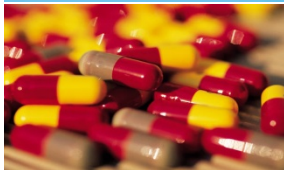
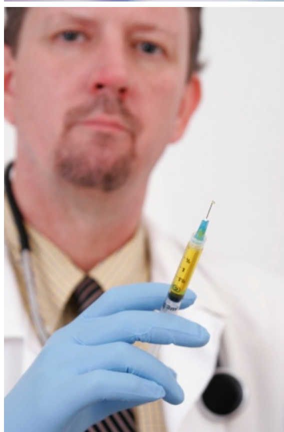
Mississippi Division Of Medicaid

Quality Health Care Services, Improving Lives





Mississippi Medicaid Web Portal Registration and Submission of Pharmacy Prior Authorizations Guide

Fall 2011

Agenda

Web Portal Registration
Prior Authorization Submission
Inquiry Options
Communication Options

Mississippi *Envision* Homepage

Mississippi Envision

Quality Health-care Services Improving Lives

Home | Online Security | Terms of Usage | Privacy Policy | Help

Provider | Beneficiary | Reach Us | Search

LOGIN

User Id | Password

Login | Reset

Forgot your Password ?

Web Registration

Visit

Medicaid and Me

Electronic Health Records Incentive Program

What's New?

ATTENTION: Med. Profes. Providers! Provider Incentive Program Workshop Presentation

Latest News

- All Late Breaking News
- Banner Messages

Beware of fraudulent e-mails / Chain Mails

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Welcome to the Envision Web Portal

Account Registration

Mississippi Envision

Quality Health-care Services Improving Lives

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Account Registration

Please select the user to Register into the WebPortal

Select User : Select

Select
Beneficiary
Provider

You should have a valid Email Address to reg[...] have one, then please get one from any Email Services like www.yahoo.com, www.hotmail.com etc.,

Submit | Reset

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This is the Account Registration Page

1. Using the drop down menu select “Provider”
2. Click the <Submit> button

Quick Tips

- Each prescriber in a group practice should register using their individual Medicaid provider number
- Prescribers may designate multiple users with PA submission rights
- Only prescribers may submit PA requests

Account Registration Form

Provider Account Registration

To register as a Provider, please enter the following information. Please note that registration designates you as your organization's Master Administrator and you will be required to perform user maintenance duties. If you are not a registered Mississippi Medicaid provider, you can find out how to ENROLL HERE.

*Indicates Mandatory Field

Please choose your type of organization and create your "Login ID", please note that your Login ID is case-sensitive and should consist of 6-14 alpha-numeric characters; example Login ID: "example123"

Individual Group *LOGIN ID

Please enter your Medicaid provider number and the last five digits of the bank account to which your Medicaid Direct Deposits are posted.

*Provider ID: *Account #:

To use the EDI Exchange feature, you must supply your EDI Submitter information below. If you are not registered as an EDI Submitter but wish to do so, please contact ACS EDI Gateway Services by phone at (866) 225-2502 or online at http://acs-gcro.com.

EDI Submitter ID: EDI Password:

If you are registering as an individual, please enter your Last Name, First Name, Middle Initial and Last 4 digits of Social Security Number (SSN).

*Last Name: *First Name: Middle Initial: *SSN: (Last Four Digits)

Please enter your Organization Name and EIN if you are registering as a group.

*Organization Name: *EIN:

Please enter your Email Address and select your hint question/answer.

*What is your Email Address ? *Verify your Email Address *Hint Question: Who is your childhood hero?

Submit Reset

All fields with asterisks are mandatory

Quick Tips

1. Login ID
   - Established by the user
   - Should be easy to remember
   - Every employee with access must have a different Login ID
2. Provider ID
   - Individual Provider will be the social security number
   - If group is selected you will need the EIN (or Tax ID) number
3. Email Address
   - Mandatory
   - Your temporary password will be upon completion of the form
4. Hint Question
   - Required security feature for every Log In

Mississippi Envision Web Portal Registration Guide

1. Using your internet browser go to http://msmedicaid.acs-inc.com .
2. The homepage for Mississippi Envision web portal will display.
3. On the left hand side of the screen, click on the <Website Registration> button under the "Log In" section.
4. The next screen will be the type of registration account you will create. In the "Select User" field, click on the down arrow. This will open a drop down ladder with the following two selections to choose from: Beneficiary and Provider. Select Provider.
5. After the selection, click on the <Submit> button.
6. The next screen is the Account Registration Form. All fields with an asterisk are mandatory fields. The first section asks for your type of Medicaid Provider and Login ID. If you are a Medicaid provider who is a part of a billing group, choose Group. If you are in a private practice and bill for yourself, choose Individual.
7. The next step is the Log ID. This is created by you and should be easy to remember. The ID will have to be at least six characters and no more than fourteen. They can be all letters or numbers or a combination of the two.
8. The next field is the "Provider ID." Please enter you Medicaid Provider Number.
9. In the next block, enter the last five digits of the bank account where your Medicaid payments are posted.
10. The next two blocks (EDI Submitter ID and EDI Password) are not required for account registration, please skip.
11. The next section is information to establish you as the Master Administrator.
    - If you are registered as a group, please enter your Last Name and First Name. Then move onto the next section. **Please note that last 4 digits Social Security Number (SSN) are not required when registering as a group.**
    - If you did select Individual on this form, the last four digits of your Social Security Number (SSN) are **required**.
12. The next section is for Medicaid providers that registered as a group.
    - If you are registering as an Individual please move on step thirteen.
    - Enter your Group Name and Tax ID as it appears on your Medicaid Enrollment form. Now move on to the last section of the form.
13. This is the final section of the form. Please enter an email address that you have current access to. Then in the next block enter the email address again to verify it.
14. Next you will have to choose a Hint Question in case you forget your password. Below are the questions to choose from:
    - Who is your Childhood Hero?
    - What is your place of Birth?
    - What is your Mother's Maiden Name?
15. In the final block, enter the answer to your Hint Question.
16. Now click the <Submit> button.
17. At this point your registration is complete. A password will be sent to the email address submitted on this form.

