m.

CPT Code 41899
The Division of Medicaid will reprocess claims billed with CPT code 41899 for dates of service October 1, 2014 through February 27, 2015. The mass adjustment will appear on your remittance advice dated February 1, 2016. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention All Providers  
(1/28/16) 4:15 p.m.

2015 HCPCS Physician Administered Drug Code Update
The Division of Medicaid will reprocess claims for the dates of service January 1, 2015 through January 15, 2015 due to 2015 HCPCS Physician Administered Drug Code Update. The mass adjustment will appear on your remittance advice dated February 1, 2016. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Advanced Imaging Changes  
(1/28/16) 11:30 a.m.

Effective March 1, 2016, eQHealth Solutions (eQHS) will begin performing prior authorization reviews for advanced imaging services, in accordance with Mississippi Administrative Code Title 23, Part 220 Radiology Services. Currently, advanced imaging services are prior authorized through MedSolutions (eviCore). The Mississippi Division of Medicaid (DOM) will honor MedSolutions (eviCore) treatment authorization numbers issued to rendering providers for dates of services on or before March 30, 2016. Advanced imaging prior authorization requests pended for additional information by MedSolutions (eviCore) on or after March 1, 2016 must be submitted to eQHS as a new prior authorization request.

eQHS will conduct webinar sessions designed to assist providers with this transition. All providers and staff are encouraged to attend one of these informative sessions. Please visit [http://ms.eqhs.org](http://ms.eqhs.org) to register for the upcoming sessions. For additional information, please contact eQHS at 601-360-4833 or by email at education@eqhs.org. Providers may also contact DOM Office of Medical Services at 601-359-6150.

This change does not impact Medicaid beneficiaries enrolled in the MS Coordinated Access Networks (MSCAN).
Attention Hospice Providers
(1/22/16) 2:27 p.m.

Routine Home Care Reimbursement Methodology Change
Effective January 1, 2016

Effective January 1, the reimbursement methodology and rates for Hospice "Routine Home Care" level services have changed. The new methodology changes the “Routine Home Care” service reimbursement from a single rate to a two tier rate. This change will result in a higher base payment for the first sixty (60) days of hospice care and a reduced base payment rate for days 61 and thereafter. In addition, the change establishes an add-on payment for certain professional services provided during the last seven (7) days of life, provided the services were performed by a Registered Nurse or Social Worker for a beneficiary during the last seven (7) days. The Routine Home Care reimbursement rates will transition from a single rate by county to a two tier rate (Day 1 - 60 and Days 61+) by county, and a Service Intensity Add-On (SIA) payment, if applicable.

DOM will update the new rates on the FY 2016 Hospice Rates (revised) table on our Internet website, as well as in our MMIS payment system. We anticipate the changes in the MMIS payment system to be completed by January 31, 2016. There will not be any changes in the way providers submit their claims.

This change was mandated by CMS regulation. More information can be found in the following CMS publications: 'FY 2016 Medicare Hospice Final Rule’ (CMS-1629-F) and 'Medicaid Memorandum: Annual Change in Medicaid Hospice Payment Rates--ACTION’.

If you have questions, please contact T.J. Walker @ 601-359-6827, or T.J.Walker@medicaid.ms.gov.
Attention: Family Planning Providers  
(1/14/16) 2:52 p.m.

**DISCONTINUED CODE J7302 REPLACED WITH J7297 AND J7298 EFFECTIVE 1/1/2016**
Effective 12/31/2015, HCPCS code J7302 (Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG) will be discontinued. The new HCPCS codes J7297 (Liletta) and J7298 (Mirena) should be utilized for billing Levonorgestrel-Releasing Intrauterine Contraceptive System, 52 MG beginning with dates of service on or after 01/01/2016. If you have any questions, please contact your Provider Representative or the Office of Medical Services at 601-359-6150.

**Medicaid Program Integrity Education**  
(1/11/16) 9:30 a.m.

The Center for Program Integrity provides educational resources to educate providers, beneficiaries and other stakeholders in promoting best practices and awareness of Medicaid fraud, waste and abuse. Medicaid Provider Integrity Education (MPIE) materials are applicable to providers, beneficiaries, and State managed care plans. MPIE materials include topic-based information in an easy to read format that aid in furthering education efforts of providers, beneficiaries and other Medicaid stakeholders. The information provided is intended to further the education efforts of Medicaid Program Integrity Education, assist providers with being in compliance with their billing and assist in the fight against fraud, waste and abuse. Please visit Medicaid Program Integrity Education - Centers for Medicare & Medicaid Services to access educational booklets, fact sheets and provider checklist resources and tools which promote efforts to prevent Medicaid fraud, waste and improper payments.

Attention All Providers  
(1/7/16) 4:00 p.m.

The Division of Medicaid will reprocess inpatient claims with date of service beginning 10/01/2015 paid through 11/02/2015 that paid incorrectly due to a system issue. The affected claims will be adjusted to correct the associated payment errors. The mass adjustment will appear on your Remittance Advice dated 01/11/2016. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention: All Providers (12/24/15) 11:00 a.m.
A review of the infusion Current Procedural Codes (CPT) 96372 and 96375 was completed and corrections to the maximum units of these codes have been made. Due to these changes, outpatient hospital claims for CPT code 96372 dates of service beginning September 1, 2012 and CPT code 96375 dates of service beginning July 1, 2013 and through August 12, 2013 will require reprocessing. Physicians claims billed with CPT code 96372 dates of service beginning July 1, 2013 through August 12, 2013 will also require reprocessing. The adjusted claims will appear on your Provider Remittance Advice dated 12/28/2015. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION ALL PROVIDERS (12/24/15) 11:00 a.m.
HCPCS Code J0885 and J0886
The Division of Medicaid will reprocess outpatient hospital claims for dates of service January 1, 2013 through June 16, 2014 due to changes on HCPCS codes J0885 and J0886. The mass adjustment will appear on your remittance advice date 12/28/2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services 800-884-3222.

ATTENTION: PROFESSIONAL AND FACILITY PROVIDERS
(12/24/15) 11:00 a.m.
INFLUENZA VIRUS VACCINE CODES 90686 AND 90688
The Division of Medicaid will reprocess claims for influenza virus vaccines billed using CPT codes 90686 and 90688. All claim lines billed using either code will be reprocessed for dates of service beginning July 1, 2013 through February 10, 2014 for 90686 and September 1, 2013 through February 10, 2014 for 90688. These reprocessed claims will appear on your remittance advice dated 12/28/2015. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

ATTENTION PROFESSIONAL AND OUTPATIENT HOSPITAL PROVIDERS
(12/24/15) 11:00 a.m.
The Division of Medicaid will reprocess professional and outpatient claims for dates of service January 1, 2014 through April 1, 2014 due to changes in age, diagnosis, and/or maximum units on the CPT/HCPCS codes listed below. The mass adjustment will appear on your remittance advice dated December 28, 2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
CPT/HCPCS Codes: 52287 64612 64613 64614 64615 64616 64617 64642 64643 64644 64645 64647 64650 64653 67345 J0585 J0586 J0587
Hospital and Nursing Facilities Physician’s Signature Notification Announcement (12/23/15) 11:26 a.m.

