Mississippi Division Of Medicaid

Provider Workshops

2019

MISSISSIPPI DIVISION OF MEDICAID

Morning Agenda

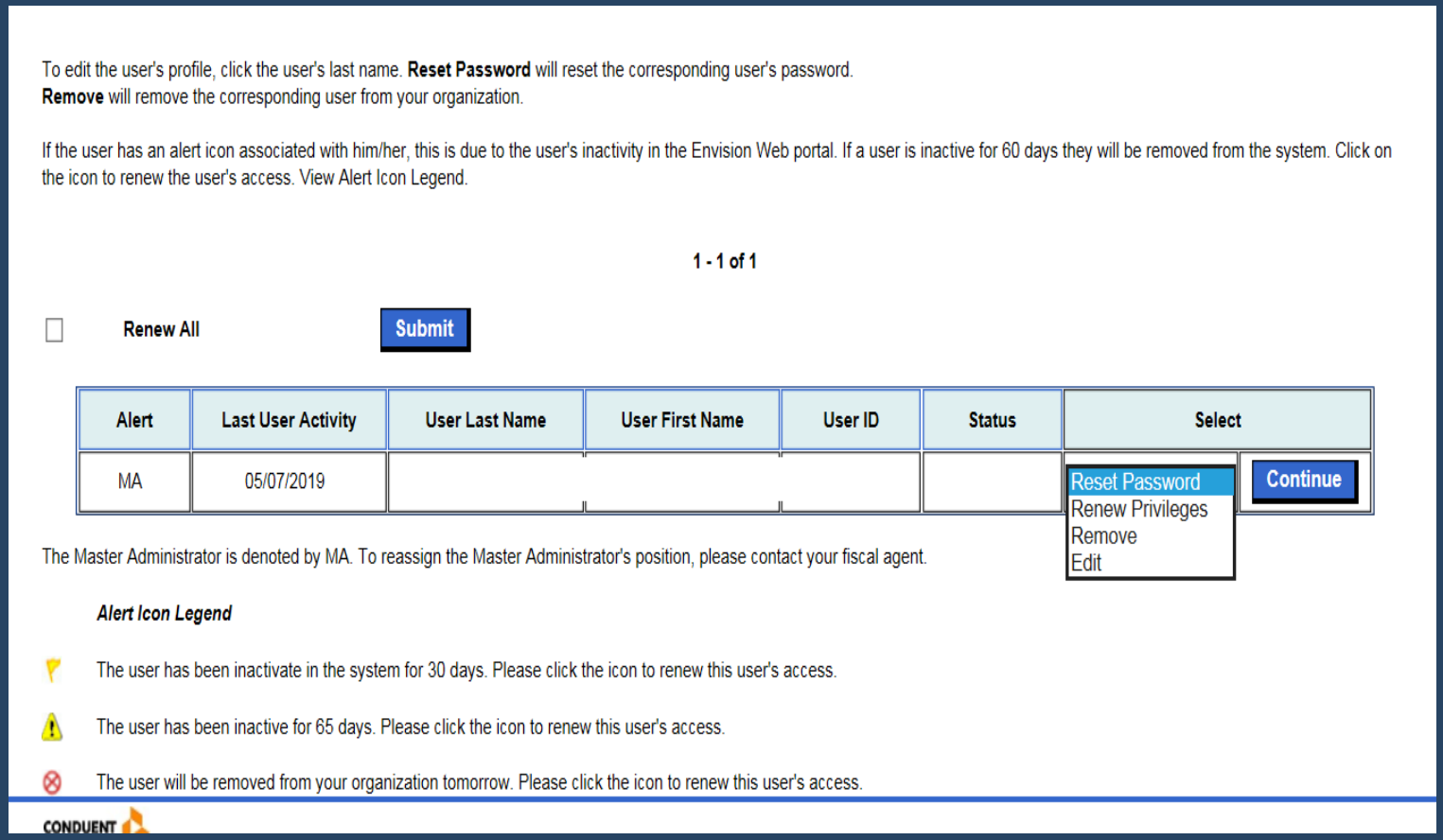
8:30 a.m.	9:00 a.m.	Registration
9:00 a.m.	9:15 a.m.	Welcome & Introductions
9:15 a.m.	11:00 a.m.	New Providers Medicaid Issues Managed Care Top Issues
11:00 a.m.	11:30 a.m.	Question & Answer Session
11:30 a.m.	12:30 p.m.	Help Desk
12:30 p.m.	1:30 p.m.	**LUNCH ON YOUR OWN**

General Claims Billing, Reviews, and Processing

Table of Contents

Top 10 Medicaid Issues

Web Portal Password Resets



To edit the user's profile, click the user's last name. **Reset Password** will reset the corresponding user's password.
Remove will remove the corresponding user from your organization.

If the user has an alert icon associated with him/her, this is due to the user's inactivity in the Envision Web portal. If a user is inactive for 60 days they will be removed from the system. Click on the icon to renew the user's access. View Alert Icon Legend.

1 - 1 of 1

Renew All Submit

Alert	Last User Activity	User Last Name	User First Name	User ID	Status	Select
MA	05/07/2019					Reset Password / Renew Privileges / Remove / Edit — Continue

The Master Administrator is denoted by MA. To reassign the Master Administrator's position, please contact your fiscal agent.

Alert Icon Legend

The user has been inactivate in the system for 30 days. Please click the icon to renew this user's access.

The user has been inactive for 65 days. Please click the icon to renew this user's access.

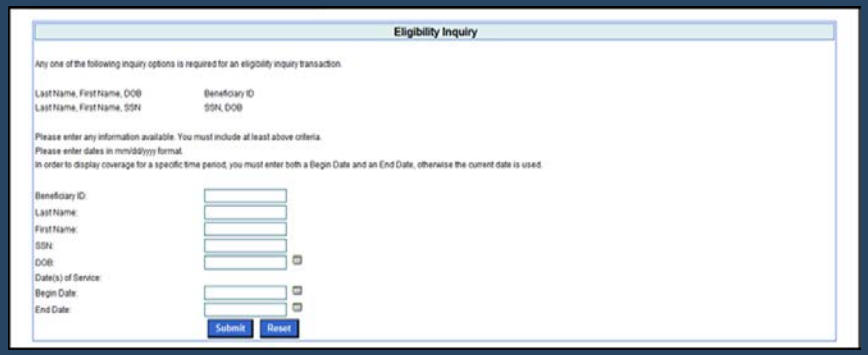
The user will be removed from your organization tomorrow. Please click the icon to renew this user's access.

CONDUENT

Verifying Eligibility

Providers may verify beneficiary eligibility using one of the following:

- Calling the fiscal agent at 1-800-884-3222,
- Calling the Automated Voice Response System (AVRS)
- Accessing the Point of Service eligibility verification system
- Accessing the Envision Web Portal at http://ms-medicaid.com

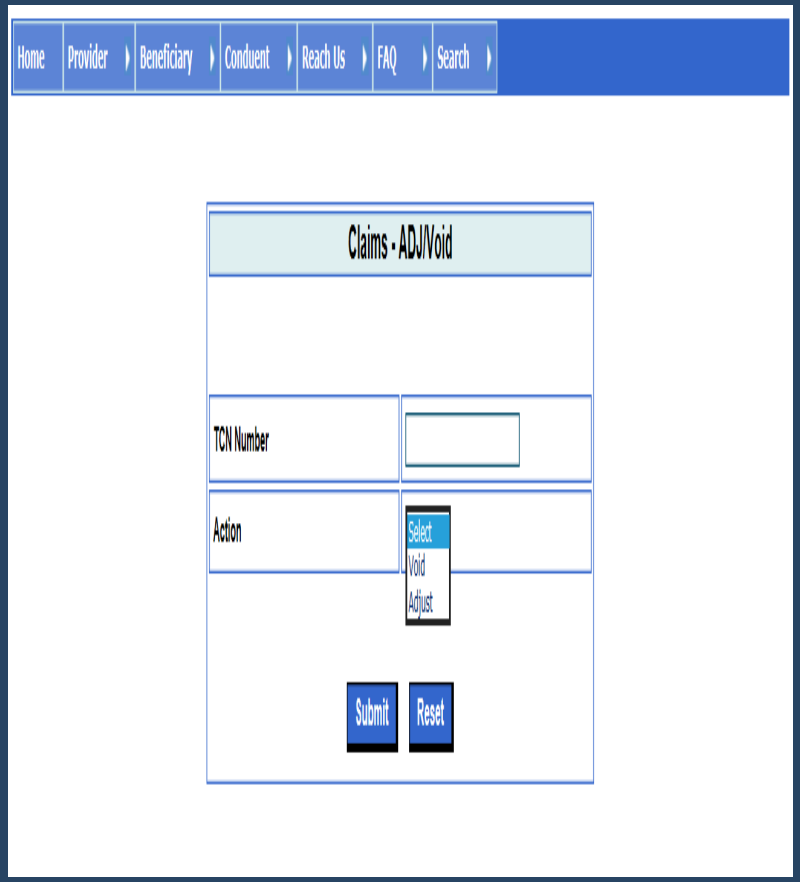


- You may check a Beneficiary's eligibility status by entering the following options:
  - Beneficiary ID or
  - SSN or
  - Beneficiary's name (*first name, last name*) and DOB

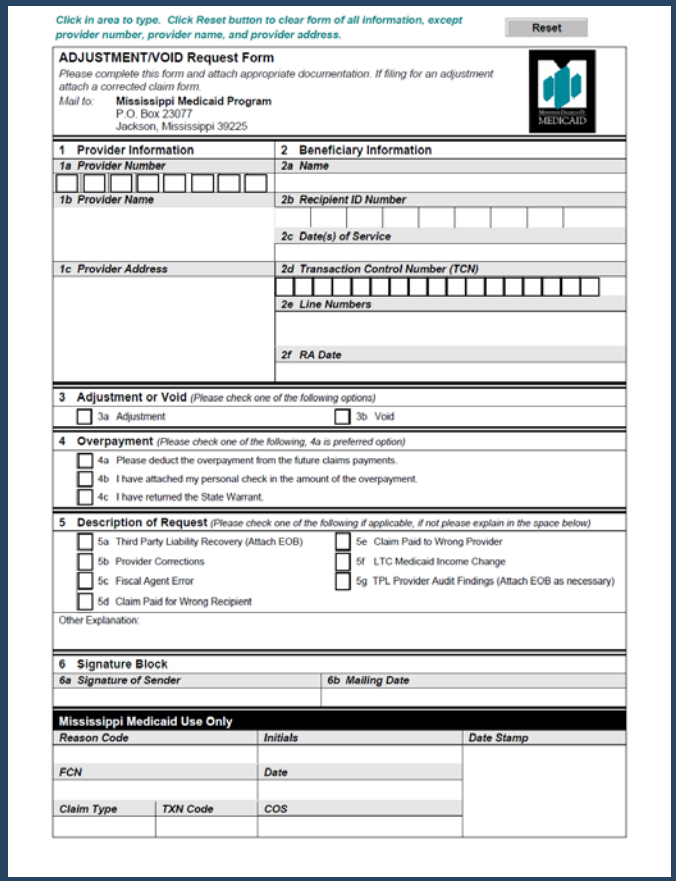
Adjusting and Voiding Claims

- **Adjustment** –The money is recouped and reprocessed based on the provider's corrections
- Denied claims cannot be adjusted
- Crossover claims cannot be adjusted
- **Void** – ***Completely recoups funds that were previously paid***
- Crossovers can be voided
- Any previously paid claim can be voided
  (Timely filing still applies)
- Claims with adjusting and voiding claims will be on the same remittance advice

Web Portal Option



Paper Form Option



Click in area to type. Click Reset button to clear form of all information, except provider number, provider name, and provider address.

Reset

ADJUSTMENT/VOID Request Form

Please complete this form and attach appropriate documentation. If filing for an adjustment attach a corrected claim form.

Mail to: Mississippi Medicaid Program
P.O. Box 23077
Jackson, Mississippi 39225

1 Provider Information

1a Provider Number

1b Provider Name

1c Provider Address

2 Beneficiary Information

2a Name

2b Recipient ID Number

2c Date(s) of Service

2d Transaction Control Number (TCN)

2e Line Numbers

2f RA Date

3 Adjustment or Void (Please check one of the following options)

☐ 3a Adjustment ☐ 3b Void

4 Overpayment (Please check one of the following, 4a is preferred option)

☐ 4a Please deduct the overpayment from the future claims payments.
☐ 4b I have attached my personal check in the amount of the overpayment.
☐ 4c I have returned the State Warrant.

5 Description of Request (Please check one of the following if applicable, if not please explain in the space below)

☐ 5a Third Party Liability Recovery (Attach EOB)
☐ 5b Provider Corrections
☐ 5c Fiscal Agent Error
☐ 5d Claim Paid for Wrong Recipient
☐ 5e Claim Paid to Wrong Provider
☐ 5f LTC Medicaid Income Change
☐ 5g TPL Provider Audit Findings (Attach EOB as necessary)

Other Explanation:

6 Signature Block

6a Signature of Sender

6b Mailing Date

Mississippi Medicaid Use Only

Reason Code | Initials | Date Stamp

FCN | Date

Claim Type | TXN Code | COS

Importance of Updating Your Banking Information

- **Why is it important**?
  - Incorrect banking information by an individual or group can cause payments to incorrect payees.
    - Ex: If Individual Provider leaves a billing group.

- **How to update your banking information.**
  - EFT Form can be located on Web Portal and voided check or letter from the bank showing your account type, number, and routing number can be uploaded.
  - EFT Form can be mailed in along with a voided check or letter from the bank showing your account type, number, and routing number.
  - There will be three payment cycles before you see your direct deposit take effect. Paper checks will be mailed out to the address listed on your provider file.
  - Link Information:
    https://www.msmedicaid.com/msenvision/eftEnrollment.do?method=eFTForm

Beneficiary File Updates

- The fiscal agent for Medicaid does not create or update the data for beneficiary files.

- Various Medicaid Sources (Regional Offices, Social Security Offices etc.) are responsible for creating, and updating all beneficiary data.

All 9's National Provider Identifier

EDIT #	Edit Description	Reason
0426	**Billing provider NPI is missing/invalid**	Billing Provider Medicaid ID on claim; No Billing NPI billed on claim, **Billing NPI** will default to 9999999999.
0427	**Servicing provider NPI is missing/invalid**	Servicing Provider Medicaid ID on claim; No Servicing NPI billed, **Servicing NPI** will default to 9999999999.
0429	**NPI/Provider Number Mismatch**	Medicaid ID (Billing and/or Servicing) on claim; NPI billed on the claim does not match the Medicaid ID on claim.
0120	**Billing Provider Number is Missing**	No Medicaid ID submitted on claim; NPI submitted not found on Provider file, **Medicaid ID** will be defaulted to 99999998.
0300	**Billing Provider Not On File**	Medicaid ID submitted on claim is not on provider file; No NPI on claim; **Medicaid ID** defaulted to all 99999998.