Mississippi *Envision* Homepage Login

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LOGIN
User Id: XXXXXX
Password: XXXXXX
Login | Reset
Forgot your Password ?

Web Registration

Visit

Beware of fraudulent e-mails / Chain Mails

Medicaid and Me

Electronic Health Records Incentive Program

What's New?
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Steps to Login

1. Enter the Log In ID created during Account Registration Process
2. Enter the Temporary Password sent to your email address

Quick Tip

- Copy and paste the password from the system generated email sent to you

Selecting the Pharmacy PA Request

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Logout

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- Frequently Asked Questions
- General Billing Tips
- Provider Bulletins
- Provider Enrollment
- Provider Hotlinks
- Provider Rates
- Provider Type Specific Information
- Report Third Party Insurance
- Search for Provider
- Statistics
- Training Materials / CBT
- WINASAP 2003 Software
- Claims Entry
- Communication Options
- Inquiry Options
- Long Term Care
- Prior Authorization
  - Cancel a PA
  - Enter PA Request
    - Dental
    - Eye Glass/Hearing Aid
    - Oral Surgery
    - Orthodontics Services
    - Pharmacy
      - PA Instructions
      - PA Request
    - Mental Health
    - MS Cool Kids(EPSDT)
  - PA Addendum
  - Update PA Request
- School Based Services
- Submission Options
- User Admin Options

Medicaid and Me

Electronic Health Records Incentive Program

What's New?
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Steps to select the Pharmacy Prior Authorization request

1. Click on the Provider Tab
2. Once the drop ladder appears, click on Prior Authorizations
3. To the right of Prior Authorization, click on Enter PA Request
4. Then click on Pharmacy and PA Request

The Beneficiary and Type of PA Request

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PHARMACY PRIOR AUTHORIZATION

Beneficiary ID
Dates of Service
Begin Date | End Date
PA Request Type
Submit | Reset

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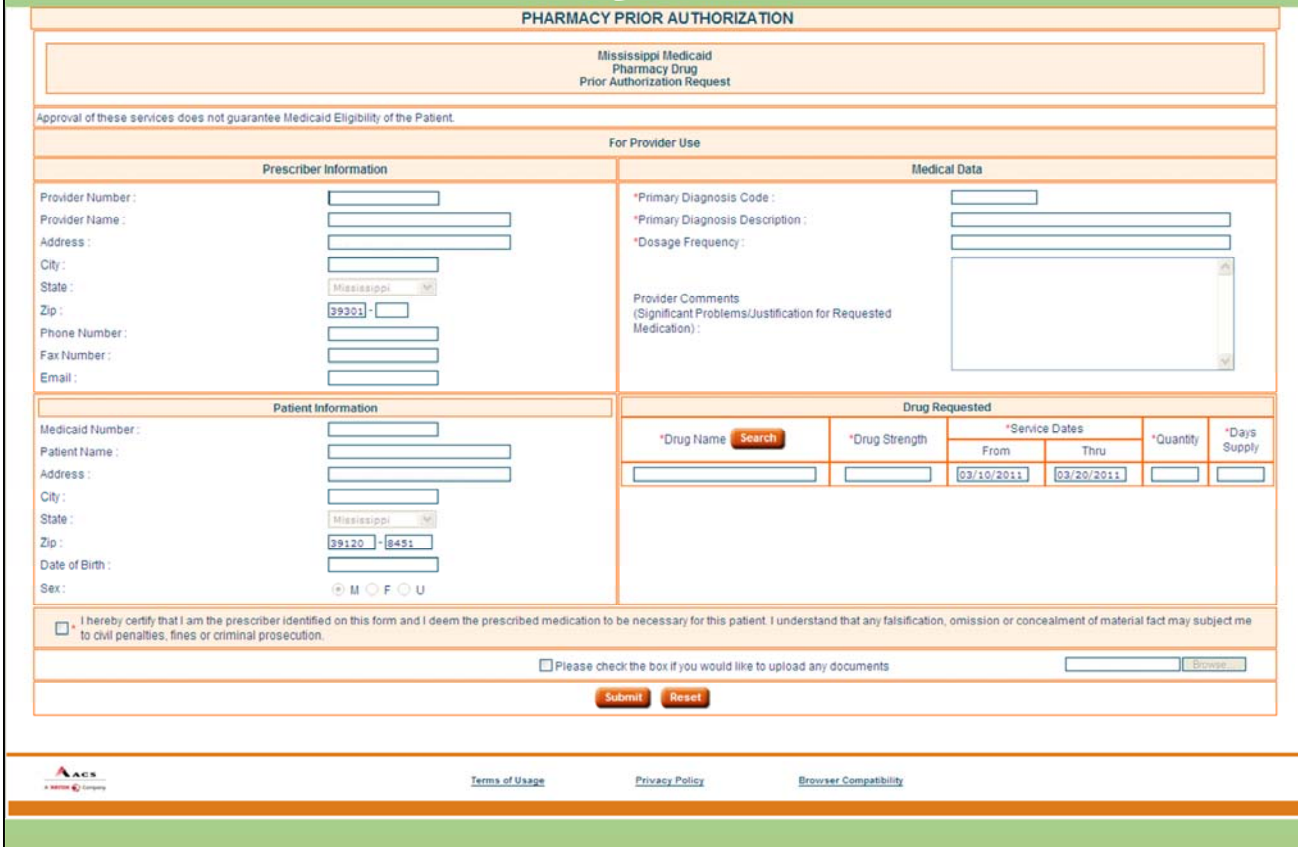
Selecting the Beneficiary and Type of Request

1. Enter the beneficiary's Medicaid number
2. Enter date span of PA Request – this will check for Medicaid Eligibility and MSCAN
3. Select the Type of Request (choose from the following)
    - Brand-Name Medically Necessary
    - Children's Medical Necessity (More than 2 brands / 5 Rxs needed or Non-covered drug)
    - Early Refill
    - Maximum unit Override
    - Non-Preferred Drug
    - Prescriber Office Administered
    - Synagis (this is the only type available for specified pharmacy submitters)
    - Other
4. Click <Submit>


Pharmacy PA Form

PHARMACY PRIOR AUTHORIZATION

Mississippi Medicaid
Pharmacy Drug
Prior Authorization Request

Approval of these services does not guarantee Medicaid Eligibility of the Patient.