Effective January 1, 2016, Mississippi Division of Medicaid (DOM) will no longer require the physician’s certification, electronic or hardcopy signature, to confirm clinical eligibility of a nursing facility resident. Applicable sections of Mississippi Administrative Code Title 23 are being revised to reflect these changes for Pre-Admission Screening and Resident Review (PASRR), formerly known as the Pre-Admission Screening (PAS). The following sections will be included in this update:

- Part 303, Chapter 1, Rule 1.2: Level I Pre-Admission Screening and Resident Review, and
- Part 207, Chapter 1: Long Term Care Pre-Admission Screening, Rule 1.1: Clinical Eligibility Determination

If you have any questions or need additional information, please contact Gay Gipson or Michele Bates at 601-359-9545. Thank you for your continued participation in the Medicaid program and your service to these Mississippians.

**ATTENTION HOSPITAL PROVIDERS** (12/23/15) 10:00 a.m.

Effective July 1, 2015, certain hospital outpatient claims began denying inappropriately for edit 0110-Date Bundling Not Allowed. The Division of Medicaid (DOM) is working on a system resolution to correct this issue. A mass adjustment will be done to correct any inappropriately denied claims. No further action on the part of the provider is required. Please continue to check the Mississippi Medicaid website at http://www.medicaid.ms.gov for Late Breaking News regarding updates.

If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention: All Providers! 12/22/2015 10:59 a.m.


Please be informed that Conduent EDI Solutions will be setting aside the below timeframes for performing our planned maintenance activities in January, 2016. All batch and real time transaction processing (including Switch Vendor) will experience timeouts during this maintenance time frame. This regular maintenance will help us to improve reliability and performance of our systems. We appreciate your understanding and cooperation. If you have any questions, please do not hesitate to contact the EDI Helpdesk or your Switch Vendor Contact.

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NOTICE TO PHARMACY and Pharmacy DME PROVIDERS ONLY! (12/18/2015) 9:00 a.m.

(Pharmacy Disease Management Providers ARE NOT included)

Pharmacy License Renewal- Final Notice!

Pharmacies enrolled in the MS Medicaid program must be in good standing with their regulatory authority to be a Medicaid provider. Pharmacies who have not submitted their annual pharmacy permit renewal to Conduent by 01/31/2016 will be terminated from the MS Medicaid program, and claims submitted after 01/31/2016 will be denied. Additionally, DOM will recoup monies paid during 1/1/2016 – 1/31/2016 for those pharmacy providers without a valid pharmacy permit on file during January 2016.

To ensure your MS Medicaid provider file is updated, please fax a copy of the pharmacy permit to Conduent at 601-206-3015. A copy of the permit must be provided; letters from the Board of Pharmacy do not suffice as documentation of permit renewal. For questions or additional information, please contact Conduent at 1-800-884-3222.
Attention: All Providers! (12/18/2015) 9:00 a.m.

ICD-9 Codes 258.01, 258.02 and 258.03

The division of Medicaid will reprocess Outpatient Hospital Claims for dates of service October 1, 2007 through July 1, 2014 due to changes on ICD-9 Diagnosis codes 258.01, 258.02 and 258.03. The mass adjustment will appear on your Remittance advice dated December 21, 2015. No further action on the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: All Providers! (12/18/2015) 9:00 a.m.

The Division of Medicaid will reprocess professional claims for dates of service July 1, 2013 through June 30, 2014 for CPT code 77427. The mass adjustment will appear on your remittance advice dated December 21, 2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-844-3222.

Attention: All Providers! (12/18/2015) 9:00 a.m.

The Division of Medicaid will reprocess professional claims for dates of service July 1, 2013 through February 9, 2015 for HCPCS Codes J0881, J0882, J0885 and J0886. The mass adjustment will appear on your remittance advice date December 21, 2015. No further action on the part of the provider is needed. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: Outpatient Hospitals! (12/18/2015) 9:00 a.m.

OUTPATIENT HOSPITAL CLAIMS

ICD9-CM DIAGNOSIS CODE V46.14 GENDER CORRECTION

The Division of Medicaid will reprocess claims due to an error in the gender setting for ICD9-CM Diagnosis Code V46.14. The gender has been corrected and all outpatient claims billed with this code will be reprocessed for dates of service beginning October 1, 2005 through May 1, 2014. These reprocessed claims will appear on your remittance advice dated 12/21/2015. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Attention: Outpatient Hospitals! (12/18/2015) 9:00 a.m.

HCPCS CODE J1442

The Division of Medicaid will reprocess outpatient claims for dates of service January 1, 2014 through March 21, 2014 which were billed with HCPCS code J1442. This mass adjustment will appear on your remittance advice dated December 21, 2015. No further action on the part of the provider is required. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: All Providers! (12/11/2015) 3:14 p.m.

DISCONTINUED CODE 0262T REPLACED WITH CODE 33477 EFFECTIVE 1/1/2016

The 2016 CPT code changes include the discontinuance of CPT procedure code 0262T effective 12/31/2015. The new CPT code 33477 should be utilized for billing of this procedure beginning with dates of service 01/01/2016. If you have any questions, please contact your Provider Representative or the Office of Medical Services at 601-359-6150.

Attention: All Providers! (12/10/2015) 4:26 p.m.

The Division of Medicaid will reprocess claims with adjudication dates from 10/01/2012 through 10/12/2015 for Claim Exception 0143-beneficiary not eligible/not found and/or 0149-beneficiary has partial eligibility. The mass adjustment will appear on your remittance advice date 12/14/2015. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention: All Hospital Providers! (12/10/2015) 4:25 p.m.

Inpatient Hospital claims with an adjudication date of June 15, 2014 through April 13, 2015 will require reprocessing due to Claim Exception 0605-AUTHORIZATION/SERVICE DATE CONFLICT not applying correctly. This Mass Adjustment will occur the week of 12/14/2015. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Mental Health Provider Enrollment Announcement
(11/25/2015)

Effective January 1, 2016, Licensed Professional Counselors (LPCs) can submit an application to become an individual MS Medicaid provider. LPCs will be allowed to provide Therapeutic and Evaluative Mental Health Services to Medicaid beneficiaries.

The Envision website lists application instructions, documentation and forms required to enroll as a Medicaid provider. A provider may begin the enrollment process by completing the Mississippi Medicaid Provider Enrollment Application located at https://msmedicaid.acs-inc.com/msenvision/pef/Login.do.

If you have any questions regarding the enrollment application or process, contact a Conduent provider enrollment specialist toll-free at 800-884-3222.

Attention: DME, Medical Supply, Orthotic, and Prosthetic Providers!!! (11/20/2015)

Due to a delay in implementation of the July 1, 2015 Fee Update for these providers, claims for dates of service July 1, 2015 through September 15, 2015 billed with certain impacted codes will require reprocessing. This mass adjustment will appear on your remittance advice dated November 23, 2015. No further action on the part of the provider is required. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

**Attention Providers** (11/20/2015)

The Division of Medicaid will reprocess professional claims for dates of service January 1, 2015 through February 8, 2015 for certain impacted codes due to an update error. The mass adjustment will appear on your remittance advise dated November 23, 2015. No further action on the part of the provider is needed. If you have questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
Join Us for a Webinar on Newborns And The Inpatient Transition

The Mississippi Division of Medicaid (DOM) is preparing for the inclusion of inpatient services into our managed care program (MississippiCAN) and is collaborating with our partners to ensure a smooth transition. This transition will be effective Dec. 1, 2015.

Join us Monday, Nov. 23 to learn about changes affecting newborns from representatives at DOM and our MississippiCAN coordinated care organizations, Magnolia Health and UnitedHealthcare Community Plan. During the webinar we will cover many topics, including: observation, concurrent review, notification, the newborn form, prior authorization, neonatal intensive-care unit policies, interim billing, enrollment challenges and more.