National Correct Coding Initiative

- The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. The Affordable Care Act of 2010 required state Medicaid programs to incorporate compatible NCCI methodologies in their systems for processing Medicaid claims.
- NCCI associated modifiers may be appended when and only when appropriate clinical circumstances are documented in accordance with the NCCI policies and the HCPCS/CPT Manual instructions/definitions for the modifier/procedure code combination.
- NCCI/MUE service limits supersedes system service limits.
- Claim coding should be reviewed for accuracy.
- Billing Handbook (Section 0.3)
- Link: https://medicaid.ms.gov/providers/national-correct-coding-initiative/

NCCI Resources

- Find more information about the CMS National Correct Coding Initiative in Medicaid on the Medicaid website. The Medicaid NCCI Policy Manual should be reviewed for more on the appropriate use of modifiers.
- Mississippi Medicaid Billing Handbook
- NCCI Billing Guidance
- A procedure or service code included in the attached documents is not an indication of coverage. Please verify coverage on the Medicaid Envision web portal.
- Global Surgical Days – effective Jan. 1, 2015
- Bilateral Code List – effective Jan. 1, 2018
- Multiple Surgery Code List – effective Jan. 1, 2018
- The Centers for Medicare and Medicaid Services establishes new procedure-to-procedure associated modifiers – effective Jan. 1, 2015

Billing Vs. Coding

Your Provider Field Representative

can . . . .

assist with Billing includes helping providers with policies and procedures in relation to the Medicaid Administrative Code and the Billing Handbook.

Your Provider Field Representative

cannot . . .

assist with Coding as in providing procedure codes, diagnosis codes, modifiers.

It is the providers responsibility to educate themselves on the proper coding for the submission of their claims.

Exception Code 0610

- Explanation of Benefits (EOB) requires review or is missing or invalid.
- This exception code is received when a traditional Medicare cross-over claim/Advantage Plan claim is submitted via the Web Portal or hardcopy.
- This exception code is three-part:
  - Suspended – needs to be reviewed
  - Denied – EOMB is missing (EOMB did not electronically upload or file is not compatible)
  - Denied – EOMB is invalid (EOMB does not include payor name, beneficiary mismatch, date of service mismatch or Medicare amount mismatch

Request for Information (RFI) Submittal

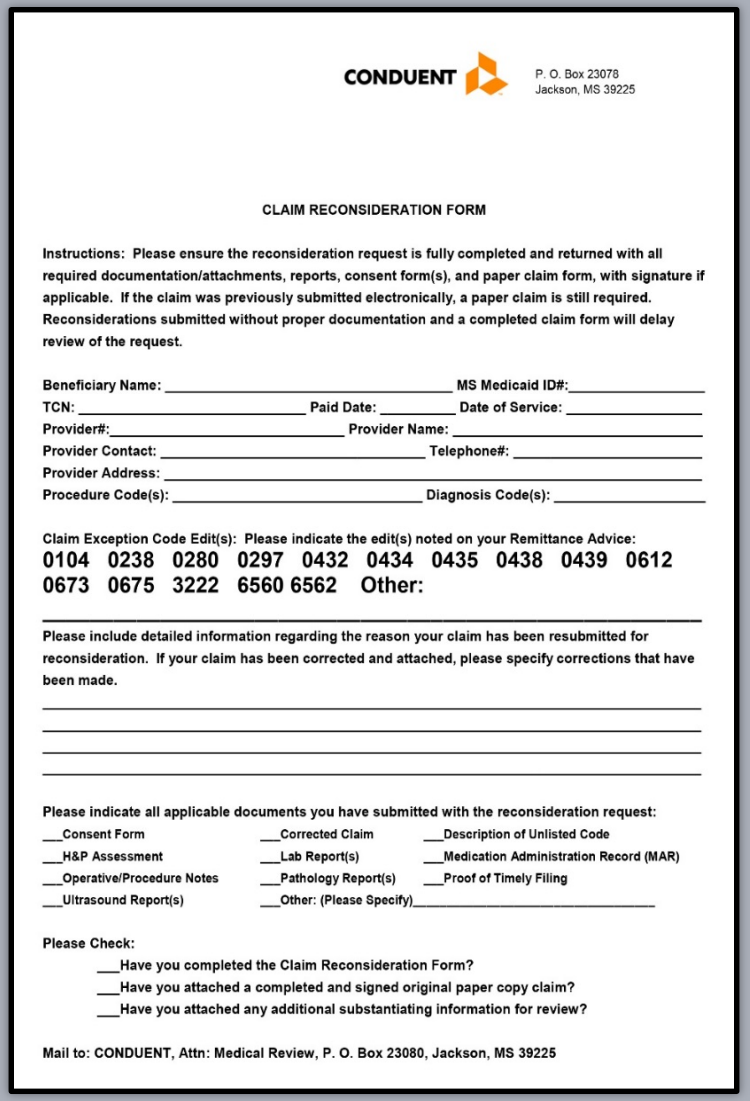
- Submit a RFI or request for public records in writing, by:
- You can submit a RFI or request for public records in writing by contact the Mississippi Division of Medicaid (DOM) multiple ways as listed below, including postal mail, fax and email. It is advised that you do not email forms or submit online forms with protected health information or personally identifiable information, to protect your confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996.
  - Mailing address: Mississippi Division of Medicaid, Attn: Public Records Officer, 550 High Street, Suite 1000, Jackson, MS 39201-1399
  - Fax: 601-576-6342
  - Email: **RFI@medicaid.ms.gov**
- If you have questions regarding RFI policy or procedure, contact the RFI Public Records Officer by phone at **601-359-6093**.

Medicaid Fee-for-Service Claims Review

Claim Reconsideration

- The Claim Reconsideration Form is the tool used by providers to initiate a request for reconsideration review by Conduent Medical Review of a denied claim. Information submitted on this form provides an at-a-glance view of the code(s)/ issue(s) to be reviewed and directs the Medical Review staff in determining the next step in the process for the reconsideration review.

- https://medicaid.ms.gov/wp-content/uploads/2014/04/ClaimCheck_Reconsideration_Form.pdf



CONDUENT

P. O. Box 23078
Jackson, MS 39225

CLAIM RECONSIDERATION FORM

Instructions: Please ensure the reconsideration request is fully completed and returned with all required documentation/attachments, reports, consent form(s), and paper claim form, with signature if applicable. If the claim was previously submitted electronically, a paper claim is still required. Reconsiderations submitted without proper documentation and a completed claim form will delay review of the request.

Beneficiary Name: _____ **MS Medicaid ID#:**_____
TCN: _____ **Paid Date:** _____ **Date of Service:** _____
Provider#:_____ **Provider Name:** _____
Provider Contact: _____ **Telephone#:** _____
Provider Address: _____
Procedure Code(s): _____ **Diagnosis Code(s):** _____

Claim Exception Code Edit(s): Please indicate the edit(s) noted on your Remittance Advice:
0104 0238 0280 0297 0432 0434 0435 0438 0439 0612 0673 0675 3222 6560 6562 Other:
_____

Please include detailed information regarding the reason your claim has been resubmitted for reconsideration. If your claim has been corrected and attached, please specify corrections that have been made.
_____
_____
_____
_____

Please indicate all applicable documents you have submitted with the reconsideration request:

___Consent Form	___Corrected Claim	___Description of Unlisted Code
___H&P Assessment	___Lab Report(s)	___Medication Administration Record (MAR)
___Operative/Procedure Notes	___Pathology Report(s)	___Proof of Timely Filing
___Ultrasound Report(s)	___Other: (Please Specify)_____	

Please Check:
___Have you completed the Claim Reconsideration Form?
___Have you attached a completed and signed original paper copy claim?
___Have you attached any additional substantiating information for review?

Mail to: CONDUENT, Attn: Medical Review, P. O. Box 23080, Jackson, MS 39225

Completing a Claim Reconsideration Form

A completed Claim Reconsideration Form will include a summary of the following information:

- Specifics of the claim (Bene Name/ Medicaid ID#, TCN, date paid, date(s) of service, etc.)
- The specific provider contact(s) information: name, address, and phone number (which may be used for further contact if needed);
- The specific code(s) and related diagnosis to be reviewed;
- The Exception Code pended to the claim;
- A checklist of documentation submitted with the Claim Reconsideration Form; and
- Additional narrative detail the provider wants to be considered in the review of the claim.

A signed, original claim form, applicable documentation, and a completed Claim Reconsideration Form should be submitted to expedite the reconsideration review process.

Claim Reconsideration Process

- Only claims that have gone through the system and denied, need to be sent in to Medical Review to be reviewed. Please make sure all proper documentation is included. *(The filly completed Reconsideration Form should be attached to the claim each time it is sent to Conduent Medical Review.)*

- Once claims are in the review process, if there's any information missing or required, instead of resending all documentation back to provider, the provider will receive a letter requesting any and all information required to continue the process of the individual claim(s).

- All codes billed for the same date of service should be billed on the same claim form **(unless additional lines are needed)**

Provider File Maintenance and Updates

Change of Address Form

- When updating a provider's file with a new address, the Change of Address form must be utilized. Requests on company letterhead is not acceptable.

- Change of address forms should be submitted, when an individual provider or group provider has changed servicing, billing, or mail other locations.

Change of Address Form

- Change of Address Forms submitted by an individual provider must be signed by that provider. Only the individual Provider may sign the Change of Address Form.

- Change of Address Forms submitted by a group provider can be signed by the authorized contact persons or personnel in the office.

- Forms can be mailed or faxed to Provider Enrollment:

- **Conduent Provider Enrollment Department**
  P. O. Box 23078
  Jackson, MS 39225

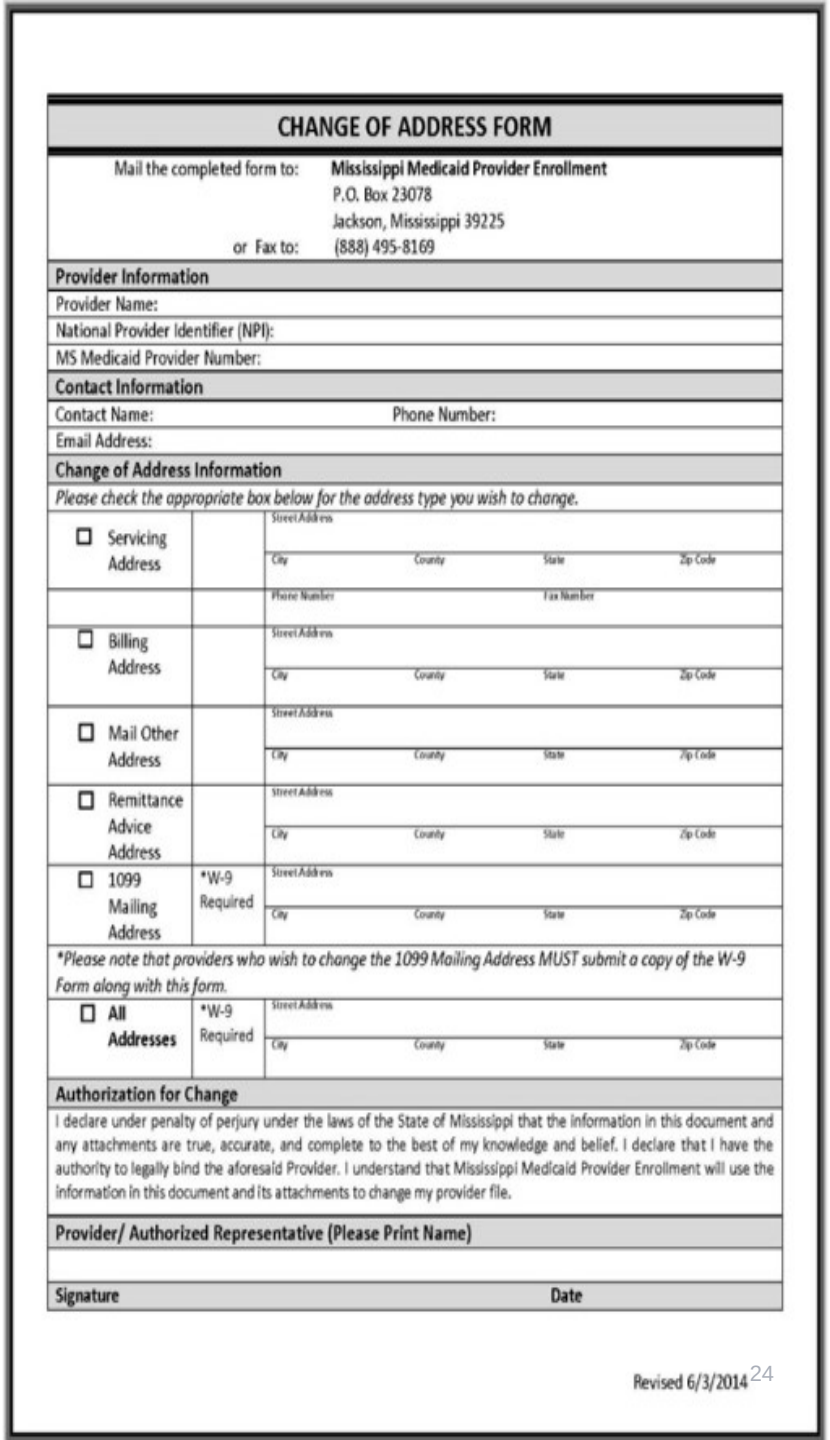
  Fax: 888-495-8169

- Incomplete forms will be returned to the provider.

Change of Address Form

The Change of Address form should be printed from the web portal at and must be completed and signed by the provider. The Change of Address form can be faxed to Conduent Provider Enrollment at (888) 495-8169 or can be mailed to the following address:

Conduent
Provider Enrollment Department
P.O. Box 23078
Jackson MS 39225



CHANGE OF ADDRESS FORM

Mail the completed form to: **Mississippi Medicaid Provider Enrollment**
P.O. Box 23078
Jackson, Mississippi 39225
or Fax to: (888) 495-8169

Provider Information

Provider Name:
National Provider Identifier (NPI):
MS Medicaid Provider Number:

Contact Information

Contact Name: Phone Number:
Email Address:

Change of Address Information

Please check the appropriate box below for the address type you wish to change.

☐ Servicing Address		Street Address City County State Zip Code Phone Number Fax Number
☐ Billing Address		Street Address City County State Zip Code
☐ Mail Other Address		Street Address City County State Zip Code
☐ Remittance Advice Address		Street Address City County State Zip Code
☐ 1099 Mailing Address	*W-9 Required	Street Address City County State Zip Code

**Please note that providers who wish to change the 1099 Mailing Address MUST submit a copy of the W-9 Form along with this form.*

☐ **All Addresses**	*W-9 Required	Street Address City County State Zip Code

Authorization for Change

I declare under penalty of perjury under the laws of the State of Mississippi that the information in this document and any attachments are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the aforesaid Provider. I understand that Mississippi Medicaid Provider Enrollment will use the information in this document and its attachments to change my provider file.