For Provider Use

Prescriber Information

Provider Number :
Provider Name :
Address :
City :
State : Mississippi
Zip : 39301 -
Phone Number :
Fax Number :
Email :

Medical Data

*Primary Diagnosis Code :
*Primary Diagnosis Description :
*Dosage Frequency :
Provider Comments (Significant Problems/Justification for Requested Medication) :

Patient Information

Medicaid Number :
Patient Name :
Address :
City :
State : Mississippi
Zip : 39120 - 8451
Date of Birth :
Sex : M F U

Drug Requested

*Drug Name Search	*Drug Strength	*Service Dates From	*Service Dates Thru	*Quantity	*Days Supply
		03/10/2011	03/20/2011		

* I hereby certify that I am the prescriber identified on this form and I deem the prescribed medication to be necessary for this patient. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Please check the box if you would like to upload any documents Browse...

Submit Reset

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Below are the different sections of the electronic form

1. Prescriber Information
    - Envision auto-populates this field
2. Patient Information
    - Envision auto-populates this field
3. Medical Data
    - Please enter all fields with an (*) asterisk
4. Drug Requested
    - Envision auto-populates the Service Dates fields
    - Please enter Drug Name, Drug Strength, Quantity and Days Supply fields
5. Certification Statement
6. Uploading of Documentation
7. Submit and Reset Buttons

Entering the Primary Diagnosis Code

PHARMACY PRIOR AUTHORIZATION

Mississippi Medicaid
Pharmacy Drug
Prior Authorization Request

Approval of these services does not guarantee Medicaid Eligibility of the Patient

For Provider Use

Prescriber Information

Provider Number:
Provider Name:
Address:
City:
State: Mississippi
Zip: 39301 -
Phone Number:
Fax Number:
Email:

Medical Data

*Primary Diagnosis Code: 771.82
*Primary Diagnosis Description:
*Dosage Frequency:
Provider Comments (Significant Problems/Justification for Requested Medication):

Patient Information

Medicaid Number:
Patient Name:
Address:
City:
State: Mississippi
Zip: 39120 - 8451
Date of Birth:
Sex: M F U

Drug Requested

*Drug Name Search	*Drug Strength	*Service Dates From	*Service Dates Thru	*Quantity	*Days Supply
		03/10/2011	03/20/2011		

* I hereby certify that I am the prescriber identified on this form and I deem the prescribed medication to be necessary for this patient. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Please check the box if you would like to upload any documents Browse