Webinar: Newborns and the inpatient transition for hospitals and providers

Date: Monday, Nov. 23
Time: 1:30 – 3:30 p.m. CDT

To register for the webinar, please RSVP by emailing inpatient@medicaid.ms.gov with the following information:

- Hospital or facility name
- Hospital or facility address
- Contact person name
- Contact person phone number
- Contact person email address

The webinar information will be sent after your registration information is received. Please limit attendance to one line per hospital or facility. Capacity is limited.

Questions?
Your questions and concerns are important to us. For that reason, we have established a dedicated email box for the inpatient transition. We encourage you to submit your questions about the inpatient transition and your inquiry will be addressed. Contact us by emailing inpatient@medicaid.ms.gov
ATTENTION ALL HOSPITALS AND PROVIDERS!!

11/10/2015 11:00am

Join us for a webinar on behavioral health and the inpatient transition
The Mississippi Division of Medicaid (DOM) is preparing for the inclusion of inpatient services into our managed care program (MississippiCAN) and is collaborating with our partners to ensure a smooth transition. This transition will be effective Dec. 1, 2015.

As part of the inpatient services transition, there will also be changes affecting inpatient behavioral health. As a valued Medicaid provider specializing in behavioral health, we want to give you the opportunity to learn about these changes through a webinar.

Join us Tuesday, Nov. 17 to hear from representatives at DOM and our MississippiCAN coordinated care organizations, Magnolia Health and UnitedHealthcare Community Plan. During the webinar we will cover many topics, including: prior authorization processes, reimbursement and claims instructions, applicable policies, provider enrollment for inpatient services and more.

Webinar: Behavioral health and the inpatient transition for hospitals and providers
Date: Tuesday, Nov. 17
Time: 10 a.m. – 12 p.m. CDT

To register for the webinar, please RSVP by emailing inpatient@medicaid.ms.gov with the following information:

- Hospital or facility name
- Hospital or facility address
- Contact person name
- Contact person phone number
- Contact person email address

The webinar information will be sent after your registration information is received. Please limit attendance to one line per hospital or facility. Capacity is limited.

Questions?
Your questions and concerns are important to us. For that reason, we have established a dedicated email box for the inpatient transition. Please don’t hesitate to contact us by emailing inpatient@medicaid.ms.gov.
****ATTENTION ALL PROVIDERS!!!**** 10/29/2015 4:00pm

Please be informed that Conduent EDI Solutions will be setting aside the below timeframes for performing our planned maintenance activities in November 2015. All batch and real time transaction processing (including Switch Vendor) for the states noted above will experience timeouts during this maintenance time frame. This regular maintenance will help us to improve reliability and performance of our systems. We appreciate your understanding and cooperation.

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**ATTENTION ALL HEARING, VISION, AND OPTICAL DISPENSARY PROVIDERS** 10/23/2015 9:22 am

National Correct Coding Initiative (NCCI) Billing Requirements

The Patient Protection and Affordable Care Act of 2010 (ACA) requires state Medicaid agencies to incorporate National Correct Coding Initiative (NCCI) methodologies for processing of claims effective April 1, 2011. This methodology includes the billing of anatomic modifiers on appropriate vision, hearing, and optical medical device HCPCS codes to prevent denials. In some instances this will require the billing of the same code on two separate lines to provide the correct anatomic modifier for each code. Information on the correct use of NCCI associated modifiers is located in the Medicaid NCCI Policy Manual at [http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html](http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html). Providers should review this NCCI Policy Manual and other articles located on the website for information on correct billing of these modifiers. If you have any questions, please contact your Conduent representative or the Division of Medicaid.
Attention All Providers!! 10/20/15  2:52 pm

The Automated Voice Response System’s (AVRS) menu options have changed. In order to check a beneficiary’s eligibility, you will need to press option 2, 2 and 2.

Attention Hospital Providers!! 10/20/15  2:46 pm

Join us for a webinar on the inpatient transition
The Mississippi Division of Medicaid (DOM) is preparing to roll inpatient services into our managed care program (MississippiCAN) and collaborating with our partners to ensure a smooth transition. This transition is set to be effective Dec. 1, 2015. Rolling inpatient services into managed care will change claims submission and other procedures. As a valued Medicaid provider, we want to give you the opportunity to learn about these changes through a webinar. (More webinars will be scheduled in November; one will specifically address behavioral health.)

Join us in a webinar to hear from representatives at DOM and our MississippiCAN coordinated care organizations, Magnolia Health and UnitedHealthcare Community Plan. During the webinar we will cover many topics, including: the prior authorization process, reimbursement and claims instructions, applicable policies, provider enrollment for inpatient services and more.

Webinar: Inpatient transition training and education for hospitals and providers
Date: Monday, October 26
Time: 10 a.m. – 12 p.m. CDT

To register for the webinar, please RSVP by emailing inpatient@medicaid.ms.gov with the following information:

- Hospital or facility name
- Contact person name
- Contact person phone number
- Contact person email address

The webinar information will be sent after your registration information is received. Please limit attendance to one line per hospital or facility. Capacity is limited.

Questions?
Your questions and concerns are important to us. For that reason, we have a dedicated email box for the inpatient transition. Please don’t hesitate to contact us by emailing inpatient@medicaid.ms.gov.
Providers participating in the Primary Care Provider (PCP) Program were previously notified to re-attest using the 1/1/2015 - 6/30/2016 Self-Attestation form in order to continue receiving increased payments. Previously eligible providers who did not re-attest will have applicable claims retroactively adjusted for the increased portion of their payment for dates of service (DOS) beginning January 1, 2015. Providers whose 1/1/2015 - 6/30/2016 Self-Attestation forms were sent/postmarked after March 31, 2015, will receive the increased PCP payment for DOS beginning on the date the form is received or postmarked. A mass adjustment of the affected claims will be processed the week of October 19, 2015 to recoup the increased portion of the provider payments. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Notice to Pharmacy Providers Only!!! 10/09/15 4:09 pm

There will be a change to the Automated Voice Response System (AVRS) options to allow Medicaid pharmacies quicker entry into the Pharmacy queue. Previously, upon calling into the AVRS 800-884-3222 pharmacies pressed 2 (Medicaid Provider), then pressed 2 (Pharmacy), and after entering their Medicaid ID were obligated to listen to one or more general provider messages. With the new change, scheduled to be implemented at noon on October 12, 2015, pharmacies will press 2 (Medicaid Provider), then press 1 (Pharmacy). After entering their Medicaid ID, they will then be routed directly into the Pharmacy queue, bypassing the general Medicaid Provider messages. This will greatly reduce wait times for pharmacies who need quick resolution on questions regarding Point-of-Sale claims.

Attention Providers!!! 10/02/15 2:21 pm

The Division of Medicaid will reprocess certain claims with date of service beginning 7/1/2015 paid through 9/14/2015 which posted edit 0110 and denied incorrectly due to a system issue. The affected claims will be adjusted to correct associated payment errors. The mass adjustment will appear on your 10/05/2015 Remittance Advice. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.
NCCI MASS ADJUSTMENT FOR NURSE PRACTITIONER AND PHYSICIAN ASSISTANT CLAIMS  10/02/15  12:20 pm

The Division of Medicaid will reprocess claims due to an error in implementation of the National Correct Coding Initiative (NCCI) methodology required by the Patient Protection and Affordable Care Act of 2010 (H.R 3490 Section 6507). Claims billed by certain group provider for nurse practitioner or physician assistant services for dates of service April 1, 2011 through February 24, 2014 will be reprocessed and will appear on the remittance advice dated 10/05/2015. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222 or the Division of Medicaid.