Provider/ Authorized Representative (Please Print Name)

Signature **Date**

Revised 6/3/2014

Provider Linkage Letters

- Provider Link Letters must be submitted to link a individual to a particular group provider. The provider link letter entails:
  - Individual provider ID that's being linked to group number.
  - Group provider ID that the individual provider will be linked to.
  - Effective date of the individual provider being linked.
  - Must be mailed or faxed on company letterhead.
  - Linkage letter must be signed by authorized personnel.

Provider De-Linkage Letters

- Provider De-link Letters must be submitted to de-link a individual from a particular group provider. The provider de-link letter entails:
  - Individual provider ID that's being de-linked to group number.
  - Group provider ID that individual provider will be de-linked from.
  - Effective date of the individual provider being de-linked.
  - Must be mailed or faxed on company letterhead.
  - Linkage letter must be signed by authorized personnel.

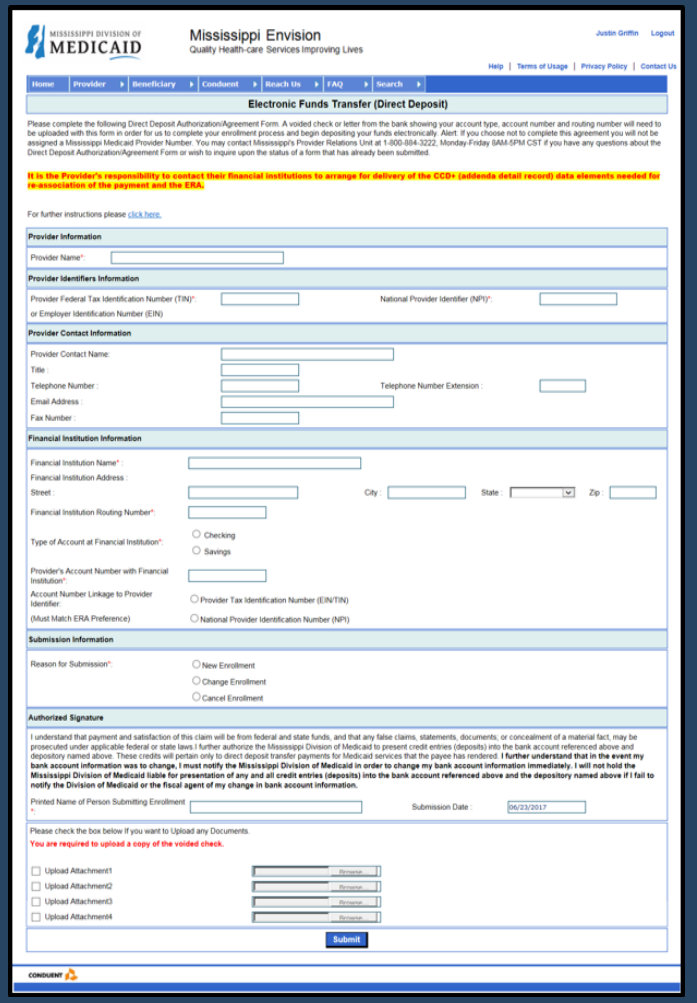
Banking (EFT) Form

The Banking (EFT) is used to update any banking information by a provider. (Group or individual)

Incorrect banking information by individual or group providers can cause payments to incorrect payees.

When an individual provider leaves a billing group, it is imperative to update banking information.

Form can be found online on the Envision website and submitted via fax or mailed in to Provider Enrollment or submitted through the web portal/Envision website



MISSISSIPPI DIVISION OF MEDICAID

Mississippi Envision
Quality Health-care Services Improving Lives

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Electronic Funds Transfer (Direct Deposit)

Please complete the following Direct Deposit Authorization/Agreement Form. A voided check or letter from the bank showing your account type, account number and routing number will need to be uploaded with this form in order for us to complete your enrollment process and begin depositing your funds electronically. Alert: If you choose not to complete this agreement you will not be assigned a Mississippi Medicaid Provider Number. You may contact Mississippi's Provider Relations Unit at 1-800-884-3222, Monday-Friday 8AM-5PM CST if you have any questions about the Direct Deposit Authorization/Agreement Form or wish to inquire upon the status of a form that has already been submitted.

It is the Provider's responsibility to contact their financial institutions to arrange for delivery of the CCD+ (addenda detail record) data elements needed for re-association of the payment and the ERA.

For further instructions please click here.

Provider Information

Provider Name*:

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN)*:
or Employer Identification Number (EIN)

National Provider Identifier (NPI)*:

Provider Contact Information

Provider Contact Name:
Title :
Telephone Number :
Email Address :
Fax Number :

Telephone Number Extension :

Financial Institution Information

Financial Institution Name* :
Financial Institution Address :
Street :
City :
State :
Zip :
Financial Institution Routing Number*:
Type of Account at Financial Institution*: Checking / Savings
Provider's Account Number with Financial Institution*:
Account Number Linkage to Provider Identifier:
(Must Match ERA Preference)
Provider Tax Identification Number (EIN/TIN)
National Provider Identification Number (NPI)

Submission Information

Reason for Submission*: New Enrollment / Change Enrollment / Cancel Enrollment

Authorized Signature

I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal or state laws.I further authorize the Mississippi Division of Medicaid to present credit entries (deposits) into the bank account referenced above and depository named above. These credits will pertain only to direct deposit transfer payments for Medicaid services that the payee has rendered. **I further understand that in the event my bank account information was to change, I must notify the Mississippi Division of Medicaid in order to change my bank account information immediately. I will not hold the Mississippi Division of Medicaid liable for presentation of any and all credit entries (deposits) into the bank account referenced above and the depository named above if I fail to notify the Division of Medicaid or the fiscal agent of my change in bank account information.**

Printed Name of Person Submitting Enrollment *:
Submission Date : 06/23/2017

Please check the box below if you want to Upload any Documents.
You are required to upload a copy of the voided check.

Upload Attachment1 Browse...
Upload Attachment2 Browse...
Upload Attachment3 Browse...
Upload Attachment4 Browse...

Submit

CONDUENT

Clarification

Attestation

Qualified providers who are enrolled as a Mississippi Medicaid provider are eligible for increased payments for certain primary care evaluation and management. (E&M & Vaccine Administration Code).

Updating Licenses

Based on your provider type, your license renewal is due by the appropriate expiration date. (In order to revalidate, you must have a current license).

Provider Revalidation

A CMS requirement that mandates that providers who have been enrolled in Medicaid, regardless of provider type, must revalidate at least every five (5) years.

Common Edits not subject to Medical Review

Common Edits Not Subject to Medical Review

Edits

- **1109 - S**ervice Not Authorized for MSCAN Beneficiary
- **3222 –** Provider Name/Number Mismatch
- **3259 -** Claim Exceeds the Filing Time Limit
- **3272 -** DOS>1 Year No Timely Filing TCN on Claim

Edits

- **3273 -** DOS>2 Years from Current TCN date
- **3341 –** Claim Requires Prior Authorization or Appropriate Modifier
- **3457 -** Global Claim Rendering Taxonomy does not match provider record.
- **3458 -** Global Claim Rendering Taxonomy Required

Medical Review Reminders

- Please make sure you have received a denial before submitting your claim/documentation to Medical Review.
- New claims (never processed) are not reviewed by Medical Review.
- If documentation has been requested by phone, fax or via letter from Medical Review, your claim will not be further processed until all needed documentation has been resubmitted to Conduent Medical Review. All requested forms and documentation should be received within 30 business days of the date of the RTP letter.
- Please remember to include a Reconsideration form with the appropriate contact information for all Reconsiderations.
- When checking the status of a reconsideration and there has been no record on file for at least 60 days, please resubmit all documentation.

Revalidation

What is Provider Revalidation?

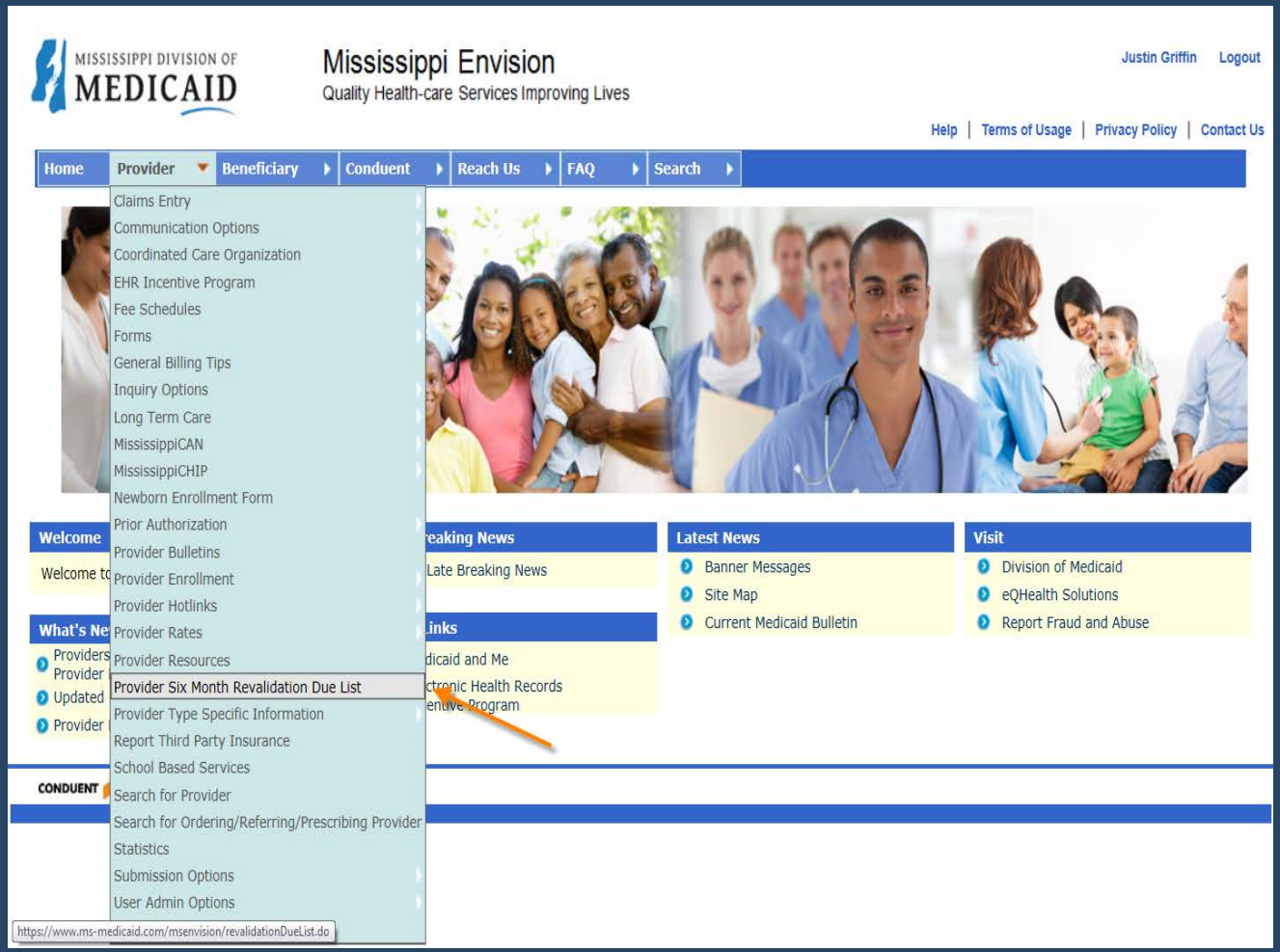
Provider Revalidation – a CMS requirement that mandates that providers who have been enrolled in Medicaid, regardless of provider type, must revalidate at least every five (5) years. Providers will need to verify that the information currently on his/her provider file is accurate and up-to-date in order to receive notifications.

What if I Fail to Revalidate

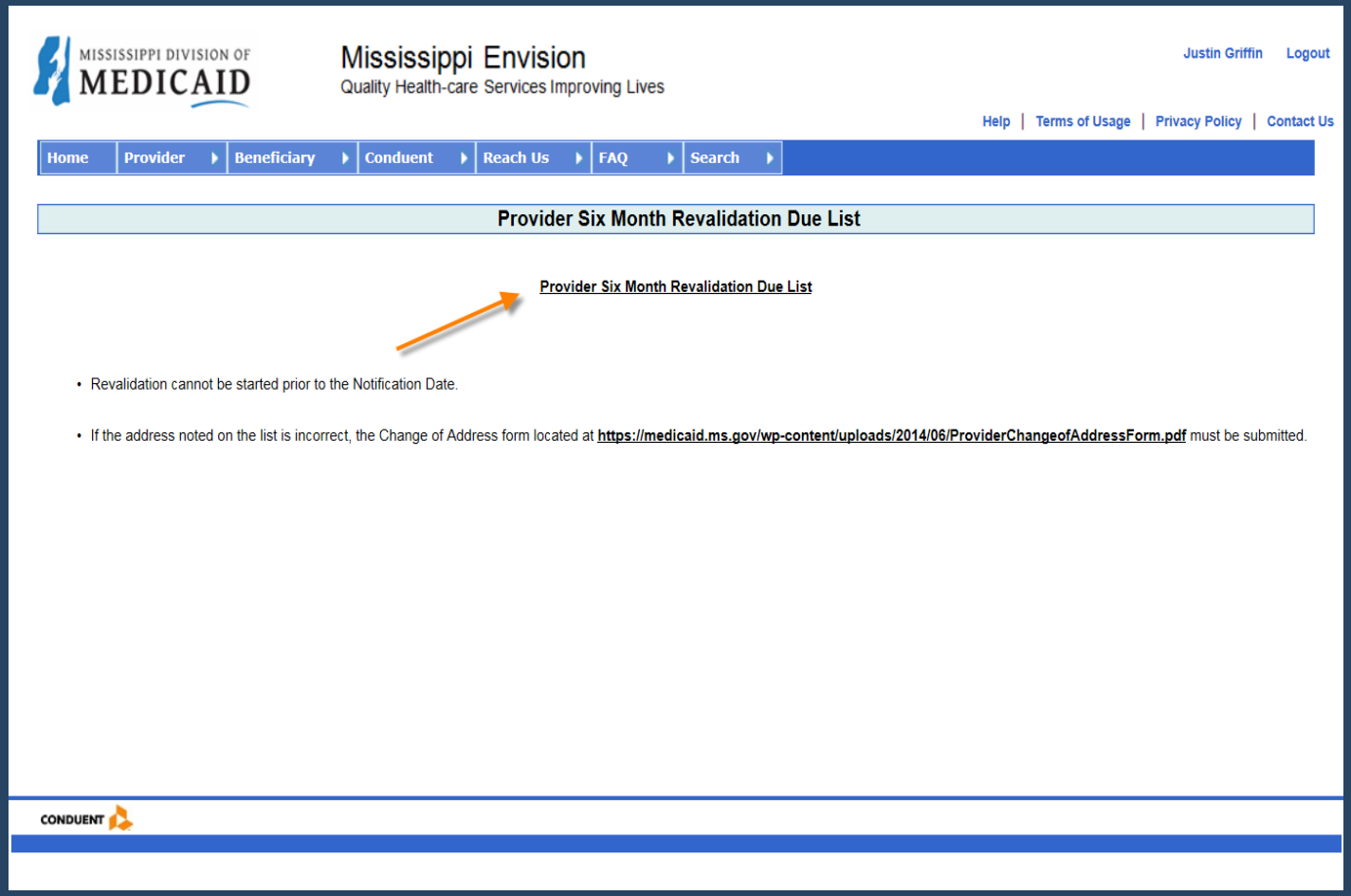
- Providers that fail to revalidate by the deadline will be terminated and required to re-enroll.
- If your Mississippi Medicaid Provider Number is termed due to failure to complete revalidation, your participation with the CCOs (Magnolia and United Healthcare and Molina Healthcare) will be termed as well.
- If you are terminated, you will have the option to appeal the decision. The appeal must be in writing, and the reasons the provider believes the denial is incorrect should be clearly identified. The appeal letter must be submitted within thirty (30) calendar days of the date of the termination letter. Appeals should be mailed to:

Division of Medicaid
Office of Appeals
550 High Street, Suite 1000
Jackson, MS 39201

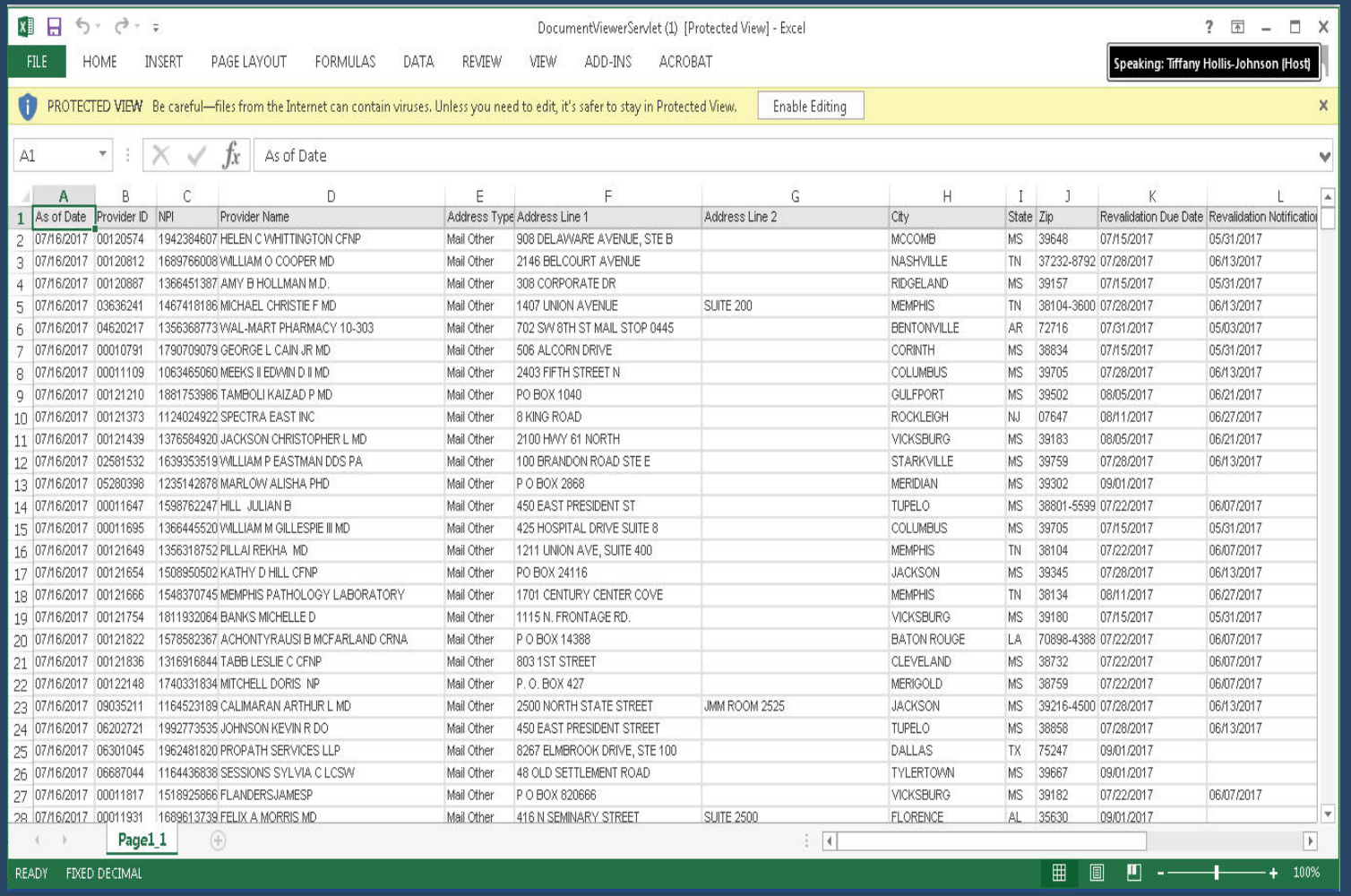
Six Month Provider Revalidation Due List



Six Month Provider Revalidation Due List



Six Month Provider Revalidation Due List



DocumentViewerServlet (1) [Protected View] - Excel

FILE HOME INSERT PAGE LAYOUT FORMULAS DATA REVIEW VIEW ADD-INS ACROBAT

Speaking: Tiffany Hollis-Johnson [Host]

PROTECTED VIEW Be careful—files from the Internet can contain viruses. Unless you need to edit, it's safer to stay in Protected View. Enable Editing

A1 | As of Date

As of Date	Provider ID	NPI	Provider Name	Address Type	Address Line 1	Address Line 2	City	State	Zip	Revalidation Due Date	Revalidation Notificatio
07/16/2017	00120574	1942384607	HELEN C WHITTINGTON CFNP	Mail Other	908 DELAWARE AVENUE, STE B		MCCOMB	MS	39648	07/15/2017	05/31/2017
07/16/2017	00120812	1689766008	WILLIAM O COOPER MD	Mail Other	2146 BELCOURT AVENUE		NASHVILLE	TN	37232-8792	07/28/2017	06/13/2017
07/16/2017	00120887	1366451387	AMY B HOLLMAN M.D.	Mail Other	308 CORPORATE DR		RIDGELAND	MS	39157	07/15/2017	05/31/2017
07/16/2017	03636241	1467418186	MICHAEL CHRISTIE F MD	Mail Other	1407 UNION AVENUE	SUITE 200	MEMPHIS	TN	38104-3600	07/28/2017	06/13/2017
07/16/2017	04620217	1356368773	WAL-MART PHARMACY 10-303	Mail Other	702 SW 8TH ST MAIL STOP 0445		BENTONVILLE	AR	72716	07/31/2017	05/03/2017
07/16/2017	00010791	1790709079	GEORGE L CAIN JR MD	Mail Other	506 ALCORN DRIVE		CORINTH	MS	38834	07/15/2017	05/31/2017
07/16/2017	00011109	1063465060	MEEKS II EDWIN D II MD	Mail Other	2403 FIFTH STREET N		COLUMBUS	MS	39705	07/28/2017	06/13/2017
07/16/2017	00121210	1881753986	TAMBOLI KAIZAD P MD	Mail Other	PO BOX 1040		GULFPORT	MS	39502	08/05/2017	06/21/2017
07/16/2017	00121373	1124024922	SPECTRA EAST INC	Mail Other	8 KING ROAD		ROCKLEIGH	NJ	07647	08/11/2017	06/27/2017
07/16/2017	00121439	1376584920	JACKSON CHRISTOPHER L MD	Mail Other	2100 HWY 61 NORTH		VICKSBURG	MS	39183	08/05/2017	06/21/2017
07/16/2017	02581532	1639353519	WILLIAM P EASTMAN DDS PA	Mail Other	100 BRANDON ROAD STE E		STARKVILLE	MS	39759	07/28/2017	06/13/2017
07/16/2017	05280398	1235142878	MARLOW ALISHA PHD	Mail Other	P O BOX 2868		MERIDIAN	MS	39302	09/01/2017	
07/16/2017	00011647	1598762247	HILL JULIAN B	Mail Other	450 EAST PRESIDENT ST		TUPELO	MS	38801-5599	07/22/2017	06/07/2017
07/16/2017	00011695	1366445520	WILLIAM M GILLESPIE III MD	Mail Other	425 HOSPITAL DRIVE SUITE 8		COLUMBUS	MS	39705	07/15/2017	05/31/2017
07/16/2017	00121649	1356318752	PILLAI REKHA MD	Mail Other	1211 UNION AVE, SUITE 400		MEMPHIS	TN	38104	07/22/2017	06/07/2017
07/16/2017	00121654	1508950502	KATHY D HILL CFNP	Mail Other	PO BOX 24116		JACKSON	MS	39345	07/28/2017	06/13/2017
07/16/2017	00121666	1548370745	MEMPHIS PATHOLOGY LABORATORY	Mail Other	1701 CENTURY CENTER COVE		MEMPHIS	TN	38134	08/11/2017	06/27/2017
07/16/2017	00121754	1811932064	BANKS MICHELLE D	Mail Other	1115 N. FRONTAGE RD.		VICKSBURG	MS	39180	07/15/2017	05/31/2017
07/16/2017	00121822	1578582367	ACHONTYRAUSI B MCFARLAND CRNA	Mail Other	P O BOX 14388		BATON ROUGE	LA	70898-4388	07/22/2017	06/07/2017
07/16/2017	00121836	1316916844	TABB LESLIE C CFNP	Mail Other	803 1ST STREET		CLEVELAND	MS	38732	07/22/2017	06/07/2017
07/16/2017	00122148	1740331834	MITCHELL DORIS NP	Mail Other	P. O. BOX 427		MERIGOLD	MS	38759	07/22/2017	06/07/2017
07/16/2017	09035211	1164523189	CALIMARAN ARTHUR L MD	Mail Other	2500 NORTH STATE STREET	JMM ROOM 2525	JACKSON	MS	39216-4500	07/28/2017	06/13/2017
07/16/2017	06202721	1992773535	JOHNSON KEVIN R DO	Mail Other	450 EAST PRESIDENT STREET		TUPELO	MS	38858	07/28/2017	06/13/2017
07/16/2017	06301045	1962481820	PROPATH SERVICES LLP	Mail Other	8267 ELMBROOK DRIVE, STE 100		DALLAS	TX	75247	09/01/2017	
07/16/2017	06687044	1164436838	SESSIONS SYLVIA C LCSW	Mail Other	48 OLD SETTLEMENT ROAD		TYLERTOWN	MS	39667	09/01/2017	
07/16/2017	00011817	1518925866	FLANDERSJAMESP	Mail Other	P O BOX 820666		VICKSBURG	MS	39182	07/22/2017	06/07/2017
07/16/2017	00011931	1689613739	FELIX A MORRIS MD	Mail Other	416 N SEMINARY STREET	SUITE 2500	FLORENCE	AL	35630	09/01/2017	

Page1_1

READY FIXED DECIMAL 100%

Claims Timely filing

(Administrative code Part 200; Chapter 1; Rules 1.6, 1.7 and 1.8)

Effective July 1, 2019

MISSISSIPPI DIVISION OF MEDICAID

Timely Filing
Fee-For-Service Claims

42 C.F.R. § 447.45 (d)(1) "*The Medicaid agency must require providers to submit all claims no later than 12 months from the date of service.*"

- Claims filed within three-hundred sixty-five (365) calendar days from the initial date of service, but denied, can be resubmitted with the transaction control number (TCN) from the original denied claim. The original TCN must be placed in the appropriate field on the resubmitted claim and be received by the Division of Medicaid within three-hundred and sixty-five (365) days from the date of the submittal of the original claim.
- If a provider is unable to submit a claim within three-hundred sixty-five (365) days from the date of service due to retroactive beneficiary eligibility, claims must be submitted within sixty (60) days of the eligibility determination.
- Claims by newly enrolled providers must be submitted within three hundred sixty-five (365) calendar days from the date of service and must be for services provided on or after the effective date of the provider's enrollment.

Timely Filing – Crossover Claims

Medicare crossover claims for coinsurance and/or deductible must be filed with DOM within 180 days of the Medicare Paid Date.

- Providers may resubmit a corrected claim within 180 days of the Medicare paid date.
- Providers may request an Administrative Review within thirty (30) calendar days of a denied Medicare crossover claim once the 180 day timely filing has been met.
- Providers are encouraged to submit a corrected claim within 180 days of the Medicare paid date if the claim can be corrected.

Administrative Claim Review

Providers may request an Administrative Review of a claim when:

- A beneficiary's retroactive eligibility prevents the provider from filing the claim timely and the provider submits the claim within sixty (60) days of the beneficiary's eligibility determination,
- The Division of Medicaid adjusts claims after timely filing and timely processing deadlines have expired, or
- The provider has submitted a Medicare crossover claim within one-hundred and eighty (180) days of the Medicare paid date and the provider is dissatisfied with the disposition of the claim.