Submit Reset

ACS

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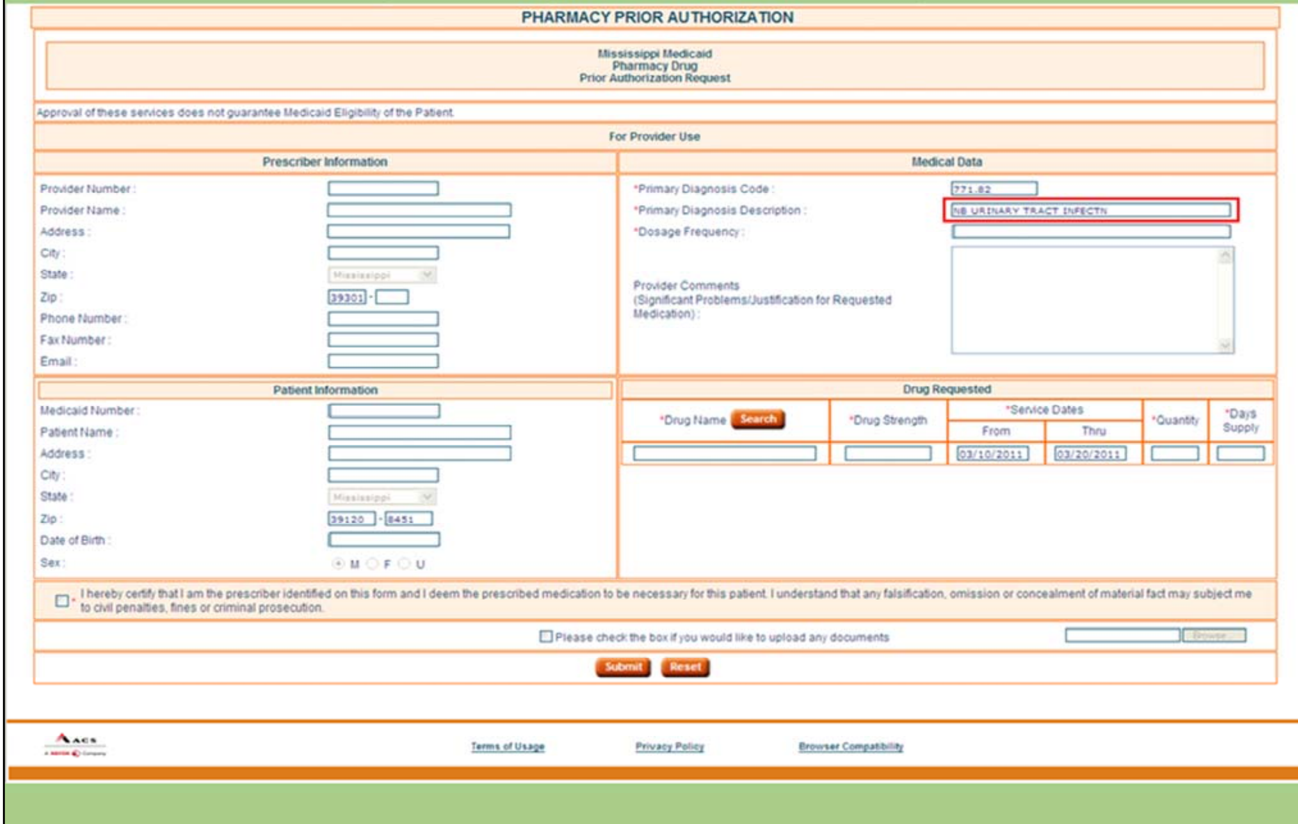
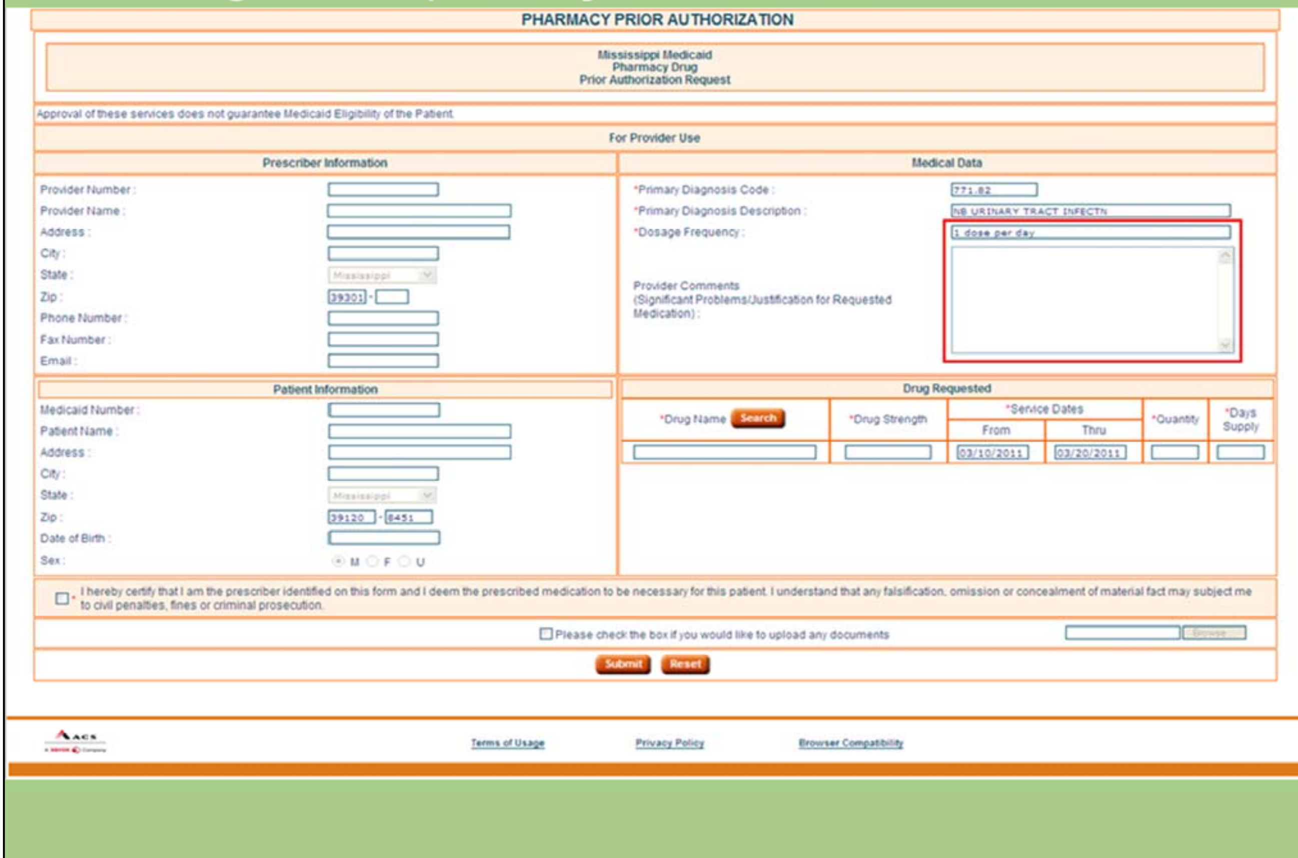
In the field “Primary Diagnosis Code”, enter the primary diagnosis associated with the reason for the drug. Once it is entered, hit the <Tab> key

Please note the following:

- Use the current ICD-9 codes
- Be specific in the code used
- Do not forget the decimal point
- Be sure the diagnosis code on form PA must match the Medical Claim
- Hit the <Tab> key after each field is entered



This field will auto-populate after the <Tab> key is hit



Dosage Frequency and Provider Comments Fields

1. Dosage Frequency Field
   - Enter the Dosage
2. Provider Comments Field
   - Enter any medical / clinical justification for the PA request

Drug Name

Steps to enter the Drug Name

1. Click on the <Search> button beside the “Drug Name”
    - A pop-up window will appear
2. Enter name of the drug and click <Search>
    - Another pop-up window will appear

Drug Search

Drug Search

Please enter at least the first three letters of the desired drug's name into the Drug Name field and select the Search button. Locate the desired drug in the list of results, click the link of the drug's name and you will be returned to the Pharmacy Prior Authorization Request form where your selected drug information will be pre-filled on the form.