Attention All Providers!!! April 2015 Quarterly Physician Administered Drug Fee Update  10/02/15  11:27 am

Due to a delay in implementation of the April 2015 Quarterly Physician Administered Drug Fee Update, claims for dates of service April 1, 2015 through June 4, 2015 billed with certain impacted codes will require reprocessing. This mass adjustment will begin with remittance advice dated 10/12/2015. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

Attention All Providers!!  09/28/15  4:12 pm

The ICD-10 test region will not be available to receive 837 files for 24 hours, starting at 7 a.m. central time, Sept. 30th through 7 a.m. on Oct. 1, 2015. Please refrain from submitting test files during this period.

Notice: All Providers of Therapeutic and Evaluative Mental Health Services for Children  09/18/15  5:37 pm

Due to the very low number of T&E providers registered to attend and participate, Medicaid (DOM), Office of Mental Health Programs has made the decision to cancel the 2nd Annual 2015 Medicaid Therapeutic and Evaluative Provider Workshops that were to be held on Monday, September 21, 2015 in Batesville, and Thursday, September 24, 2015 in Gulfport.

If you are one of the providers that registered and/or planned to attend our Batesville or Gulfport workshop locations in person, we apologize for any inconvenience to you or your staff.

The following workshop/webinar will occur as scheduled:

Date Time Location
• Wednesday, September 23, 2015 9:00 a.m. until Noon cQHealth Solutions (5th Floor Conference Room)
  460 Briarwood Dr.
  Jackson, MS 39206
If you are a Therapeutic and Evaluative Mental Health Services for Children provider, and have not already done so, we highly encourage you to **register** for and **participate** in our **webinar** scheduled to be held simultaneously with our **September 23, 2015** workshop listed above.

To register for the Webinar please log on to: https://attendee.gotowebinar.com/register/9129009019111890434. The title of this presentation is: **2015 DOM/2nd Annual Therapeutic and Evaluative Mental Health Services Provider Workshop-Webinar**. After registration, you will receive a confirmation email containing instructions for joining the Webinar. DOM will have a recorded version of this training presentation available on the eQHealth Solutions website, under the Education tab, no later than **September 30, 2015**, for your reference. The link for this recorded presentation will be: http://ms.eqhs.org/Education/PriorRecordedPresentations.aspx

Any questions and/or concerns regarding this provider workshop should be directed to: Kimberly Evans at 601-359-3830

**NOTICE TO PHARMACY PROVIDERS ONLY** 09/11/15 12:00 pm (DME or Pharmacy Disease Management Providers ARE NOT included)

There will be a point of sale (POS) system outage on Saturday, September 12, 2015 from 11:00PM CT until Sunday, September 13, 2015 4:00AM CT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a “System Unavailable” message and will not process. Please resubmit POS claims after 4:00AM CT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

**Attention All Providers!!** 08/21/15 3:17 pm

Please be advised that an extended system outage will occur on Sunday, August 23, 2015 from 12:00 AM ET, until Sunday, August 23 , 2015, 8:00 AM ET, to accommodate an EDI upgrade. This scheduled maintenance will affect all batch and real time transactions. Additionally, Switch Vendors will experience timeouts during this timeframe as well. If you submit a claim during this time, you will receive a “System Unavailable” message. If you have any additional questions, please contact Conduent Provider and Beneficiary Services at 1-800-884-3222.

**Attention All Providers!!** 08/21/15 3:17 pm

Please be advised that an extended system outage will occur on Sunday, August 23, 2015 from 12:00 AM ET, until Sunday, August 23 , 2015, 8:00 AM ET, to accommodate an EDI upgrade. This scheduled maintenance will affect all batch and real time transactions. Additionally, Switch Vendors will experience timeouts during this timeframe as well. If you submit a claim during this time, you will receive a “System Unavailable” message. If you have any additional questions, please contact Conduent Provider and Beneficiary Services at 1-800-884-3222.

**Attention All Nursing Facility Providers and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Billing Reminder!** 08/13/15 9:58 am

Nursing facilities and ICF/IID billing for bedhold inpatient days and/or therapeutic leave days should use the actual date span of the leave on the respective lines, when filing for those services. If additional information is required, contact the Bureau of Long Term Care Institutional Division at: 601-359-6141.
Attention Providers! 08/07/15 4:02 pm
The Division of Medicaid will reprocess procedure code 76642– ULTRASOUND, BREAST, UNILATERAL, REAL TIME WITH IMAGE DOCUMENTATIONS, INCLUDING AXILLA WHEN PERFORMED; LIMITED’, for dates of service January 5, 2015 through March 09, 2015 for certain impacted codes due to an update error. A mass adjustment of affected claims will be processed in near future. No further action on the part of the provider is needed. Please watch for additional information under Late Breaking News or Banner Messages located at www.Medicaid.ms.gov

Attention Providers! 08/07/15 3:59 pm
The Division of Medicaid will reprocess Independent Laboratory Code claims for dates of service January 1 , 2015 through March 25, 2015 for certain impacted codes due to a delay in annual code update. A mass adjustment of affected claims will be processed in near future. No further action on the part of the provider is needed. Please watch for additional information under Late Breaking News or Banner Messages located at www.Medicaid.ms.gov.

Attention All Elderly and Disabled (E&D) Waiver Adult Day Care (ADC) Providers! Rate Change!! 08/07/15 3:45 pm
For dates of service on or after July 1, 2015, the ADC rate is $60.61 per day. This is the maximum rate allowed under the current CMS approved Elderly and Disabled Waiver. Claims submitted with a rate less than $60.61 for dates of service on or after July 1, 2015, will need to be voided and adjusted. The procedure code for ADC is S5102 and must always be billed with a U1 modifier for services provided under the Elderly and Disabled Waiver.

Attention All Medicaid Providers 07/31/15 3:57pm
Effective February 1, 2015 the Mississippi Division of Medicaid (DOM) covers Trumenba (CPT code 90621) and Bexsero (CPT code 90620), two new vaccines to prevent invasive disease caused by Neisseria Meningitis Serogroup B. The vaccines are listed on the most current Mississippi State Department of Health’s (MSDH) Vaccine for Children’s (VFC) list. Both vaccines are covered services for DOM beneficiaries ages 10 through 25.

Bexsero is limited to one (1) unit for each dose in the two (2) dose series and has a lifetime maximum of two (2) units. Trumenba is limited to one (1) unit for each dose in the three (3) dose series and has a lifetime maximum of three (3) units.

For more information regarding coverage please refer to Title 23: Medicaid Part 224, Immunization, Rule 1.3, Rule 1.4. The MSDH administered VFC Program for vaccines is provided at no cost to participating healthcare providers for eligible children age 18 and under.

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**Attention All Providers**  07/23/15  6:14pm

The Division of Medicaid will reprocess claims for dates of service January 1, 2012 through December, 23, 2013 which denied incorrectly for Edit 0760 – NDC BILLED WITH HCPCS CODE MUST BE FOR REBATABLE DRUG due to billing of certain National Drug Codes (NDC) for powdered drugs. The adjusted claims will appear on your Remittance Advice dated August 3, 2015. Please direct your questions or inquiries to Provider and Beneficiary Services at 800-884-3222. No further action on the part of the provider is required.