Administrative Claims Review

Requests for Administrative Reviews must be submitted to the Office of Appeals at the Division of Medicaid and must include:

- Documentation of timely filing or documentation that the provider was unable to file the claim timely due to the beneficiary's retroactive eligibility,
- Documentation supporting the reason for the Administrative Review, and
- Other documentation as required or requested by the Division of Medicaid.
- Submit Administrative Reviews to:

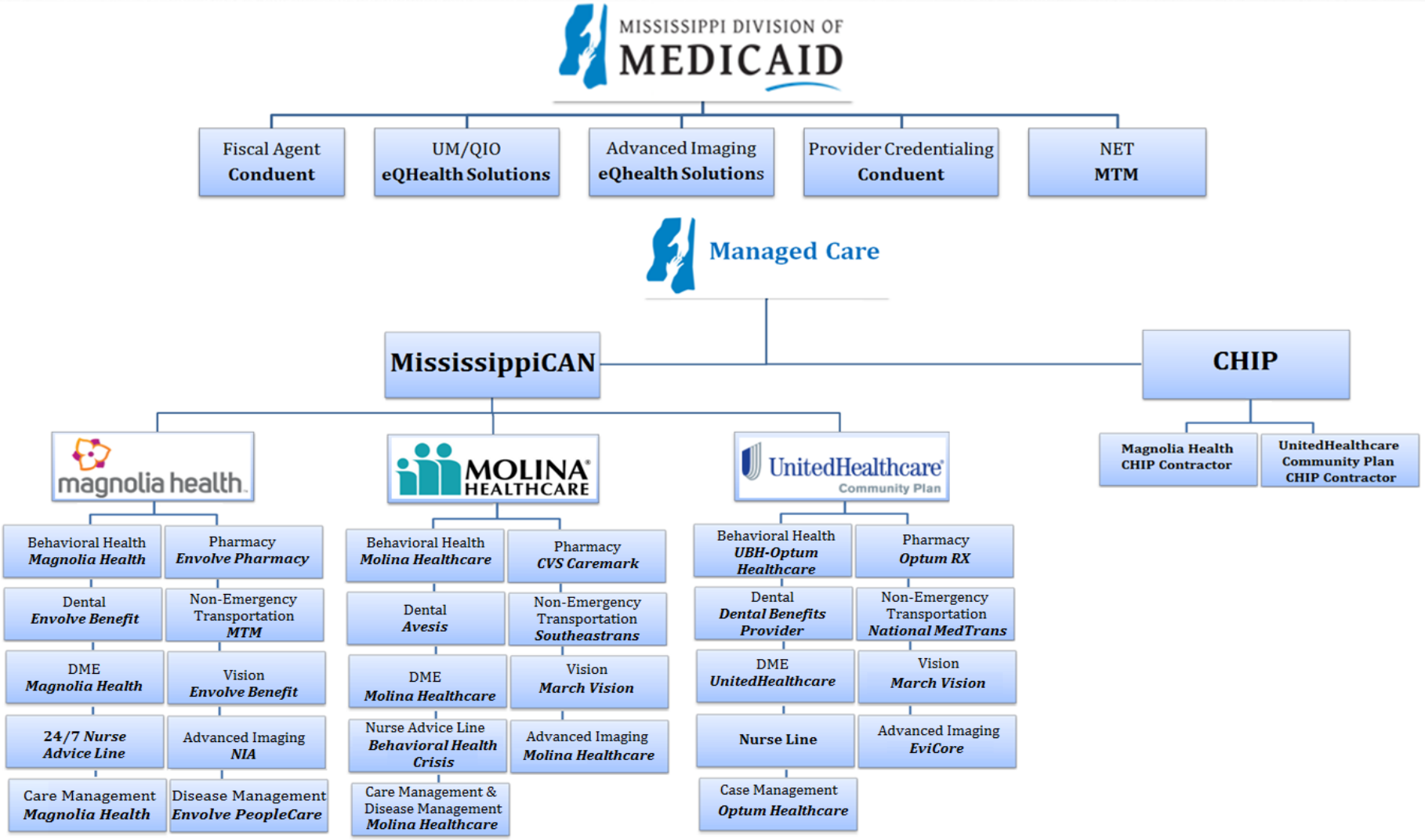
Division of Medicaid
Attention: Office of Appeals
550 High Street, Suite 1000
Jackson, MS 39201

Phone: **601-359-6050**

Fax: **601-359-9153**

Managed Care Overview

Medicaid Organizational Chart
Effective October 1, 2018



MISSISSIPPI DIVISION OF MEDICAID	magnolia health	MOLINA HEALTHCARE	UnitedHealthcare Community Plan	CHIP Children's Health Insurance Plan
Division of Medicaid Toll Free: 1-800-421-2408 Local: 601-359-6050 www.medicaid.ms.gov UM/QIO **eQHealth Soulutions** Toll Free: 1-866-740-2221 Local: 601-359-6353 Advanced Imaging **eQHealth Soulutions** Toll Free: 1-877-791-4106 Fiscal Agent and Provider Credentialing **Conduent** Toll Free: 1-800-884-3222 Non-Emergency Transportation **MTM** Toll Free: 1-866-331-6004	**Magnolia Health** Toll Free: 1-866-912-6285 www.magnoliahealthplan.com Behavioral Health **Magnolia** Toll Free: 1-866-912-6285 Pharmacy **Envolve Pharmacy Solutions** Toll Free: 1-800-460-8988 Dental **Envolve Benefit Options - Dental** Toll Free: 1-844-464-5636 Non-Emergency Transportation **MTM** Toll Free: 1-866-331-6004 Vision **Envolve Benefit Options - Vision** Toll Free: 1-800-531-2818 Disease Management **Envolve PeopleCare™** Toll Free: 1-866-912-6285 DME **Magnolia** Toll Free: 1-866-912-6285 **EPSDT/ Well-Child Care Services** 1 -866-912-6285 **After-Hours Support & Nurse Advice Line** Toll Free: 1-866-912-6285	**Molina Healthcare of Mississippi** Toll Free: (844) 809-8438 www.molinahealthcare.com/ Behavioral Health: **Molina Healthcare of Mississippi** Toll Free: (844) 826-4335 Pharmacy **CVS Caremark** Toll Free: (844) 826-4335 Dental **Avesis** Toll Free: 833-282-2419 Toll Free: (844) 826-4335 Non-Emergency Transportation **Southeastrans** Toll Free: (855) 391-2355 Toll Free: (844) 826-4335 DME **Molina Healthcare of Mississippi** Toll Free: (844) 826-4335 Vision **March Vision** Toll Free: (844) 606-2724 Toll Free: (844) 826-4335 **Care Management & Disease Management** Toll Free: (844) 826-4335 Advanced Imaging **Molina Healthcare of Mississippi** Toll Free: (844) 826-4335 **Nurse Advice Line/ Behavioral Health Crisis** Toll Free: (888) 275-8750	**UnitedHealthcare Community Plan** Toll Free: 1-877-743-8731 www.uhccommunityplan.com Behavioral Health **UBH-Optum Healthcare** MSCAN: 1-866-480-0074 CHIP: 1-800-992-9940 Pharmacy **Optum RX** Toll Free: 1-888-306-3243 Dental **Dental Benefit Prov** Toll Free: 1-800-508-4862 Non-Emergency Transportation **National MedTrans** Toll Free: 1-844-525-3085 Vision **March Vision** Toll Free: 1-877-743-8731 Case Management **Optum Health Care** Toll Free: 1-877-743-8731 **EviCore National** Toll Free: 1-866-889-8054 **NurseLine** MSCAN: 1-877-370-4009 CHIP: 1-877-410-0184	**Magnolia Health** Toll Free: 1-866-912-6285 www.magnoliahealthplan.com **UnitedHealthcare Community Plan** Toll Free: 1-800-992-9940 www.uhccommunityplan.com

Managed Care Contact Information

Enrollment & Eligibility	**Charlotte McNair** Telephone Number: 601-359-5785 Fax Number: 601-359-5252 *Charlotte.McNair@medicaid.ms.gov*
Member Issues	**Michelle Robinson** Telephone Number: 601-359-9131 Fax Number: 601-359-5252 *Michelle.Robinson@medicaid.ms.gov*
Provider Issues	**Tanya Stevens** Telephone Number: 601-359-4143 Fax Number: 601-359-5252 *Tanya. Stevens@medicaid.ms.gov*

For questions regarding MississippiCAN or CHIP please view the website at https://medicaid.ms.gov/programs/managed-care/.

Managed Care Inquires and Complaints

Please submit MississippiCAN/ CHIP inquires or complaints with the below detailed information:

Fax: 601-359-5252

Mail: Division of Medicaid
Office of Coordinated Care
550 High Street
Jackson, MS 39201

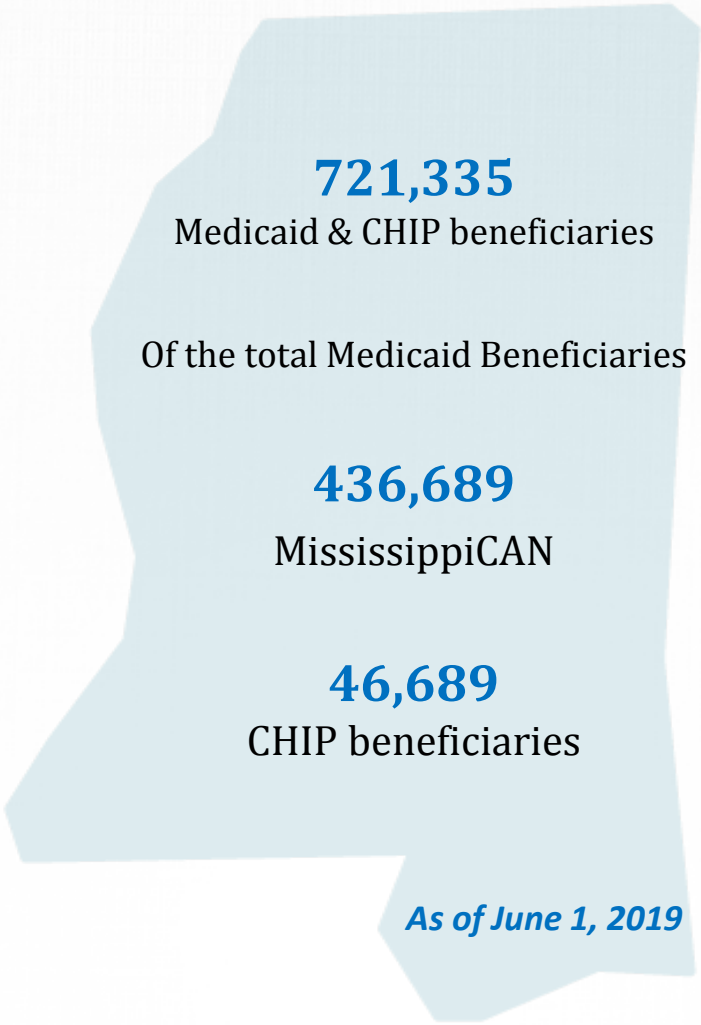
Managed Care Inquiries and Complaints	
Date	
Provider Name	
Provider ID Number	
Facility Name	
Contact Person	
Telephone Number	
Fax Number	
Beneficiary Name	
Beneficiary ID Number	
Telephone Number	
PLEASE PROVIDED DETAILED QUESTIONS AND/OR COMPLAINTS	

Goals of MississippiCAN Program

Mississippi Coordinated Access Network (MississippiCAN) implemented on January 1, 2011 is a statewide care coordination program designed to:

- Improve beneficiary access to needed medical services;
- Improve the quality of care; and
- Improve program efficiencies as well as cost effectiveness

MississippiCAN and CHIP Enrollment Statistics



721,335
Medicaid & CHIP beneficiaries

Of the total Medicaid Beneficiaries

436,689
MississippiCAN

46,689
CHIP beneficiaries

As of June 1, 2019

Evolution of MississippiCAN Program

2009

- Mississippi Medicaid Managed Care approved by Legislature

January 1, 2011

- Mississippi Coordinated Access Network (**MississippiCAN)** Go Live Medicaid disabled members were enrolled, including SSI, Disabled Children Living at Home, Working Disabled, CWS Foster Care, and Breast and Cervical Cancer member.

December 1, 2012

- MississippiCAN Expansion, and carve-out of Hemophilia
- MississippiCAN population became mandatory, except disabled children MississippiCAN population expanded to include Pregnant Women and Infants, all Foster Care children, and Medical Assistance adults.
- MississippiCAN expanded services to include Behavioral Health.

July 1, 2014

- MississippiCAN expanded contract
- MississippiCAN expanded services to include non-emergency transportation

Evolution of MississippiCAN Program

December 1, 2014

- MississippiCAN population expanded to include Quasi-CHIP children, who were formerly eligible for CHIP

January 1, 2015

- Mississippi CHIP program delivery system was changed from one vendor to a managed care delivery system with two vendors, CCOs.

July 1, 2015

- MississippiCAN population expanded services to include non-disabled Medical Assistance Children

December 1, 2015

- MississippiCAN expanded services to include Inpatient Hospital Services/Long Term Accute Care (LTAC), and deemed Newborns enrolled the month of birth.
- Also, case management and ancillary services (e.g. physician, pharmacy) for PRTF residents.

Evolution of MississippiCAN Program

July 1, 2017

- MississippiCAN new contract

July 1, 2018 to August 31, 2018

- Special Open Enrollment period allowing members to choose between the three CCOs. This replaces the Annual Open Enrollment period from October to December for MississippiCAN.

October 1, 2018

- Effective date on which MississippiCAN members will receive services from three CCOs – Magnolia Health, Molina Healthcare, and UnitedHealthcare.
- MYPAC and PRTF Facility services were added to MississippiCAN.

2019

- New CHIP Contract
- CHIP members will receive services from two CCOs – UnitedHealthcare and Molina Healthcare.

OFFICE OF THE GOVERNOR | MISSISSIPPI DIVISION OF MEDICAID 52

Mississippi Managed Care Overview

Legislative Updates

- **SB 2268 Mental Health Services**
- During the 2019 legislative session, lawmakers passed Senate bill (SB) 2268, which authorizes the Mississippi Division of Medicaid (DOM) to reimburse for psychiatric services provided to Medicaid beneficiaries in any free-standing acute care psychiatric hospital in the state.

Beneficiaries Not Eligible for MississippiCAN

Not Eligible for MississippiCAN
Hemophilia diagnosis and treatment
Dual Eligible (Medicare/Medicaid)
Waiver program enrollees (ex. HCBS, TBI, IL, etc.)
Institutionalized Residents (ex. Nursing Facility, ICF-MR, Correctional Facilities, etc.)
Beneficiaries currently with inpatient hospital stays
American Indians *(They may choose to opt into the program)*

Who is eligible for MississippiCAN?

CATEGORY OF ELIGIBILITY	AGE	POPULATION
SSI- Supplemental Security Income	19 - 65	Mandatory
SSI- Supplemental Security Income	0 - 19	Optional
DCLH- Disabled Child Living at Home	0 - 19	Optional
CPS- Foster Care Children IV-E	0 - 19	Optional
CPS –Foster Care Children CWS	0 - 19	Optional
Working Disabled	19 - 65	Mandatory
Breast and Cervical Cancer	19 - 65	Mandatory
Parent and Care Takers (TANF)	19 - 65	Mandatory
Pregnant Women (below 194% FPL)	8 - 65	Mandatory
Newborns (below 194% FPL)	0 - 1	Mandatory
Children	1 - 19	Mandatory
Children (< age 6) (=143% FPL)	1 - 5	Mandatory
Children (< age 19) (=100% FPL)	6 - 19	Mandatory
Quasi-CHIP (100% - 133% FPL)	6 - 19	Mandatory

Optional Population may return to regular Medicaid. Mandatory Population may switch between CCOs. Note: Always check eligibility on the Date of Service to ensure submission to correct payer by methods below:	**Telephone 1-800-884-3222 Envision Web Portal at new address www.ms-medicaid.com**

MississippiCAN Enrollment

CATEGORY OF ELIGIBILITY	AGE	POPULATION
SSI- Supplemental Security Income	19 - 65	Mandatory
Working Disabled	19 - 65	Mandatory
Breast and Cervical Cancer	19 - 65	Mandatory
Parent and Care Takers (TANF)	19 - 65	Mandatory
Pregnant Women (below 194% FPL)	8 - 65	Mandatory
Newborns (below 194% FPL)	0 - 1	Mandatory
Children	1 - 19	Mandatory
Children (< age 6) (=143% FPL)	1 - 5	Mandatory
Children (< age 19) (=100% FPL)	6 - 19	Mandatory
Quasi-CHIP (100% - 133% FPL)	6 - 19	Mandatory

Mandatory Population:

- These beneficiaries in above categories are required to be enrolled in the program.
- Beneficiaries are encouraged to check with their doctor to see which plan they accept. They mark the CCO of their choice on the back of this letter.
- If you DOM does not receive enrollment form in 30 days selecting a choice, a CCO will be picked for them. Beneficiaries will have 90 days to switch CCOs.
- After the 90 days they will be locked into the program and will not be eligible to change from CCOs or “opt out” except during annual open enrollment.