Drug Name

Search Reset

Search Results

Drug Name	Drug Strength
CIPRO HC OTIC SUSPENSION	0.2%-1%
CIPRO I.V. 10 MG/ML VIAL	10 MG/ML
CIPRO I.V. 10 MG/ML VIAL	200MG/20ML
CIPRO I.V. 10 MG/ML VIAL	400MG/40ML
CIPRO I.V. 200 MG/100 ML D5	200MG/0.1L
CIPRO I.V. 400 MG/200 ML D5	400MG/0.2L
CIPRO XR 1,000 MG TABLET	1000 MG
CIPRO XR 500 MG TABLET	500 MG
CIPRO 10% SUSPENSION	500 MG/5ML
CIPRO 100 MG TABLET	100 MG
CIPRO 250 MG TABLET	250 MG
CIPRO 5% SUSPENSION	250 MG/5ML
CIPRO 500 MG TABLET	500 MG
CIPRO 750 MG TABLET	750 MG
CIPRODEX OTIC SUSPENSION	0.3-0.1%
CIPROFLOXACIN ER 1,000 MG T	1000 MG

Drug Search Window

- “Click” on the name of the drug and dosage that you want to request a prior authorization on
- After clicking on the drug dosage, your selection will auto-populate on the PA Form. This screen will disappear

Other Drug Request Information

PHARMACY PRIOR AUTHORIZATION

Mississippi Medicaid
Pharmacy Drug
Prior Authorization Request

Approval of these services does not guarantee Medicaid Eligibility of the Patient.

For Provider Use

Prescriber Information

Provider Number :
Provider Name :
Address :
City :
State : Mississippi
Zip : 39301 -
Phone Number :
Fax Number :
Email :

Medical Data

*Primary Diagnosis Code : 771.82
*Primary Diagnosis Description : NB URINARY TRACT INFECTN
*Dosage Frequency : 1 dose per day
Provider Comments (Significant Problems/Justification for Requested Medication) :

Patient Information

Medicaid Number :
Patient Name :
Address :
City :
State : Mississippi
Zip : 39120 - 8451
Date of Birth :
Sex : M F U

Drug Requested

*Drug Name (Search)	*Drug Strength	*Service Dates		*Quantity	*Days Supply
		From	Thru		
CIPRO 500 MG TABLET	500 MG	03/10/2011	03/20/2011	10	10

* I hereby certify that I am the prescriber identified on this form and I deem the prescribed medication to be necessary for this patient. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Please check the box if you would like to upload any documents Browse

Submit Reset

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The following information will need to be completed to complete this section.

- Service dates – auto-populated
- Quantity
- Days Supply

Certification Statement

PHARMACY PRIOR AUTHORIZATION

Mississippi Medicaid
Pharmacy Drug
Prior Authorization Request

Approval of these services does not guarantee Medicaid Eligibility of the Patient.

For Provider Use

Prescriber Information

Provider Number :
Provider Name :
Address :
City :
State : Mississippi
Zip : 39301 -
Phone Number :
Fax Number :
Email :

Medical Data

*Primary Diagnosis Code : 771.82
*Primary Diagnosis Description : NB URINARY TRACT INFECTN
*Dosage Frequency : 1 dose per day
Provider Comments (Significant Problems/Justification for Requested Medication) :

Patient Information

Medicaid Number :
Patient Name : GEORGE WASHINGTON
Address :
City :
State : Mississippi
Zip : -
Date of Birth :
Sex : M F U

Drug Requested

*Drug Name Search	*Drug Strength	*Service Dates From	*Service Dates Thru	*Quantity	*Days Supply
CIPRO XR 500 MG TABLET	500 MG	03/10/2011	03/20/2011	10	10

☑ * I hereby certify that I am the prescriber identified on this form and I deem the prescribed medication to be necessary for this patient. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

☐ Please check the box if you would like to upload any documents Browse...

Submit Reset

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“Click” the check box beside the certification statement

Adding Documentation

PHARMACY PRIOR AUTHORIZATION

Mississippi Medicaid
Pharmacy Drug
Prior Authorization Request

Approval of these services does not guarantee Medicaid Eligibility of the Patient.

For Provider Use

Prescriber Information

Provider Number :
Provider Name :
Address :
City :
State : Mississippi
Zip : 39301 -
Phone Number :
Fax Number :
Email :

Medical Data

*Primary Diagnosis Code : 771.82
*Primary Diagnosis Description : NB URINARY TRACT INFECTN
*Dosage Frequency : 1 dose per day
Provider Comments (Significant Problems/Justification for Requested Medication) :

Patient Information

Medicaid Number :
Patient Name : GEORGE WASHINGTON
Address :
City :
State : Mississippi
Zip : 39648 -
Date of Birth :
Sex : M F U

Drug Requested

*Drug Name Search	*Drug Strength	*Service Dates From	*Service Dates Thru	*Quantity	*Days Supply
CIPRO XR 500 MG TABLET	500 MG	03/10/2011	03/20/2011	10	10

* I hereby certify that I am the prescriber identified on this form and I deem the prescribed medication to be necessary for this patient. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Please check the box if you would like to upload any documents Browse...