**Attention Dental Providers!! July 2014 Dental Fee Update**  07/17/15  5:35pm

The July 1, 2014 Mississippi Division of Medicaid (DOM) dental fee update for professional services is complete and an updated fee schedule has been posted on the DOM Website [www.medicaid.ms.gov](http://www.medicaid.ms.gov). Due to a delay in implementation of fee update, claims with dates of service on or after July 1, 2014 billed with certain impacted CDT codes will require reprocessing. No further action on the part of the provider is required. Watch for further information under Late Breaking News and in the Banner Messages located on your remittance advice. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

**Attention All Providers!!**  07/17/15  5:01 pm

The minimum age requirement for CPT codes 64612 – 64617 has been changed to Zero, effective for dates of service on and after November 22, 2013. A mass adjustment of affected claims will be processed the week of 07/20/2015. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222.

**Attention All Providers!!**  07/17/15  4:43 pm

Please be advised that an extended system outage will occur on Sunday, July 19, 2015 from 12:00 AM ET, until Sunday, July 19, 2015, 6:00 AM ET, to accommodate an EDI upgrade. This scheduled maintenance will affect all batch and real time transactions. Additionally, Switch Vendors will experience timeouts during this timeframe as well. If you submit a claim during this time, you will receive a “System Unavailable” message. If you have any additional questions, please contact Conduent Provider and Beneficiary Services at 1-800-884-3222.

**Attention Providers!!**  07/10/15  2:27 pm

The Division Of Medicaid will reprocess Inpatient Newborn Physician Visits for dates of service October 1, 2012 through June 24, 2013 that denied for not having a Prior Authorization for the discharge visit on the 6th day. The adjustments will appear on your Remittance Advice dated July 13th 2015. No further action is required from the provider.
Attention Providers!! 07/15/2015 2:12 pm

Due to a delay in implementation of the January 2015 Annual Independent Laboratory Code update for dates of service January 1, 2015 through March 31, 2015, laboratory codes in Family Planning Waiver will require reprocessing. A mass adjustment of affected claims will be processed in the near future. Please watch for additional information under Late Breaking News or Banner Messages located at www.Medicaid.ms.gov.

Attention Providers!! 07/09/2015 3:52 pm

The Division Of Medicaid will reprocess claims for dates of service November 17, 2011 through December 18, 2013 for certain immunization administration claim lines which denied incorrectly for Edit 0632 - 90472 MUST BE BILLED WITH 2 VACCINE CODES. The adjusted claims will appear on your Provider Remittance Advise dated July 20th 2015. Please direct questions or inquiries to Provider and Beneficiary Services at 800-884-322. No further action on the part of the provider is needed.

Recovery Audit Contractors (RACs) Upcoming Changes 07/07/2015 8:55 am

Effective July 1, 2015, PRGX Global Inc. is no longer the Mississippi Medicaid Recovery Audit Contractor (RAC). Until further notice, Division of Medicaid (DOM), Office of Program Integrity will review any outstanding audits initiated by PRGX. Providers must continue to follow current RAC processes as outlined in all correspondence received. Providers can submit inquiries, complaints and other communications as it relates the MS RAC program to MSRAC@medicaid.ms.gov.

All updates are outlined on the DOM website located at http://www.medicaid.ms.gov/providers/recovery-auditor-contractors/. DOM encourages providers to monitor the website for updates and announcements regarding the Mississippi Overpayment Audit Recovery program.

Attention Providers! 06/26/2015 10:43 am

Due to a delay in implementation of the January 2015 Annual Independent Laboratory Code update for dates of service January 1, 2014 through March 2, 2015, certain billed codes will require reprocessing. A mass adjustment of affected claims will be processed in the near future. No attention is required on the part of the provider. Please watch for additional information under Late Breaking News or Banner Messages located at www.Medicaid.ms.gov.

Attention All Hospital Providers!!! 05/29/2015 2:39 pm

A hospital mass adjustment will be released within the next several weeks to reflect corrections for the proper payment of hospital inpatient and outpatient fee-for-service claims for the application of the three-day window. The payment logic for the three-day window was implemented for hospital inpatient dates of service beginning on or after October 1, 2012, under the APR-DRG payment methodology.

Attention All Hospital Administrators, CFOs, Coders, & Billers 05/20/2015 3:25 pm

The Division of Medicaid (DOM) Outpatient Prospective Payment System (OPPS) fee schedule will be updated July 1, 2015, as required by the State Plan.

DOM will move forward with OPPS Phase 2 on July 1, 2015. Conduent and DOM will offer training opportunities prior to these changes. The training schedule is as follows:
DOM strongly encourages coders and billers to participate in these sessions. This is an opportunity for individuals who prepare claims for payment to better understand the DOM OPPS and provide feedback.

You may RSVP for the Webinar and/or forward any questions concerning the Webinar to Elizabeth Gillette at (770) 829-1195 or via email at Elizabeth.Gillette@Conduent.com. The WebEx link and conference call number will be provided via email prior to the training.

DOM’s webpage is an excellent source of OPPS information http://www.medicaid.ms.gov/providers/finance/. Documents will be available by Thursday, May 28, 2015:
- Updated OPPS Frequently Asked Questions
- Updated OPPS Quick Tips
- 2015 OPPS Provider Training Presentation

Your participation in this training is greatly appreciated.

Attention Hospital Administrators and CFOs!!!! 05/15/15 4:01pm

In preparation for the Division of Medicaid’s (DOM) July 1, 2015 APR-DRG updates, DOM will adopt V.32 of the 3M Health Information System Hospital Inpatient APR-DRG Grouper and V.32 of the Health Care Acquired Conditions (HCAC) utility for payment of hospital inpatient claims effective for discharges on or after July 1, 2015. Hospitals are not required to purchase 3M software in order to be paid. However, all hospitals that have purchased the 3M software should ensure their internal systems are updated to reflect the change to V.32 for discharges on or after July 1, 2015.

This will be Year 4 of the DRG payment method. In addition to the transition from V.31 to V.32 of the 3M APR-DRG grouper and V.32 of the Health Care Acquired Conditions (HCAC) utility, the Division intends to make the following changes to APR-DRG payment policies effective July 1, 2015:

Year 4 is intended to be budget-neutral relative to Years 1, 2 and 3 overall. The statewide DRG base price will remain $6,415. On balance, we expect average payment per stay to be unchanged between Years 1, 2, 3 and 4.

The Cost Outlier Threshold will be increased from $35,175 to $50,000, reflecting the growth in average charges on claims submitted to the Division. The increase also is consistent with the goal that DRG cost outlier payments comprise approximately 5% of DRG payments.
Year 4 is intended to be budget-neutral relative to Years 1, 2 and 3 overall. The statewide DRG base price will remain $6,415. On balance, we expect average payment per stay to be unchanged between Years 1, 2, 3 and 4.

The Cost Outlier Threshold will be increased from $35,175 to $50,000, reflecting the growth in average charges on claims submitted to the Division. The increase also is consistent with the goal that DRG cost outlier payments comprise approximately 5% of DRG payments.

The DRG Marginal Cost Percentage will be changed from 60% to 50%. This change also is consistent with the goal that DRG cost outlier payments comprise approximately 5% of DRG payments.

The adult mental health policy adjustor will be changed from 1.75 to 1.60.
The obstetrics & newborn policy adjustor will be changed from 1.40 to 1.50.
The neonate policy adjustor will be changed from 1.40 to 1.45.

Please note that the above changes are subject to CMS approval via the State Plan Amendment process.