MississippiCAN Enrollment

CATEGORY OF ELIGIBILITY	AGE	POPULATION
SSI- Supplemental Security Income	0 - 19	Optional
DCLH- Disabled Child Living at Home	0 - 19	Optional
CPS- Foster Care Children IV-E	0 - 19	Optional
CPS –Foster Care Children CWS	0 - 19	Optional

Optional Population:

- These beneficiaries do not have to join the MississippiCAN program. They may choose to keep regular Medicaid.
- If beneficiaries do not want to join, they must put a check mark by “Opt Out” on the form on the back of this letter.
- If you DOM does not receive enrollment form in 30 days selecting a choice, a CCO will be picked for them.
- Beneficiaries will have 90 days to pick a different CCO or to “opt out” of the program.
- After the 90 days they will be locked into the program and will not be eligible to change from CCOs or “opt out” except during annual open enrollment.

Open Enrollment

MississippiCAN and CHIP

- MississippiCAN and CHIP Open Enrollment is available to members from October 1 through December 15 each year.
- Beneficiaries can only switch once during the initial 90 days after CCO assignment.
- DOM will only acknowledge the first open enrollment form submitted.
- If the member calls stating they need an enrollment form direct them to the Office of Coordinated Care at:

  Toll Free: 1-800-421-2408 or
  Local: 601-359-3789

Eligibility Re-certifications and Updates

- MississippiCAN beneficiaries whose **Medicaid eligibility has ended or is about to end**, the 20th of each month is the deadline for the Medicaid Regional Offices to approve and/or reinstate to ensure that beneficiaries remain with MSCAN for the 1st day of the next effective month.

  *(**Example:** A beneficiary was approved/reinstated for Medicaid on 6.11.2019. The beneficiary is then auto assigned to the selected plan of choice on the initial enrollment form or auto assigned to a CCO assignment 7.1.2018.)*

- MississippiCAN beneficiaries whose Medicaid eligibility has ended or is about to end, and Regional Offices approve and/ or reinstate is **after the 20th of the month**, then the beneficiaries will return to regular Medicaid for a month before assignment to MSCAN CCO.

  *(**Example:** A beneficiary was approved/reinstated for Medicaid on 6.21.2019. The beneficiary will go back to fee for service Medicaid for a month and will be assigned to selected plan of choice on the initial enrollment form or auto assigned to a CCO assignment 8.1.2019.*

Eligibility Re-Certifications and Updates

- If beneficiaries have a temporary **loss of eligibility of <u>less than</u> 60 days**, then DOM will automatically re-assign beneficiaries into the CCO in which beneficiaries were most recently assigned.
- If beneficiaries have a temporary **loss of eligibility of <u>more than</u> 60 days**, then DOM will not automatically re-assign beneficiaries into the CCO in which beneficiaries were most recently assigned.
- When beneficiaries go back to regular Medicaid due to loss of eligibility and reinstatements, they will have to pay the **Medicaid co-pay** for office visits and medication.

Beneficiaries Rights

- Please **do not select a CCO for beneficiaries.** It is the responsibility of the beneficiary to make a choice, sign enrollment form, and submit to DOM within the requested time frame.
- The **member cannot be balance billed for any denied charges** under circumstances including but not limited to failure to obtain a notification or prior authorization, either prospectively or retrospectively, clinical or administrative denial of the claim or service.
  - *Per the **Medicaid Provider Agreement** and the **Administrative Code**, the Medicaid Provider agrees to accept as payment in full the amount paid by the Medicaid program for Medicaid covered services with the exception of authorized deductibles, co-insurance, and co-payments.*
- **General Provider Information. Rule 3.8**

  Charges Not Beneficiary's Responsibility

https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-200.pdf

- Members may file grievances or appeals of any dissatisfaction to the CCOs.

magnolia health™

Managed Care Overview

“Transforming the health of the community one person at a time”

8/7/2019

Magnolia Health Purpose

magnolia health

Transforming the health of the community one person at a time

OUR MISSION

Better health outcomes at lower costs

OUR BRAND PILLARS

Focus on Individuals + Active Local Involvement + Whole Health

OUR BELIEFS

- We believe in treating the whole person, not just the physical body.
- We believe treating people with kindness, respect and dignity empowers healthy decisions.
- We believe we have a responsibility to remove barriers and make it simple to get well, stay well and be well.
- We believe local partnerships enables meaningful, accessible healthcare.
- We believe healthier individuals create more vibrant families and communities.

Magnolia Health Goals

Our goals and strategic initiatives directly align with *MississippiCAN Program Goals*:

Improve access to needed medical services

Improve quality of care and population health

Improve efficiencies and cost effectiveness

Magnolia Health Overview

- NCQA accredited
- Experienced MississippiCAN health plan since 2011
- Locally-based, locally led ***Mississippians serving Mississippians***
- Nationally supported through parent company

  Centene Corporation

St. Louis
based company founded in Milwaukee in 1984

30,900 employees

#124 on the Fortune 500 list

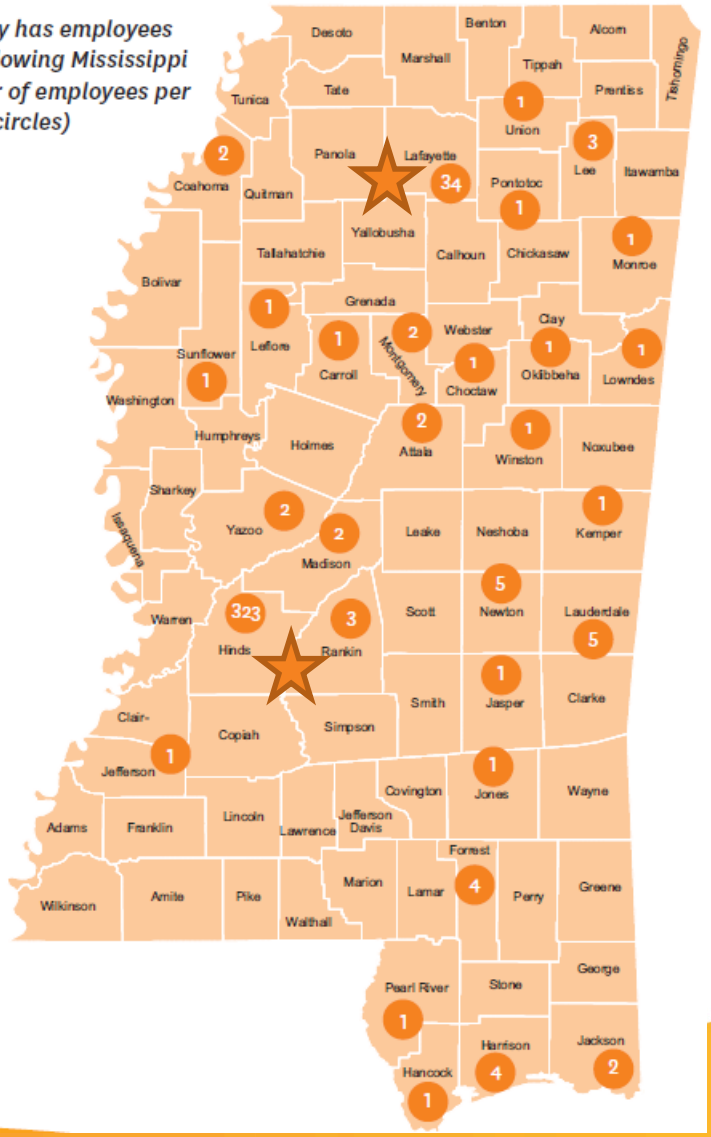
#4 Fortune's Fastest Growing Companies (2015)

Mississippians Serving Mississippians

- **Office Locations and Employment**
  - **Magnolia has two offices:** Jackson and Oxford
  - **Magnolia currently has over 400 employees in Mississippi**
    - Jackson – 323 employees
    - Oxford – 34 employees
    - Field-Based Staff – 56 employees
      - Care Management, MemberConnections, Provider Relations, Quality Improvement and Community Relations

Employees by County

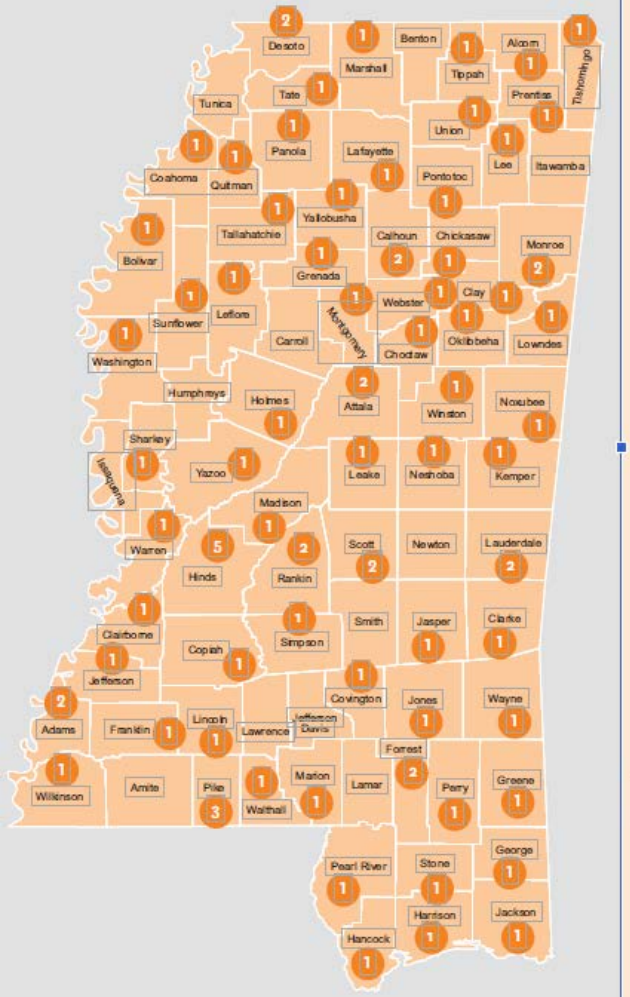
Magnolia currently has employees working in the following Mississippi counties: (number of employees per county in orange circles)



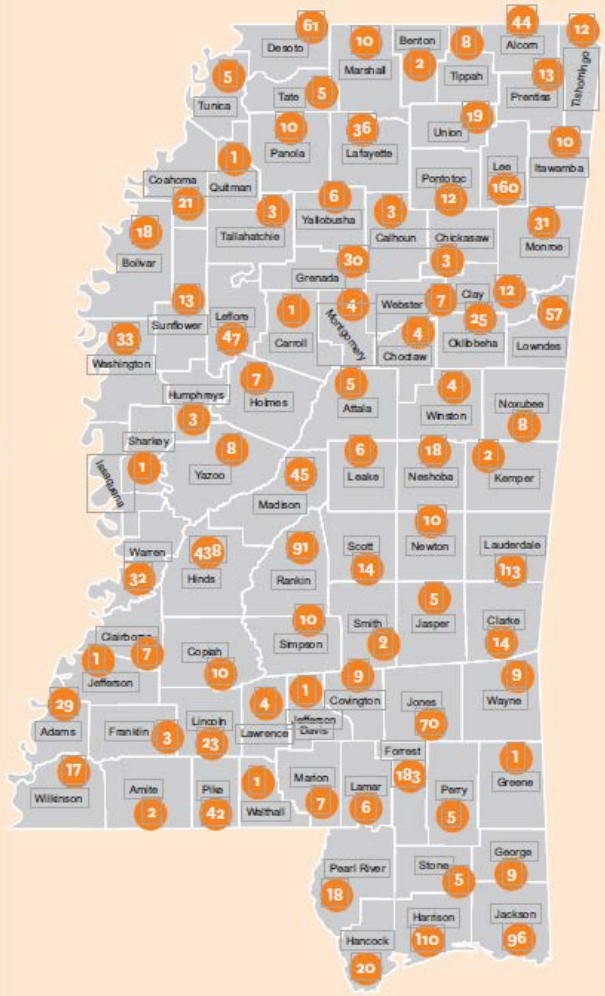
Provider Network

magnolia health™

Network Hospitals by County - 85



Network PCPs by County - 2,235



Magnolia's provider network meets or exceeds all network adequacy requirements.

Magnolia 2019

Membership		
magnolia health	MSCAN	227,587
	MSCHIP	18,002
ambetter. FROM | magnolia health	Ambetter	76,467
allwell. FROM | magnolia health	AllWell	797
Total Lives= 322,853		

Magnolia MSCHIP & CAN Services

magnolia health

Personalized Initial Outreach & Engagement

- Welcome Calls
- Member Experience Team
- MemberConnections®
- Community Events

Ongoing Engagement

- Care Gap Notifications
- Start Smart for Your Baby®
- After-Hours Outreach
- Social Media
- Appointment Wizard

Member Responsibility

- CentAccount®
- Weight and Fitness Programs
- Member Portal & Mobile App
- Tools & Training for Self-Management
- Peer Supports

magnolia health™

Joining Our Network

"Transforming the health of the community one person at a time"

8/7/2019

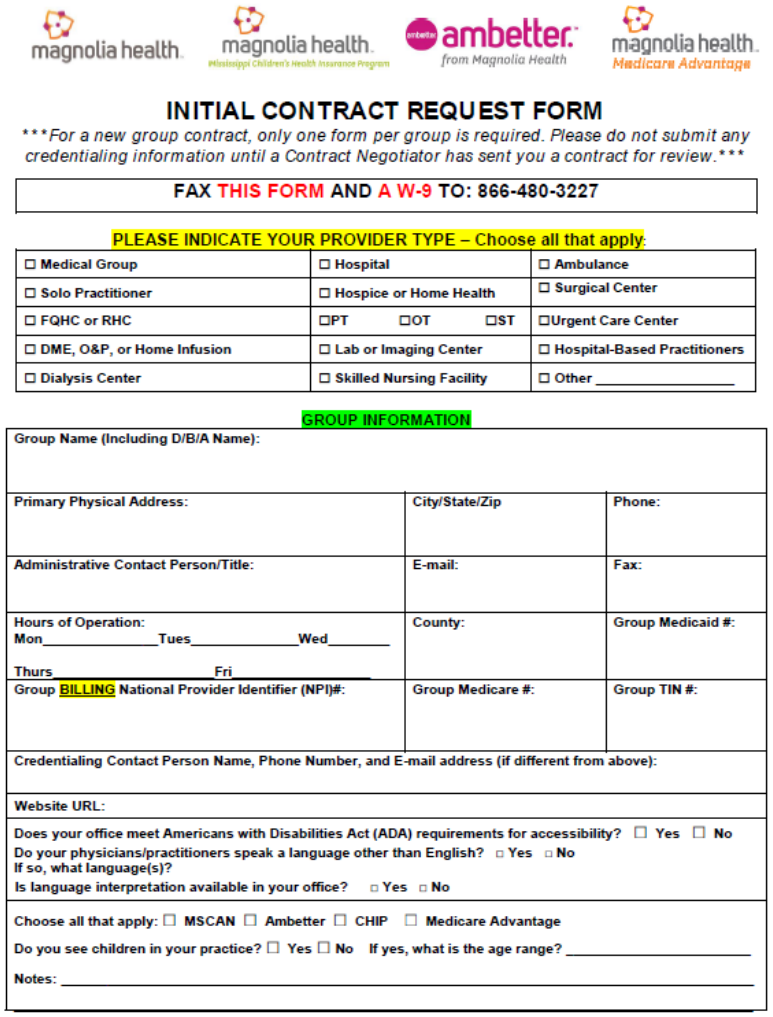
New Group Contract Process

- To begin the contracting process, complete an **Initial Contract Request Form** in its entirety.