Submit Reset

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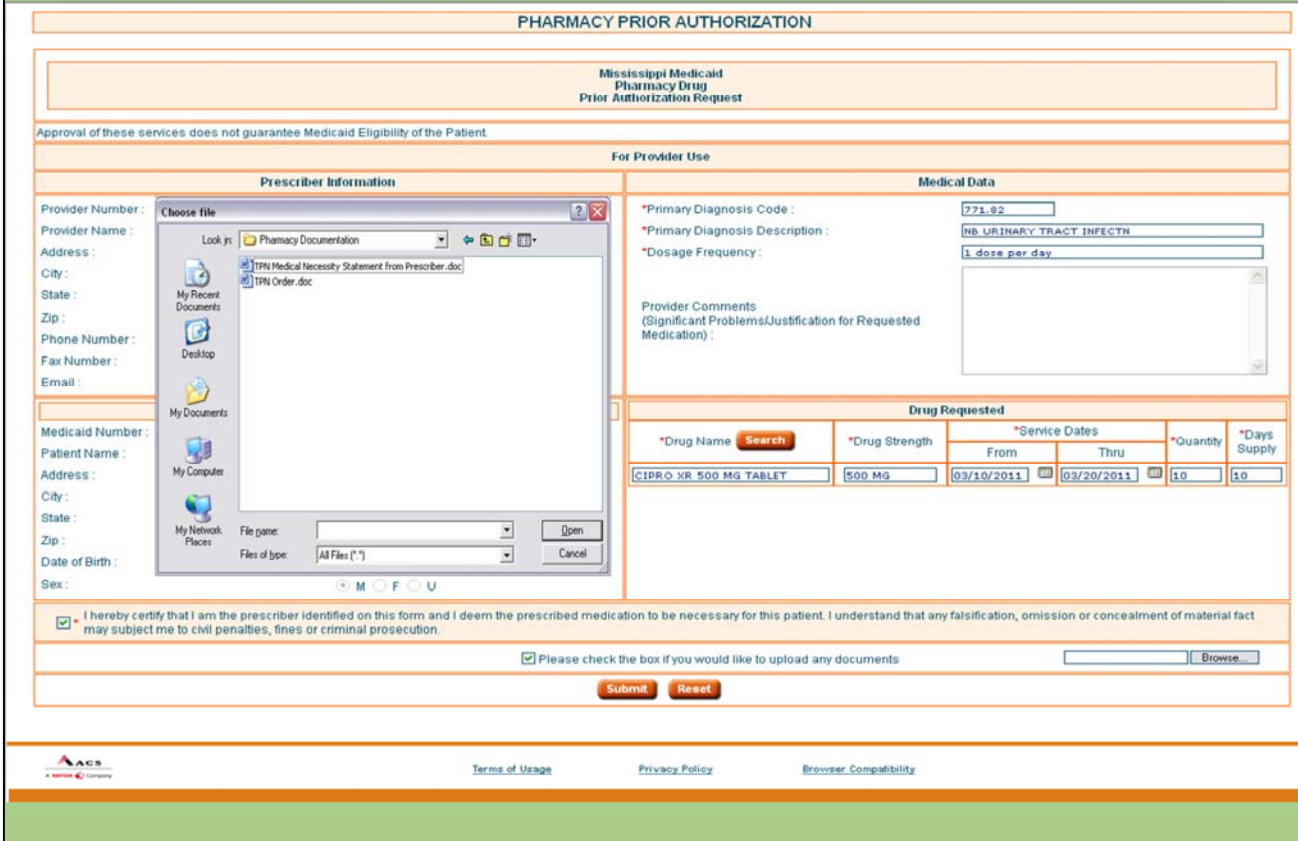
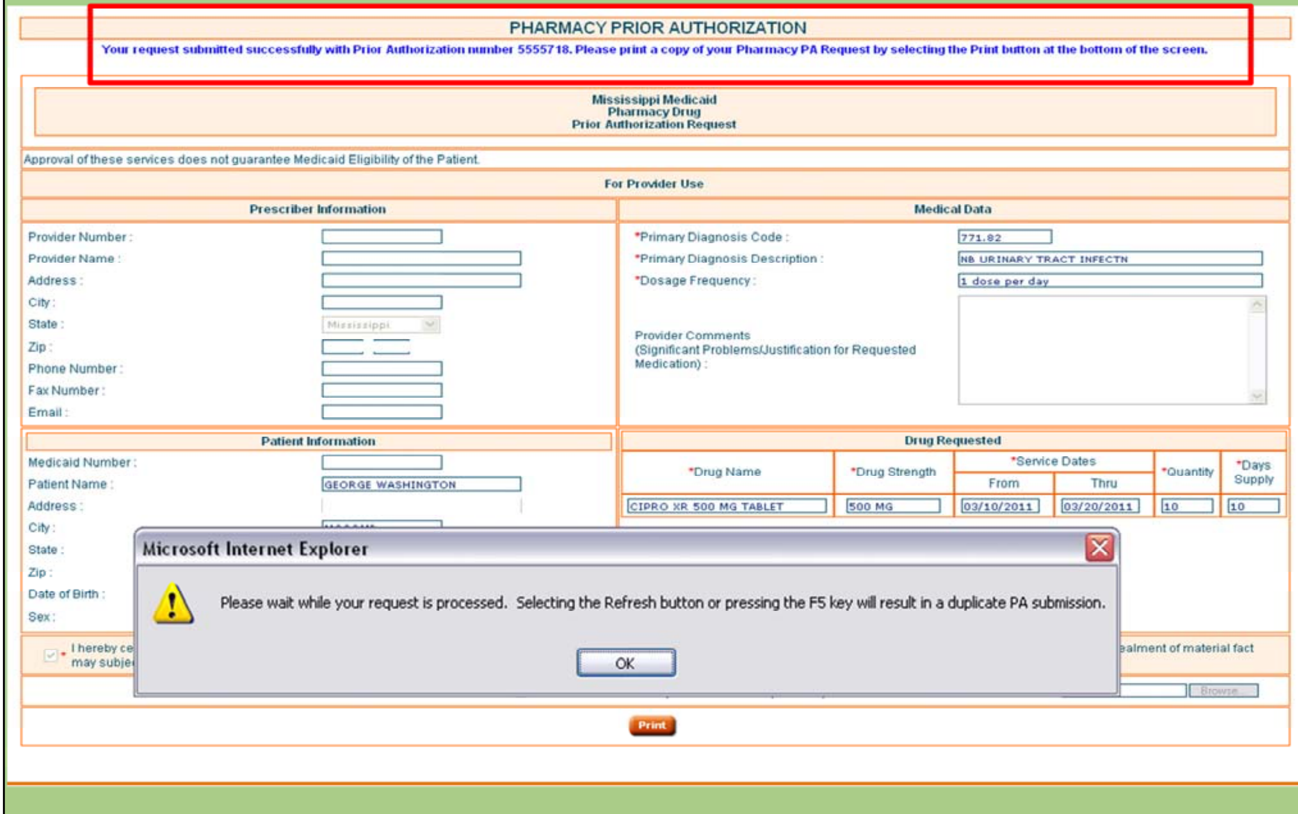
This section is optional. This section is to add any additional information to help in the determination of this Prior Authorization Request.

How to complete this section:

1. Click in the check box labeled “Please check the box if you would like to upload any documents”
2. Next click on the <Browse> button



Now another pop-up window will appear. This window is your local drive and not offsite. Please choose documents from your file that you would like to attach to this Prior Authorization. Then “double click” on the item to be attached.