Please also be aware that according to the current Medicaid Hospital Inpatient State Plan, the following changes will be made effective October 1, 2015:

Mississippi hospital-specific inpatient cost-to-charge ratios (CCRs) will be updated based on cost reports ending in fiscal year 2014. Out-of-state hospital CCRs will be updated based on the Medicare Inpatient Prospective Payment System (IPPS) Final Rule when it is published. CCRs are used in calculating outlier payments.

For teaching hospitals that receive the medical education add-on payment, the payment is expected to be adjusted to reflect the growth in the U.S. hospital market basket index as it will be published in the Medicare Inpatient Prospective Payment System (IPPS) Final Rule.

Although the final ICD-10 code set will not officially be published until late July or August, changes from the current version are expected to be minimal. DOM has been informed by 3M that the APR-DRG payment system/grouper will be ICD-10 compliant with the implementation of V.32 at July 1, 2015, along with V.33 mapper at October 1, 2015.

For the information of hospitals, we will have three webinars. The sessions will show results from the previous years of the DRG payment method, outline the changes for Year 4, and provide billing and documentations tips. DOM strongly encourages each hospital to participate in one of the three webinars.

To register for one of the three webinar training sessions listed below, please RSVP Elizabeth Gillette at (404) 840-0566 or email her at Elizabeth.Gillette@Conduent.com. (Please limit attendance to one line per hospital.)

On the web, Friday, June 12, 2015, 10:00 A.M. – 11:00 A.M.
The WebEx link will be sent after registration is complete.
On the web, Thursday, June 18, 2015, 2:00 P.M. – 3:00 P.M.
The WebEx link will be sent after registration is complete.

On the web, Tuesday, June 23, 2015, 10:00 A.M. – 11:00 A.M.
The WebEx link will be sent after registration is complete.

The Division’s DRG webpage is also an excellent source of information. At http://www.medicaid.ms.gov/providers/finance/, please see in particular the documents below, which will be available by Thursday, June 11, 2015:

- Updated DRG Pricing Calculator. This document is an Excel spreadsheet that enables the user to calculate expected payment. It does not calculate the APR-DRG itself but it does include the list of APR-DRGs and associated relative weights.
- Updated Frequently Asked Questions
- Updated APR-DRG Quick Tips
- June 2015 provider training presentation – to be posted the week of June 8.

Attention!!! Long-Term Care Providers and Long-Term Care Cost Report Preparers 05/07/15 1:36 pm

DOM has revised the Medicaid long-term care (LTC) facility cost report instructions to reflect changes in LTC reimbursement methodology. The changes were stated in the ‘Nursing Facilities Reimbursement Methodology Revision Report’, and presented to providers during the webinar training for LTC facilities on November 10th and 13th, 2014. The Medicaid LTC cost report forms and instructions have been revised or added to reflect the reimbursement changes and have replaced the previous forms on the DOM website. The forms include: Form 1, Form 3, Form 4, Form 5, Form 6, Form 13 and Form 19 (new). Also, DOM updated the ‘Instructions for Filing Long-Term Care Facility Cost Report’, Pages 1, 3, 7, 9, 11, 14, 22, 27, 28, 31, 34, 35, 53 & 54. Minor changes [ex., intensive care facilities for individuals with intellectual disabilities (ICF-IID) previously, intensive care facilities for the mentally retarded (ICF-MR)] were made to other pages of the instructions, but these changes do not affect reporting.

The above revised forms and instructions will be effective for cost report periods ending in the 2015 calendar year and forward. The previous forms can be used for the cost report periods ended in the 2014 calendar year and prior years filing of amended cost reports. The 2015 forms also can be used to file the 2014 reports as the only difference is the addition of Form 19 for VDC-approved facilities.

Also, cost report preparers filing the 2014 reports should note that the revised instructions for the changes in incontinence supplies reporting (pages 22 & 28) and asset additions capitalization policy (pages 27 & 31), as well as the return on equity (ROE, Form 13) factor percentage change from 9.5% to 5.75%, were retro-active to the 2013 calendar year cost report filings and forward.

If you have questions, please contact Eric Everett @ 601-576-2332 or T. J. Walker @ 601-359-6827.
**Attention Dental Providers**  04/30/15  2:35 pm

Replacement of Lost or Broken Retainer

Effective May 1, 2015 the Division of Medicaid will begin covering the replacement of a lost or broken retainer for EPSDT beneficiaries with a prior-authorization and supporting documentation including how the original appliance was lost or stolen. Reimbursement will be based on the fee on file. The replacement of the retainer will be covered once per lifetime; both arches are covered if necessary.

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**Qualified providers need to self- attest to receive increased primary care services payments**  03/27/15  2:16 pm

During the 2014 legislative session, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (ACA), for certain primary care services at 100 percent of the rate established under Medicare.

Effective July 1, 2015, reimbursement of primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule. The Medicaid Primary Care Provider Fee Schedule is updated July 1 of each year based on one hundred percent of the Medicare Physician Fee Schedule, which takes effect January 1 of each year.

Mississippi primary care providers who are enrolled in Medicaid can still qualify to receive increased payments even though the federal program ended Dec. 31, 2014. To qualify, eligible providers must accurately self-attest by completing the 1/1/2015 – 6/30/2016 Self-Attestation Statement form.

To receive the increased payment for dates of service (DOS) beginning Jan. 1 of this year, eligible providers must send a completed and signed self-attestation statement form to Conduent Provider Enrollment by March 31, 2015 one of the following ways:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Postal mail: P. O. Box 23078, Jackson, MS

Providers whose forms are sent/postmarked after March 31 will receive the increased payment for DOS beginning on the date the form is sent/postmarked. Providers can verify the processing of self-attestation statement forms they have submitted electronically by accessing the Envision Web Portal at ms-medicaid.com. You can locate the form on the DOM website under the Forms section and the Envision Web Portal, or request it by calling the Conduent Call Center toll-free at 800-884-3222.
NOTICE TO PHARMACY PROVIDERS ONLY (DME or Pharmacy Disease Management Providers ARE NOT included) 03/27/15 2:11 pm

There will be a point of sale (POS) system outage on Saturday, March 28, 2015 from 11:00PM CDT until Sunday, March 29, 2015 4:00AM CDT, to accommodate system maintenance. During this timeframe, Pharmacy claims/POS will receive a “System Unavailable” message and will not process. Please resubmit POS claims after 4:00AM CDT. Contact Conduent Provider and Beneficiary Services at 1-800-884-3222 if there are additional questions.

Attention: DME Providers 03/06/15 1:17 pm

A review of Durable Medical Equipment codes E0990, E0994 and E0995 was completed and corrections to the maximum units of these codes have been made. Due to these changes, claims for dates of service July 1, 2012 through July 29, 2014 will require reprocessing. The adjusted claims will appear on your Provider Remittance Advice dated 03/09/2015. No further action on the part of the provider is required. If you have any questions, please contact Conduent Provider and Beneficiary Services at 800-884-3222 or the Division of Medicaid.

Attention Providers!! 03/06/15 1:10 pm

The Division of Medicaid will reprocess claims for dates of service 07/01/2013 through 11/10/2014 for certain outpatient radiology services where prior authorizations were incorrectly applied to another claim line. The adjusted claims will appear on your Provider Remittance Advice dated 03/09/2015. Please direct questions or inquiries to Conduent Provider and Beneficiary Services at 800-884-3222. No further action on the part of the provider is needed.