- Please send it back to the Contracting department along with a current W9 to fax number 1-866-480-3227 or email to magnoliacontracting@centene.com

This form can be found on our website at: www.MagnoliaHealthPlan.com.

**NOTE: This form CANNOT be used to start the Credentialing process for individual physicians.*



magnolia health | magnolia health Mississippi Children's Health Insurance Program | ambetter from Magnolia Health | magnolia health Medicare Advantage

INITIAL CONTRACT REQUEST FORM

****For a new group contract, only one form per group is required. Please do not submit any credentialing information until a Contract Negotiator has sent you a contract for review.****

FAX THIS FORM AND A W-9 TO: 866-480-3227

PLEASE INDICATE YOUR PROVIDER TYPE – Choose all that apply:

☐ Medical Group	☐ Hospital	☐ Ambulance
☐ Solo Practitioner	☐ Hospice or Home Health	☐ Surgical Center
☐ FQHC or RHC	☐PT ☐OT ☐ST	☐Urgent Care Center
☐ DME, O&P, or Home Infusion	☐ Lab or Imaging Center	☐ Hospital-Based Practitioners
☐ Dialysis Center	☐ Skilled Nursing Facility	☐ Other _____

GROUP INFORMATION

Group Name (Including D/B/A Name):		
Primary Physical Address:	City/State/Zip	Phone:
Administrative Contact Person/Title:	E-mail:	Fax:
Hours of Operation: Mon_____Tues_____Wed_____ Thurs_____Fri_____	County:	Group Medicaid #:
Group BILLING National Provider Identifier (NPI)#:	Group Medicare #:	Group TIN #:
Credentialing Contact Person Name, Phone Number, and E-mail address (if different from above):		
Website URL:		
Does your office meet Americans with Disabilities Act (ADA) requirements for accessibility? ☐ Yes ☐ No Do your physicians/practitioners speak a language other than English? ☐ Yes ☐ No If so, what language(s)? Is language interpretation available in your office? ☐ Yes ☐ No		
Choose all that apply: ☐ MSCAN ☐ Ambetter ☐ CHIP ☐ Medicare Advantage Do you see children in your practice? ☐ Yes ☐ No If yes, what is the age range? _____ Notes: _____		

New Group Contract Process

magnolia health

Magnolia requires a contract be accompanied by:

Completed CAQH / Provider Data Form or Mississippi Uniform Credentialing Application (MUCA) for each practitioner that you want added to your contract.

Please ensure the required information below is updated in CAQH or attached with the MUCA:

- Current Attestation (signed within the last 90 days)
- Current Malpractice liability insurance face sheet
- Current license copy
- Current DEA certificate
- Current CLIA certificate (if applicable).
- W-9 form
- Ownership and Disclosure Form
- Collaborative Agreement (Nurse Practitioners and Physician Assistants)

NOTE: Please follow the checklist that is in the instruction letter that is forwarded with your contract.

Adding a New Practitioner

To add a new provider to an existing contract, submit the following documents:

- ✓ Provider Data Form
- ✓ Current licensure
- ✓ Collaborative practice agreement (Nurse Practitioners and Physician Assistant
- ✓ W-9
- ✓ Locations page

To add a new location to an existing contract, submit the following documents:

- ✓ Provider Update Form for contracted providers
- ✓ Locations Page
- ✓ W9

* Please submit all credentialing documents to Magnoliacredentialing@centene.com

magnolia health™

Prior Authorization

"Transforming the health of the community one person at a time"

8/7/2019

Pre-Auth Tool

Medicaid Pre-Auth

DISCLAIMER: All attempts are made to provide the most current information on the Pre-Auth Needed Tool. However, this does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the provider manual. If you are uncertain that prior authorization is needed, please submit a request for an accurate response.

Vision services, including all services rendered by an Optician, Ophthalmologist or Optometrist need to be verified by Envolve Vision
Dental services need to be verified by Envolve Dental
Behavioral Health/Substance Abuse need to be verified by Cenpatico
Complex imaging, MRA, MRI, PET, and CT Scans need to be verified by NIA

Non-participating providers must submit Prior Authorization for all services.
For non-participating providers, Join Our Network.

Basic laboratory chemistries and basic radiology do NOT require prior authorization for participating or non-participating providers.

Are Services being performed in the Emergency Department or Urgent Care Center, FQHC or RHC, or Family Planning services billed with a V25 to V25.9 diagnosis?

☐ Yes ☐ No

Types of Services	YES	NO
Is the member being admitted to an inpatient facility?	○	○
Are anesthesia services being rendered for pain management or dental surgeries?	○	○
Is the member receiving hospice services?	○	○
Are services other than DME, orthotics, prosthetics, and supplies, being rendered in the home?	○	○

To submit a prior authorization Login Here.

Where do I send my PA request?

Prior Authorization Form(s) can be located on our website at:

http://www.magnoliahealthplan.com/for-providers/provider-resources/

FAX

Requests can be faxed to:
1-877-291-8059 (MSCAN Inpatient)
1-877-650-6943 (MSCAN Outpatient)
1-855-684-6747 (CHIP)

WEB

Requests can be made securely at:
magnoliahealthplan.com/login/

Mail

Requests can be mailed to:
Magnolia Health Plan
Attn: Utilization Management
111 E. Capitol Street, Suite 500
Jackson, MS 39201

EMAIL

Requests can be emailed securely to:
magnoliaauths@centene.com

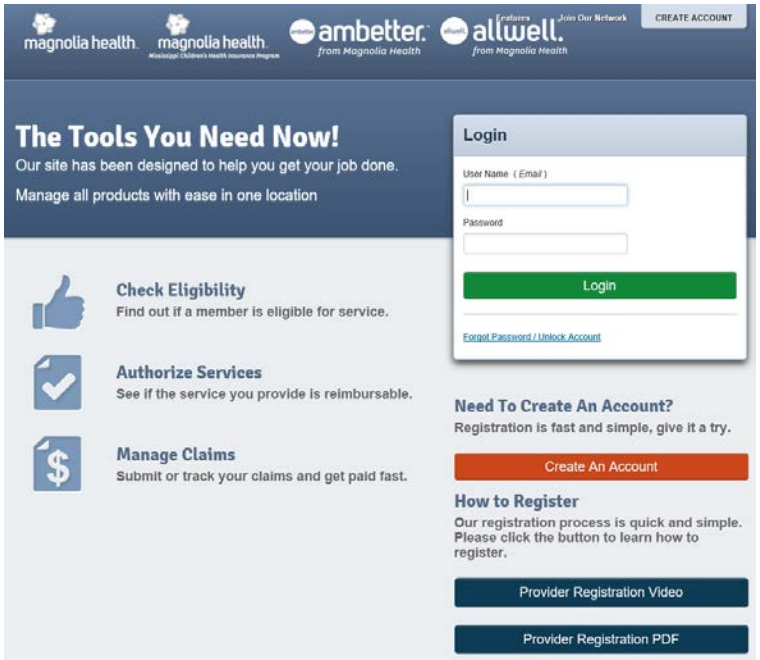
PHONE

Requests can be phoned in to:
1-866-912-6285 (MS CAN/CHIP)

How to Submit Electronic Claims

- **Electronic Claim Submission** – For a list of our EDI trading partners, please go to www.magnoliahealthplan.com > Provider Resources > Electronic Transactions.

- **Online (Secure Portal) Claim Submission** – For participating providers, you may request access to our secure site by registering for a user name and password at www.magnoliahealthplan.com



Pre-Service Review

- Prior to rendering services, providers should check the Pre-Auth Tool at www.magnoliahealthplan.com to determine if the code requires authorization.
- Authorization must be obtained prior to the delivery of services. Failure to obtain authorization may result in an administrative claim denial.

Post Service Review

- Requests for post service review will only be considered when prior authorization was not obtained due to extenuating circumstances.
- Post service review decisions and notifications will occur no later than fourteen (14) calendar days from the receipt of the request.

Concurrent Review

Concurrent review provides the opportunity to evaluate the ongoing medical necessity of care being provided and supports the health care provider in coordinating a member's care across the continuum of health care services.

Concurrent Review

111 E. Capitol Street, Suite 500
Jackson, MS 39201

PROVIDER NAME
ADDRESS
CITY, STATE, ZIP

Date

NOTIFICATION OF APPROVAL FOR REQUESTED INPATIENT SERVICES

RE: Member Name
MEMBER MEDICAID ID
MEMBER DOB

Dear: Provider

Magnolia Health is committed to assuring our member's receive medically necessary quality healthcare services. We are writing to inform you we have completed the request which is approved as follows:

REQUEST DATE: DATE
AUTHORIZATION NUMBER: IPXXXXXXXXX
SERVICING PROVIDER: PROVIDER NAME
DAYS AND/OR PROCEDURE AUTHORIZED: INPATIENT
AUTHORIZED SERVICE DATES: XX/XX/XXXX to XX/XX/XXXX
NEXT REVIEW DATE: XX/XX/XXXX

This letter was faxed to PROVIDER'S FAX NUMBER.

Authorization is based upon medical information provided. This authorization is not a guarantee of benefits or payment.

Please communicate all discharge planning needs to Magnolia Health to ensure quality transitional care and prevent re-hospitalization.

If you have any questions, please call Magnolia Health Provider Services at 1-866-912-6285 or (TDD/TTY) 1-877-725-7753.

Sincerely,

User

Coordination of PA's Between Other Payers

- In the event a member is transferring to Magnolia from another payer, Magnolia shall be responsible for the costs of continuation of medically necessary services.
- Magnolia will honor prior authorizations from Medicaid and MSCAN/CHIP CCO's.

PA Denials and Recourse

- **Peer to Peer**
  - Conducted by the Medical Director
  - To begin the process, call 1-866-912-6285 and ask to speak the UM Department
- **Appeal**
  - All appeal documents will be fully investigated
- **DOM State Fair Hearing**
  - A member or authorized representative may request a hearing if he or she is dissatisfied with the Adverse Benefit Determination

Prior Auth. Appeals Address

Prior authorization appeals should only be mailed to the address below if services have not been rendered.

Magnolia Health
Attn: Appeals Coordinator
111 East Capitol Street, Suite 500
Jackson, MS 39201
FAX 1-877-264-6519

State Fair Hearing

- A member or authorized representative may request a State Fair Hearing if he or she is dissatisfied with an Adverse Benefit Determination.
- The member can appeal to a State Fair Hearing only after the member has exhausted their appeal rights with Magnolia.
- The request for a State Fair Hearing must be made within one hundred and twenty (120) calendar days of the date of Magnolia's final decision.
- The process for filing a State Fair Hearing will be communicated to the member in the initial denial letter as well as the appeal resolution letter.

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Behavioral Health Prior Authorization

"Transforming the health of the community one person at a time"

8/7/2019

Inpatient and Outpatient

- Magnolia Health has adopted the *Mississippi Administrative Code* service descriptions and medical necessity guidelines for all community based services.

- Magnolia also utilizes *InterQual* Criteria for mental health for both adult and pediatric guidelines as it relates to parity services such as outpatient therapy.

- Medical Necessity criteria is reviewed on an annual basis by clinical leadership.

Please see Behavioral health provider manual here:

https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/Behavioral%20Health%20Provider%20Manual%20(PDF).pdf

Outpatient Behavioral Health Prior Authorizations

- Some behavioral health services require prior authorization. To check to see if pre-authorization is necessary, use our online tool. Standard prior authorization requests should be submitted for medical necessity as soon as the need for service is identified.

- Initial requests may be backdated one business day; requests for days beyond the one back day may be submitted to the retro appeals department at fax number: 1-866-714-7991. Concurrent requests for continued services may be submitted up to 21 days prior to the start of the new authorization. Example: A request was submitted on 5/31/19, could only request a start date of 5/30/19. Any services provided before that date would need to go to retro/appeals

- Authorization requests may be submitted by fax, or secure web portal and should include all necessary clinical information.

Inpatient Prior Authorization

Responsible for authorizing the following LOCs:

- Acute (IP) and Crisis Stabilization Unit (CSU)- requires authorization to be made within 48 hours of member admit
  - For acute services members are approved for 19 days if medical necessity is met
  - For CSU services members are approved for 5 days upon initial review pending medical necessity

- Psychiatric Residential Treatment Program (PRTF)- authorization can be completed up to 7 days prior to the date of admission.
  - Members are initially authorized for 30 days if medical necessity is met

Inpatient Prior Authorization (continued)

- Partial Hospitalization Program (PHP)- request are typically made within 24 hours of admit as this is an outpatient service
  - Members are approved for 5 days if medical necessity is met
- Electroconvulsive Therapy (ECT) request should be made prior to the start of treatment.
- Inpatient Utilization managers can be reached at AUGMississippium@cenpatico.com
- Provider manual https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/Behavioral%20Health%20Provider%20Manual%20(PDF).pdf
- Fax number is 1-866-535-6974

Appeals / Retro Overview

Purpose

Appeals Coordinators ensure appropriate and timely resolution of behavioral health medical necessity and benefit appeals, track and analyze appeals, identify opportunities for improvement, implement actions as needed, and re-measure to identify continued areas for improvement.

Communication

Appeals are received by the coordinators:

- ❑ Via mail
- ❑ Via email
- ❑ Via TruCare tasks (internal only)
- ❑ Via telephone

Appeal Coordinators Process:

Standard *(Pre and Post Service)*

- *Pre-service* appeal – a request to change an adverse determination for care or service that the organization must approve, in whole or in part, in advance of the enrollee obtaining care or services.
- *Post-service* appeal – a request to change an adverse determination for care or services that have already been received by the enrollee.