After clicking on the <Submit> button, a pop-up block will appear. Click the <Ok> button within the pop-up.

- **Please Note: Selecting the Refresh button or pressing the F5 key will result in a duplicate PA submission.**

The screen will now clear. In place of that screen will be a printable version with the PA number at the top of the page.

- **Please Note: The PA number does not indicate that the request is approved; the status is PENDING awaiting review.**

At this point, please hit the <Print> button at the bottom of the page.

The next page is an example of the printout.

PHARMACY PRIOR AUTHORIZATION

PA Number : 5555717

Mississippi Medicaid Pharmacy Drug Prior Authorization Request

Approval of these services does not guarantee Medicaid Eligibility of the Patient.

For Provider Use

Provider Information	
Provider Number : **000$$$$$**	*Provider Name :* **OOOOOOOOOOO**
Address : **2XXXXX 5TH ST**	*City :* **M Town**
State : **MS**	*Zip :*
Phone Number : **601-XXX-XXXX**	*Fax Number :*
Email :	

Medical Data	
Primary Diagnosis Code : **771.82**	*Primary Diagnosis Description :* **NB URINARY TRACT INFECTN**
Dosage Frequency : **1 dose per day**	*Provider Comments (Significant Problems/Justification for Requested Medication) :*

Patient Information	
Medicaid Number : **00000000000**	*Patient Name :* **GEORGE WASHINGTON**
Address : **1XXXX1 1st DRIVE**	*City :* **President Town**
State : **MS**	*Zip :*
Date of Birth : **08/30/1700**	*Sex :* **M**

Drug Requested

Drug Name	*Drug Strength*	*Service Dates From*	*Service Dates Thru*	*Quantity*	*Days Supply*
CIPRO XR 500 MG TABLET	500 MG	03/10/2011	03/20/2011	10	10

I hereby certify that I am the prescriber identified on this form and I deem the prescribed medication to be necessary for this patient. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Duplicate PA Requests

PHARMACY PRIOR AUTHORIZATION

Duplicate PA Request. A Pharmacy PA already exists matching this PA Request. Submission denied.

Mississippi Medicaid
Pharmacy Drug
Prior Authorization Request

Approval of these services does not guarantee Medicaid Eligibility of the Patient.

For Provider Use

Prescriber Information

Provider Number :
Provider Name :
Address :
City :
State : Mississippi
Zip : 39301 -
Phone Number :
Fax Number :
Email :

Medical Data

*Primary Diagnosis Code : 771.82
*Primary Diagnosis Description : NB URINARY TRACT INFECTN
*Dosage Frequency : 1 dose per day
Provider Comments (Significant Problems/Justification for Requested Medication) :

Patient Information

Medicaid Number :
Patient Name :
Address :
City :
State : Mississippi
Zip : 39120 - 8451
Date of Birth :
Sex : M F U

Drug Requested

*Drug Name Search	*Drug Strength	*Service Dates From	*Service Dates Thru	*Quantity	*Days Supply
CIPRO 500 MG TABLET	500 MG	03/19/2011	03/29/2011	14	14

* I hereby certify that I am the prescriber identified on this form and I deem the prescribed medication to be necessary for this patient. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Please check the box if you would like to upload any documents Browse

Submit Reset

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If a Pharmacy PA already exists, a message of Duplicate PA Request will display. The Service Dates fields will allow for editing and the PA Request can be resubmitted once the dates are changed.

Inquiry Options

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Provider Rates
Provider Type Specific Information
Report Third Party Insurance
Search for Provider
Statistics
Training Materials / CBT
WINASAP 2003 Software
Claims Entry
Communication Options
Inquiry Options
Long Term Care
Prior Authorization
School Based Services
Submission Options
User Admin Options

Claim Status Inquiry
Physician Administered Drug Inquiry
Eligibility Inquiry
PA Inquiry
Payment Status Inquiry

Pharmacy

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Steps to check the status of Pharmacy Prior Authorizations

1. Click on the "Provider Tab"
2. Click on "Inquiry Options"
3. Then click on "PA Inquiry"
4. Finally click on "Pharmacy"

Pharmacy PA Inquiry

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Pharmacy PA Inquiry

PA Inquiry results only include PAs less than 2 years from the current date and PAs that do not contain compound drugs.

You must include at least one of the criteria listed below:

PA Number
Or
Beneficiary ID and Service Start Date, Service End Date

Please enter dates in mm/dd/yyyy format.

PA Number:	
Beneficiary ID:	
Date(s) of Service:	
Begin Date:	
End Date:	

Submit Reset

Terms of Usage | Privacy Policy | Browser Compatibility

PA Inquiry results only include PAs less than 2 years from the current date and PAs that do not contain compound drugs.

Inquiry results are prescriber specific. Only requests submitted by the prescriber will be displayed. Other prescribers’ PA requests will not be shown.

Pharmacy PAs can be found by using one of two search criteria:

1. Enter the PA number and click the <Submit> button
2. Enter the Medicaid Beneficiary and the service dates
    a. Note: the service dates are in the formation mm / dd / yyyy

Using the PA Number

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Pharmacy PA Inquiry

PA Inquiry results only include PAs less than 2 years from the current date and PAs that do not contain compound drugs.

You must include at least one of the criteria listed below:

PA Number
Or
Beneficiary ID and Service Start Date, Service End Date

Please enter dates in mm/dd/yyyy format.