MississippiCAN Changes 02/20/15 12:26 pm

Transition of Children from regular Medicaid to MississippiCAN

- Children ages 1 to 19 will be transitioned from MS Medicaid Fee-for-Service (FFS) to MississippiCAN, except those excluded as members on Medicare, on waivers, or in institutions.
- Effective Dates - May 1, 2015 to July 31, 2015
- Mailings to Households begin March 2015
- Members or Providers may call
  - Conduent at 1-800-884-3222 or
  - Medicaid at 1-800-421-2408
- Websites

  www.ms-medicaid.com/msenvision/mscanInfo.do

  http://www.medicaid.ms.gov/programs/mississippican/
Attention All Elderly and Disabled Waiver Adult Day Care Providers   02/13/15
12:56 pm

The Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding new regulations on home and community based service (HCBS) settings requirements to all States. The effective date of the final rule is March 17, 2014. Mississippi Division of Medicaid (DOM) has submitted a transition plan to CMS regarding Adult Day Care (ADC) facilities and the final rules on HCBS settings requirements. In order to meet the HCBS settings requirements, reviews specific to the HCBS settings requirement will be conducted of all ADC providers. All Elderly and Disabled Waiver (E&D) ADC providers are required to conduct a self-assessment of each facility with a valid provider number by February 27, 2015.

Complete the self-assessment by clicking on the link below or copy and paste the link in your web browser. A response to all questions is required as the self-assessment survey cannot be submitted with unanswered questions. Be prepared to complete the survey from start to finish when the link is clicked.

The link is https://www.surveymonkey.com/s/8CVFVFN. If you have any questions, contact Sandra Bracey-Mack at 601-359-6141.

Attention Providers! Mandatory 30 Day Wait Requirement for Non-life Threatening Hysterectomy Surgical Procedure   02/12/15 11:15 a.m.

The Mississippi Administrative Code, Title 23: Medicaid, Part 202: Hospital Services, Chapter 5: Hospital Procedures, Rule 5.6: Hysterectomy, effective 05/01/2014, requires providers to complete the Sterilization Consent Form and Hysterectomy Acknowledgement Form prior to a medically necessary hysterectomy. If prior acknowledgement is not possible due to a life-threatening emergency, the physician performing the hysterectomy must complete Section C of the Hysterectomy Acknowledgment form. Federal regulation requires that informed consent must be obtained at least 30 days, but not more than 180 days, prior to the date of the sterilization, except in the case of a premature delivery or an emergency abdominal surgery. As this is a federal requirement, DOM cannot waive the 30 day requirement. The Division of Medicaid (DOM) covers a hysterectomy when deemed medically necessary in an inpatient or outpatient hospital setting. The Sterilization Content Form and Hysterectomy Acknowledgement Form are located under the Resources section of the Medicaid website at www.medicaid.ms.gov by clicking on the form link.

Questions may be directed to the Office of Medical Services at 601-359-6150 or 1-800-421-2408.
Attention Providers!! 02/12/15 11:11 am

Effective January 1, 2015, the Division of Medicaid covers CPT code 96040 for billing appropriate counseling services. Medicaid providers must seek reimbursement for rendered services according to CPT coding guidelines. These services require a prior authorization approval by the Utilization Management/Quality Improvement Organization (UM/QIO), eQHealth Solutions.

If you have any questions, please contact eQHealth Solutions at 1-866-740-2221 or the DOM Office of Medical Services at 601-359-6150.

Attention Providers!! 02/12/15 11:09 am

On November 6, 2012, the centers for Medicare & Medicaid Services (CMS) issued the final rules to implement increased Medicaid payments for certain primary care services and vaccine administration billing codes provided by attested qualified practitioners enrolled as a Mississippi Medicaid provider, for calendar years 2013 and 2014. Medicaid began paying these increased rates, for attested qualified providers, for claims submitted on or after July 1, 2013. The 01/19/2015 RA may reflect additional payments/recoupments due to mass adjustments, made by the Division of Medicaid, for impacted claims with dates of service on or after January 1, 2014 through June 30, 2014.

Attention All Providers!!! 02/04/15 4:30 pm

The Division of Medicaid will reprocess claims for dates of service from 01/01/2014 through 05/19/2014 for certain primary care services that were paid at the incorrect rate for 2014. The adjusted claims will appear on your Provider Remittance Advice dated February 2, 2015. Please direct questions or inquiries to Provider and Beneficiary Services at 800-884-3222. No Further Action on the part of the provider is needed.

Attention All Providers!!! 02/03/15 1:20 pm

Due to the high call volume in our Call Center, providers will experience a longer than normal wait time. Rather than wait, you can visit the web portal at: www.ms-medicaid.com to check claim status, eligibility, and dental/vision service limits. Additionally, Provider Field Representatives are available to assist with complex billing questions and claims issues (See page 13 of the December 2014 Provider Bulletin). We do apologize for the inconvenience; however, we are diligently working towards a resolution.
Attention Providers!!! 01/20/15 5:25 pm

2014 Owner Salary Limits for Long-Term Care Facilities

The maximum amounts that will be allowed on cost reports filed by nursing facilities, intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities as owner’s salaries for 2014 are based on 150% of the average salaries paid to non-owner/administrators that receive payment for services related to patient care. The limits apply to all salaries paid directly by the facility or by a related management company or home office. Adjustments should be made to the cost report to limit any excess salaries paid to owners. In addition, Form 15 should be filed as part of the Medicaid cost report for each owner.

The maximum allowable salaries for 2014 are as follows:

- Small Nursing Facilities (1-60 Beds) $127,937
- Large Nursing Facilities (61 + Beds) $146,652
- Intermediate Care Facilities for individuals with intellectual disabilities (ICF-IID) $136,050
- Psychiatric Residential Treatment Facilities (PRTF) $208,301

Attention Providers!!! 01/20/15 5:20 pm

Allowable Board of Directors Fees for Nursing Facilities, ICF-IID’s and PRTF’s 2014 Cost Reports

The Allowable Board of Directors fees that will be used in the desk reviews and audits of 2014 cost reports filed by nursing facilities (NF’s), intermediate care facilities for individuals with intellectual disabilities (ICF-IID’s), and psychiatric residential treatment facilities (PRTF’s) have been computed. The computations were made in accordance with the Medicaid State Plan by indexing the amounts in the plan using the Consumer Price Index for all Urban Consumers - All Items. The amounts listed below are the per meeting maximum with a limit of four (4) meetings per year.

The maximum allowable, per meeting Board of Directors fees for 2014 are as follows:

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<thead>
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<th>Category</th>
<th>Maximum Allowable Cost for 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 99 Beds</td>
<td>$ 4,010</td>
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<tr>
<td>100 – 199 Beds</td>
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<tr>
<td>200 – 299 Beds</td>
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<tr>
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<td>$10,024</td>
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<tr>
<td>500 Beds or More</td>
<td>$12,029</td>
</tr>
</tbody>
</table>
Attention Providers!!! 01/20/15 8:25 am

Attention All Providers!!!!

Effective January 1, 2015, women and men between the ages of 13-44 will be eligible for the Family Planning Waiver Program.

Eligibility Requirements:

- Family income is at or below 194% of the federal poverty level (FPL).
- Must be capable of reproducing.
- Must not have had a procedure that prevents them from reproducing.
- Must not have Medicare, CHIP, or any other health insurance or third party medical coverage.

The Family Planning waiver demonstration program is for women and men who receive Medicaid benefits limited to family planning services and family planning related services. This includes one annual visit and subsequent visits related to their birth control methods and family planning services. Beneficiaries cannot exceed a total of four visits per federal fiscal year (Oct. 1-Sept. 30). These beneficiaries are not eligible to receive any other Medicaid benefits.