PA Number:	5555717
Beneficiary ID:	
Date(s) of Service:	
Begin Date:	
End Date:	

Submit Reset

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Example of Using the PA number

Pharmacy PA Inquiry Information

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PHARMACY PA INQUIRY INFORMATION

PA Number: 5555717

Status: Pending

Prescriber Information

Provider Number:

Provider Name:

Address:

City:

State: Mississippi

Zip: 39301 -

Phone Number:

Medical Data

Primary Diagnosis Code: 771.82

Primary Diagnosis Description: NB URINARY TRACT INFECTN

Dosage Frequency: 1 dose per day

Provider Comments (Significant Problems/Justification for Requested Medication):

Patient Information

Medicaid Number:

Patient Name: GEORGE WASHINGTON

Address:

City:

State: Mississippi

Zip: -

DOB:

Sex: M F U

Services Requested

Drug Name	Strength	Service Dates		Requested Quantity	Requested Days Supply	Approved Quantity	Approved Days Supply	Used Quantity	Used Days Supply
		From	Thru						
CIPRO XR 500 MG TABLET	500 MG	03/10/2011	03/20/2011	10.00	10.00	0.00	9999999.99	0.00	0.00

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The Prior Authorization Status is found near the top right corner of the PA inquiry screen.

PA Inquiry Results Using Beneficiary Information

PHARMACY PA INQUIRY INFORMATION

1. PA Detail

PA Number:	5555713
PA Status:	Pending
Beneficiary Name:	PATRICK PARKINSON
Beneficiary ID:	
Drug Name:	DEXTROAMP-AMPHET ER 15 MG C
Begin Date:	01/01/2011
End Date:	12/31/2011

2. PA Detail

PA Number:	5555714
PA Status:	Pending
Beneficiary Name:	PATRICK PARKINSON
Beneficiary ID:	
Drug Name:	DEXTROAMP-AMPHET ER 10 MG C
Begin Date:	01/01/2011
End Date:	12/31/2011

3. PA Detail

PA Number:	5555715
PA Status:	Pending
Beneficiary Name:	PATRICK PARKINSON
Beneficiary ID:	
Drug Name:	AMPHETAMINE SALTS 10 MG TAB
Begin Date:	01/01/2011
End Date:	12/31/2011

4. PA Detail

PA Number:	5555716
PA Status:	Pending
Beneficiary Name:	PATRICK PARKINSON
Beneficiary ID:	
Drug Name:	DEXTROAMP-AMPHET ER 5 MG CA
Begin Date:	01/01/2011
End Date:	03/30/2011

New Inquiry | Back

This is an example of using the beneficiary number and a date range

Communication Options

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- EHR Incentive Program
- Fee Schedules
- Frequently Asked Questions
- General Billing Tips
- Provider Bulletins
- Provider Enrollment
- Provider Hotlinks
- Provider Rates
- Provider Type Specific Information
- Report Third Party Insurance
- Search for Provider
- Statistics
- Training Materials / CBT
- WINASAP 2003 Software
- Claims Entry
- Communication Options
  - Access Seminars
  - Manage Messages
  - Submit a Request to Customer Service
- Inquiry Options
- Long Term Care
- Prior Authorization
- School Based Services
- Submission Options
- User Admin Options

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Below are the steps to use to check for messages

1. Click on the “Provider Tab”
2. Click on “Communication Options”
3. Then click on “Manage Messages”

MISSISSIPPI DIVISION OF MEDICAID
PHARMACY PA UNIT
550 High Street, Suite 1000
Jackson, MS 39201
Phone: (877)537-0722 or Fax: (877)537-0720

April 20, 2011

FAMILY CANCER CENTER PLLC Prescriber id: 09015910
1936 W POPLAR
COLLIERVILLE, TN 38017

Beneficiary:
Medicaid ID Number: DOB:
DRUG Prior Authorization Decision: DENIAL

A request for authorization of:
MOTRIN 100 MG CAPLET (brand name) TABLET 100 MG
was submitted by the DOM Pharmacy PA Unit for the above referenced Medicaid beneficiary. After review by our clinical staff, it has been determined that the necessary criteria required have not been met based on the following:

Denial Reason Comments: PA DENIED: PDL CRITERIA NOT MET. PHARMACY CLAIMS FAIL TO INDICATE STABLE THERAPY WITH REQUESTED MEDICATION. MS DIVISION OF MEDICAID DEFINES STABLE THERAPY AS 90 DAYS CURRENT THERAPY REFLECTED IN PAID PHARMACY CLAIMS.

If there is additional information related to this case that might affect this decision, you may obtain a reconsideration of the decision. A written request or an APPEAL/RECONSIDERATION form must be submitted by mail or fax to DOM Pharmacy PA Unit within 30 days of the date of this notification. Any additional information that could result in an override of the determination must be submitted with your request. All available information will be reviewed and a decision made within three business days of the receipt of your request.

All correspondence can be mailed or faxed (preferred) to:

MISSISSIPPI DIVISION OF MEDICAID
Attn: Pharmacy PA Unit/Appeals Coordinator
550 High Street, Suite 1000
Jackson, MS 39201
Fax: (877)537-0720

If you have questions regarding this denial, please call (877)537-0722, and refer to PA number 99000000000.

Sincerely,
Division of Medicaid
Pharmacy PA Unit/Clinical Staff

Confidentiality Notice: This communication, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review use, disclosure, or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply telephone (1-877-537-0722) or fax (1-877-537-0720) and destroy all copies of the original message.

Manage Messages

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Manage Messages

The following list contains a summary of all your messages. To read a message please click on the file name. If messages are not deleted, they will be automatically deleted after 60 days.

To delete message, please check the appropriate box and then select the appropriate button.

Select	File Name	Subject	From	To	Date of Posted	Date of Expired
☐	t1ra024.20110506.5850307.00018128.pdf	Pharmacy PA Approval Letter	Division of Medicaid-Pharmacy PA UNIT	XXXXXXX	05/10/2011	07/09/2011
☐	t1ra005.20101229.5817696.00018128.pdf	Pharmacy PA Denial Letter	Division of Medicaid-Pharmacy PA UNIT	XXXXXXX	12/29/2010	02/27/2011
☐	rx054.20070219.529695.00018128.pdf	Remittance Advice	Remittance Advice	XXXXXXX	02/18/2007	04/19/2007

Delete | Upload Message

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Here are your messages.

ACS
A xerox Company