For your easy reference, a listing of covered drugs under this waiver is posted on the agency’s website. Please refer to the DOM Pharmacy section at: http://www.medicaid.ms.gov/providers/pharmacy/, go to Pharmacy Resources, Specific Drugs, and select Family Planning Drugs, 1-1-2015.

Attention All Providers!!! 01/15/15 3:25 pm

Please be advised that a system outage will occur on Sunday, January 18, 2015 from 12:00 AM ET, until Sunday, January 18, 2015, 5:00 AM ET, to accommodate EDI server maintenance. This scheduled maintenance will affect all batch and real time transactions. Additionally, Switch Vendors will experience timeouts during this timeframe as well. If you submit a claim during this time, you will receive a “System Unavailable” message. You may begin transmitting your claims at 5:15 AM ET. Any claims received prior to the schedule maintenance will process as normal once the server is restored. If you have any additional questions, please contact Conduent Provider and Beneficiary Services at 1-800-884-3222.

Attention Providers!!! 01/15/15 9:25 am

CPT Code Changes for Mental Health Providers

Effective December 31, 2014, the procedure code for Medication Management (M0064) has been discontinued. This change is in accordance with the Centers for Medicare and Medicaid Services (CMS) decision to terminate the code.

For dates of service on or after January 1, 2015, pharmacological management and oversight must be billed using the most appropriate evaluation and management (E/M) procedure code as part of the E/M visit. Providers are encouraged to review the requirements for E/M codes in the current CPT Manual.

Claims, for DOS on or after January 1, 2015, billing M0064 should be voided and re-submitted using the most appropriate E/M code.

Please contact Kim Sartin-Holloway at 601-359-9545 if you have questions.
Attention Providers!!! 01/14/15 2:25 pm

Qualified providers may receive increased primary care services payments

During the 2014 legislative session, the Mississippi Division of Medicaid (DOM) was granted the authority to continue reimbursing eligible providers, as determined by the Patient Protection and Affordable Care Act (ACA), for certain primary care services at 100 percent of the rate established under Medicare. DOM submitted a public notice to inform providers a State Plan Amendment (SPA) will be submitted, effective Jan. 1, 2015, to continue reimbursement of primary care services to providers who meet the requirements of 42 CFR § 447.440(a) at the same rate as in calendar year 2014.

Effective July 1, 2015, reimbursement of primary care services provided by eligible providers will be at 100 percent of the Medicare Physician Fee Schedule in effect as of January 1 of each year. The Medicaid Primary Care Provider Fee Schedule will be updated July 1 of each year based on one hundred percent of the Medicare Physician Fee Schedule in effect as of January 1 of each year.

Medicaid-enrolled primary care providers who qualify for the increased payment may receive increased payments after the federal program ended on Dec. 31, 2014. To qualify, eligible providers must accurately self-attest by completing the 1/1/2015 – 6/30/2016 Self-Attestation Statement form.

How to Attest
Providers must complete one 1/1/2015 – 6/30/2016 Self-Attestation Statement form for Jan. 1, 2015 through June 30, 2016. To receive the increased payment for dates of service (DOS) beginning 1/1/2015, eligible providers must send a completed and signed 1/1/2015 – 6/30/2016 Self-Attestation Statement form to Conduent Provider Enrollment by March 31, 2015 through one of the following ways:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Mail: P.O. Box 23078
Jackson, MS 39225

Providers whose 1/1/2015 – 6/30/2016 Self-Attestation Statement forms are sent/postmarked after March 31, 2015, will receive the increased payment for DOS beginning on the date the form is sent/postmarked. Providers can verify the processing of the electronically submitted 1/1/2015 – 6/30/2016 Self-Attestation Statement forms by accessing the Envision Web Portal. Forms are processed within five business days from receipt.

Self-Attestation Statement form
The 1/1/2015 – 6/30/2016 Self-Attestation Statement form is located on the DOM website at http://medicaid.ms.gov and Envision Web Portal or can be requested by calling the Conduent Call Center toll-free at 800-884-3222.

Continued on next page...
Completed forms must be submitted to Conduent Provider Enrollment in one of the following ways:

Email: msinquiries@conduent.com
Fax: 888-495-8169
Mail: P.O. Box 23078
Jackson, MS 39225

To find out more information regarding primary care physician self-attestation general instructions and to download the Self-Attestation Statement form, visit the DOM website at [http://medicaid.ms.gov](http://medicaid.ms.gov).

**Attention Providers!!! 01/09/15 11:25 am**

The Mississippi Division of Medicaid introduces Mede/Provider Access

Provider Access is a claims-based provider portal available to all providers and their staff who serve Mississippi Medicaid patients. Provider Access gives Mississippi Division of Medicaid (DOM) providers access to clinical information on Medicaid recipients, including medication, diagnoses and procedures history across the continuum of care.

DOM offers this portal **free-of-charge** to Medicaid providers and their staff in an effort to share data and improve the quality, efficiency and cost of healthcare. To learn more, read the Free online service offers Medicaid providers access to patient information article online at [http://medicaid.ms.gov](http://medicaid.ms.gov).

To register for this product, please contact our Clinical Advocate, Nancy Barton-Marini at nancy.bartonmarini@medeanalytics.com or (662) 231-7715.

**Attention Providers!!! 01/06/15 9:25 am**

Attention All Elderly and Disabled (E&D) Waiver Personal Care Services (PCS) Providers

**RATE CHANGE!**

For dates of service on or after January 1, 2015, the Personal Care Services (PCS) rate is $4.16 per 15 minute unit. For dates of service on or after July 1, 2015, the PCS rate is $4.24 per 15 minute unit. This is the maximum rate allowed under the current CMS approved Elderly and Disabled Waiver. The procedure code for PCS is T1019 and must always be billed with a U1 modifier for services provided under the Elderly and Disabled Waiver.
Attention Providers!!! 12/22/14 1:25 pm

Co-payment for Mental Health Services

Effective January 1, 2015, Mental Health services provided by a Psychologist, Licensed Clinical Social Worker (LCSW), or a Mental Health Group will require a $3 co-payment per visit. It is the provider’s responsibility to collect this co-payment from the beneficiary. The $3 co-payment will automatically be deducted, for all applicable services, from the claim when it is processed. Providers should not enter the co-payment amount or reduce the submitted charge on the claim form.

Co-payments are not required for children under the age of 18, pregnant women, or individuals in nursing homes or facilities.

Please contact Kimberly Evans or Kim Sartin-Holloway at 601-359-9545 for more information.

Attention Providers!!! 12/19/14 9:25 am

New Modifiers for Mental Health Services for NCCI Edits

Effective January 1, 2015, NCCI will require the use of modifier XE or XP rather than modifier 59 with certain NCCI edits for Mental Health claims for dates of service on or after January 1, 2015. These modifiers have been developed to provide greater reporting specificity in situations where modifier 59 was previously reported. Modifiers XE or XP should be utilized in lieu of modifier 59 if the clinical situation described by one of these modifiers is present. Modifier 59 will remain a valid procedure to procedure (PTP) modifier, but it should only be utilized if a more specific modifier is not applicable.

The new modifiers are defined as follows:

XP – “Separate Practitioner, A service that is distinct because it was performed by a different practitioner.”

XE – “Separate encounter, A service that is distinct because it occurred during a separate encounter.” This modifier should only be used to describe separate encounters on the same date of service. Applies to services that are billed by a Federally Qualified Health Center or Rural Health Clinic.

Please contact Kim Sartin-Holloway at 601-359-9545 if you have questions.