Expedited

- a request to change an adverse determination for urgent care.

Claims Appeal

- Appeals that are sent to be reviewed by the appeals department after a claim has been filed. These are submitted by the claims department.

Retroactive Authorization

- Retro reviews are requests after a service has been rendered and there is not a precertification on file.

Peer to Peer Requests

- Requests to speak to a physician after the determination has been made via notes.

What is Care Management?

Magnolia Care Management focuses on Prevention and Preventative Care by supporting and educating the member with closing their care gaps and making healthy choices.

Key Focus

Integrated Care Management

- Proactive outreach to members with multiple conditions
- Holistic Approach

Post Discharge Assessment

- For all members enrolled into care management and members who score 50 or higher on the readmission risk score, a post discharge assessment is completed following the hospital stay.

- This assessment asks questions about why the member went into the hospital and if they have a primary care provider. It goes into detail about their medications and asks about follow up care.

- Outreach is started within 72 hours of member discharge from the hospital.

- We have different types of collateral and mail out material such as disease specific education, NICU kits for our babies that are in the neonatal ICU, Sickle Cell kits to help manage our Sickle Cell members, a scale program for our CHF members, Inhalers/spacers for our Asthma members

The Golden 4

Care Management uses the premise of the “Golden 4” for all post discharge contact.

- 1) A PCP visit must be scheduled within 30 days of hospital discharge. For Behavioral Health discharges the visit should be scheduled within 7 days of facility discharge
- 2) Perform medication reconciliation
- 3) Assess and address any DME/Home Health Needs
- 4) Effective team communication & collaboration. This is to assure that the member is placed in the appropriate level of Care Management services, such as complex care management or care coordination.

With improved discharge planning, hospitals readmissions have decreased.

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Claims

“Transforming the health of the community one person at a time”

8/7/2019

How to Submit Paper Claims

- **Paper Claim Submission** – Paper Claims should be submitted to:

ATTN: Claims Department
P.O.Box 3090
Farmington, MO 63640-3825

Handwriting on a claim form or handwritten claims will be accepted.

Claims Submission

- We at Magnolia encourage our providers to file claims electronically using our Provider Secure Web Portal or by using one of our EDI trading partners. For a full list of these partners, please visit our website at

  https://www.magnoliahealthplan.com/providers/resources/electronic-transactions.html

- If you are experiencing issues or need assistance with EDI submissions, please reach out to:

Magnolia Health EDI Department
1-800-225-2573 extension 25525
EDIBA@centene.com

EFT/ERA

- We partner with PaySpan Health for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices (ERAs) at no cost. This service is provided at no cost to providers and allows online enrollment.

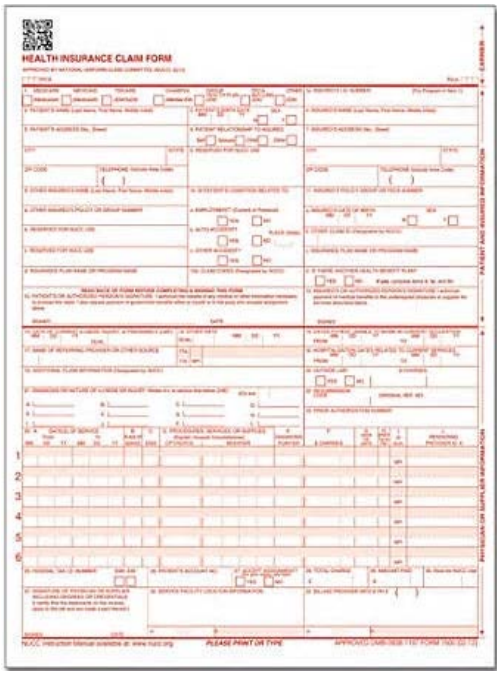
- Visit PaySpan's website for more information: www.payspanhealth.com

- Benefits of EFT Payments:
  - Receive payments faster
  - No snail mail
  - Electronic remittance
  - Safe and secure

For more information, contact PaySpan at 1-877-331-7154 or by e-mail providerssupport@payspanhealth.com

Claim Forms

Professional Claims – CMS 1500 form



Institutional Claims – UB-04 form

- Magnolia does not supply claim forms to providers.
- Providers should purchase these forms from a supplier of their choice.

Timely Filing Limitations

- **First time claims** - must submit claims within one hundred and eighty (180) calendar days of the date of service.

- **When Magnolia is the secondary payer** – must submit within three hundred and sixty five (365) calendar days of the final determination of the primary payer.

- **Corrected Claims and Reconsiderations** – must submit within ninety (90) calendar days from the issue date of notification of payment or denial.

- **Claim Appeals** – must submit within thirty days (30 days) of the notice of adverse benefit determination

Claims received after the time frames provided will be denied as untimely

Corrected Claim, Reconsideration, Claim Dispute

All requests for corrected claims, reconsiderations or claim disputes must be received within ninety (90) days of the last written notification of the denial or original submission date.

Corrected Claims	Reconsideration	Claim Dispute
•Submit via Secure Web Portal •Submit via an EDI Clearinghouse •Submit via paper claim: •Submit corrected claims to along with the original EOP to: **•Magnolia Health Plan** **•PO BOX 3090 (MSCAN)** **•PO BOX 5040 (CHIP)** **•Farmington, MO 63640**	•Written communication (i.e. letter) outlining disagreement of claim determination •Indicate "Reconsideration of (original claim number)" •Submit reconsideration to: **•Magnolia Health Plan** **•Attn: Reconsideration** **•PO BOX 3090 (MSCAN)** **•PO BOX 5040 (CHIP)** **•Farmington, MO 63640** **•If your claim denied for no authorization on file, please include the reason why a PA was not obtained in your request for reconsideration.**	•ONLY used when disputing determination of Reconsideration request •Must complete Claim Dispute form located on www.magnoliahealthplan.com •Include original request for reconsideration letter and the Plan response •Send Claim Dispute form and supporting documentation to: **•Magnolia Health Plan** **•Attn: Claim Dispute** **•PO BOX 3090 (MSCAN)** **•PO BOX 5040 (CHIP)** **•Farmington, MO 63640**

Claim Appeal

- **Claim Appeal** – A written request for review of an adverse benefit determination. Must be accompanied by a Claim Appeal Form. The Claim Appeal should be filed within thirty (30) calendar days of receiving Magnolia's notice of Adverse Benefit Determination.

Mailing Address:

Attn: Claim Appeal

P.O. BOX 3090

Farmington, MO 63640-3800

Top Issues

Issue	Resolution
Claim Denials Due to Authorization	✓ Obtain Authorization for services prior to rendering services. To determine if a service requires prior authorization, please visit https://www.magnoliahealthplan.com/providers/preauth-check.html ✓ The authorization and claim information must match: member's information, procedure code, date(s) of service, and the rendering provider's information must all match to prevent claim denial ✓ If the procedure code submitted at the time of the authorization differs from the services performed, contact provider services immediately to update the authorization; otherwise this may result in claim denials
Delay in updated Code Reimbursement	✓ Beginning 2019, Magnolia has received pricing information prior to the effective date and configuration was able to be deployed in advance.
Coding edit denials (see examples) • Unbundled • Place of service Mismatch • Incorrect CPT/HCPCS/Rev/Mod or unlisted code • Procedure code conflicts/ inconsistent with member's age or gender	✓ Magnolia administers edits based on CMS and NCCI for professional and outpatient facility claims. ✓ Review claim and ensure you are billing appropriately. If not, submit corrected claim. ✓ Providers should reference the most up-to-date sources for professional coding guidance prior to the submission of claims for reimbursement of covered services ✓ Review payment policies found on Magnolia Health Plan website: https://www.magnoliahealthplan.com/providers/resources/clinical-payment-policies.html

Top Issues

Issue	Resolution
Credentialing/ Enrollment	✓ Notify Magnolia Health Plan of changes with enrollment, such as: additions, changes, deletions of practitioners 90 days in advance. ✓ Submit clean Enrollment and Credentialing packets to MagnoliaCredentialing@Centene.com ✓ Be sure to submit W9 ✓ Nurse Practitioners require a Collaborative Agreement ✓ Signature on the Disclosure of Ownership Form ✓ All newly added practitioners require a full credentialing application which can be located on our website,www.magnoliahealthplan.com
Timely Filing for First time claims, Reconsiderations, corrected claims	✓ Submit first time claims within 180 calendar days of date of service ✓ Submit corrected claims/reconsiderations within 90 calendar days of claim determination
Claim completion Errors/ Rejected Claims	✓ If submitting claims electronically, complete a daily review your acceptance and claim status report for rejected claims. Timely filing is determined by the date Magnolia receives a clean claim. Rejected claims are not considered clean claims. ✓ Ensure all necessary claim form fields (loops or segments) are completed and no numbers are transposed.

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Contacts

“Transforming the health of the community one person at a time”

8/7/2019

Contact Information

- Magnolia Provider Services Line
  - Call: (866) 912-6285
  - Fax: (877) 811-5980
- Member Services Line
  - Call: (866) 912-6285
  - Fax: (877) 779-5219
- Authorizations/ Discharge Planning
  - Call: (866) 912-6285
  - Fax: (855)684) 6747
- Prior Authorization for Outpatient Services
  - Call: (866) 912-6285
  - Fax: (866) 399-0929
- Inpatient Admissions
  - Call: (866) 912-6285
  - Fax: (877) 291-8059
- EDI Department
  - Call: (800) 225-2573, ext. 25525
  - Email: EDIBA@centene.com
- PaySpan
  - Call: (877) 331-7154
- Envolve Dental and Vision
  - Call: (844) 464-5636
  - Fax: (844) 815-4448
  - Email: ProviderRelations@envolvehealth.com
- MTM (Non-Emergency Transportation)
  - Scheduling: (866) 331-6004
  - Complaint: (866) 436-0457
  - Where's My Ride: (866) 334-3794
- National Imaging Associates (NIA)
  - Call: (866) 912-6285
  - Online: www.RADMD.com
- Magnolia Contracting
  - Call: (866) 912-628
  - Email: MagnoliaContracting@Centene.com
- Magnolia Credentialing
  - Call: (866) 912-6285
  - Email: MagnoliaCredentailing@Centene.com

Molina Healthcare

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

About Molina Healthcare

Our Vision

We envision a future where everyone receives quality health care.

Our Mission

Our mission is to provide quality health services to people receiving government assistance.

About Molina Healthcare

We strive to be an exemplary organization. These are our values:

Caring
We care about those we serve and advocate on their behalf. We assume the best about people and listen so that we can learn.

Enthusiastic
We enthusiastically address problems and seek creative solutions.

Respectful
We respect each other and value ethical business practices.

Focused
We focus on our mission.

Thrifty
We are careful with scarce resources. Little things matter and the nickels add up.

Accountable
We are personally accountable for our actions and collaborate to get results.

Feedback
We strive to improve the organization and achieve meaningful change through feedback and coaching. Feedback is a gift.

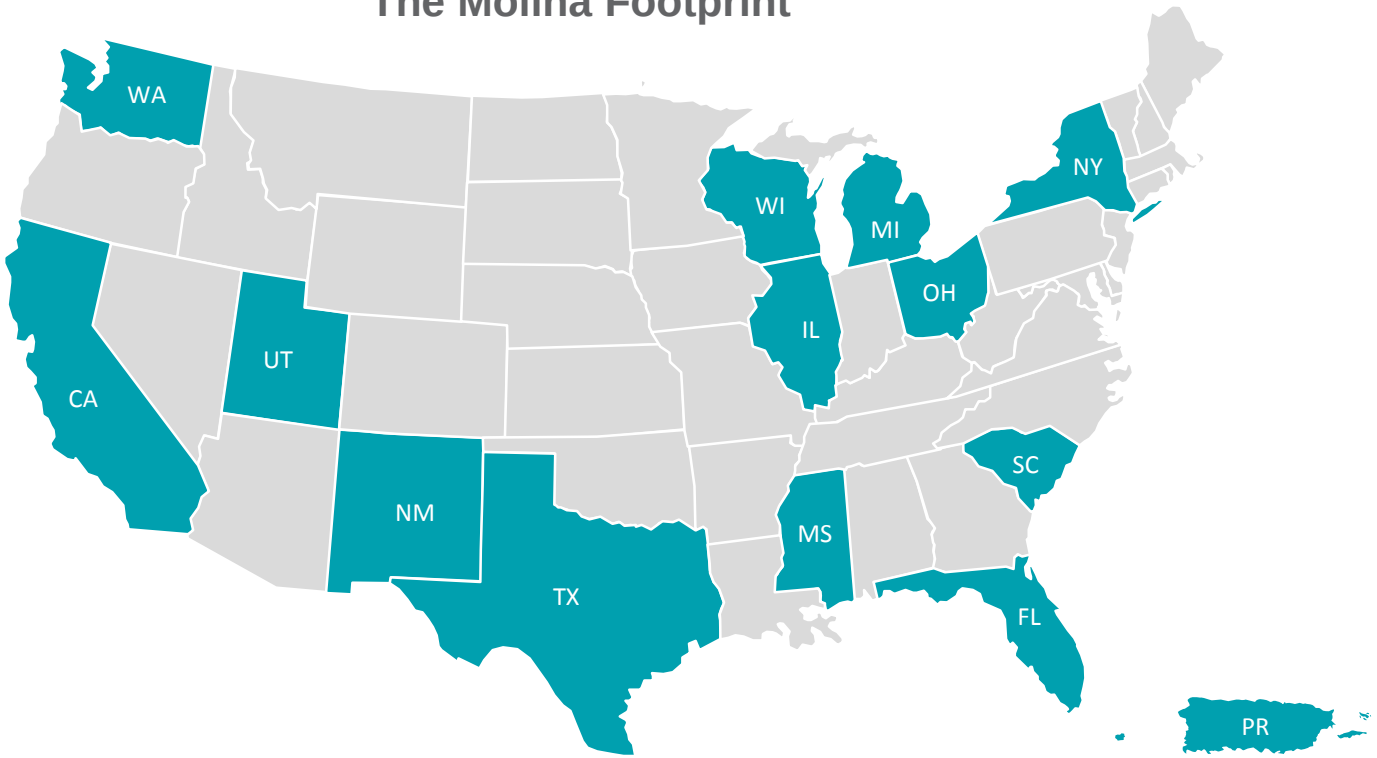
One Molina
We are one organization. We are a team.

We sustain our mission and invest in our organization by being profitable.

The Molina Story

In 1980, the late Dr. C. David Molina, founded Molina Healthcare with a single clinic and a commitment to provide quality healthcare to those most in need and least able to afford it. This commitment to providing access to quality care continues to be our mission today, just as it has been for the last 35 years.

The Molina Footprint

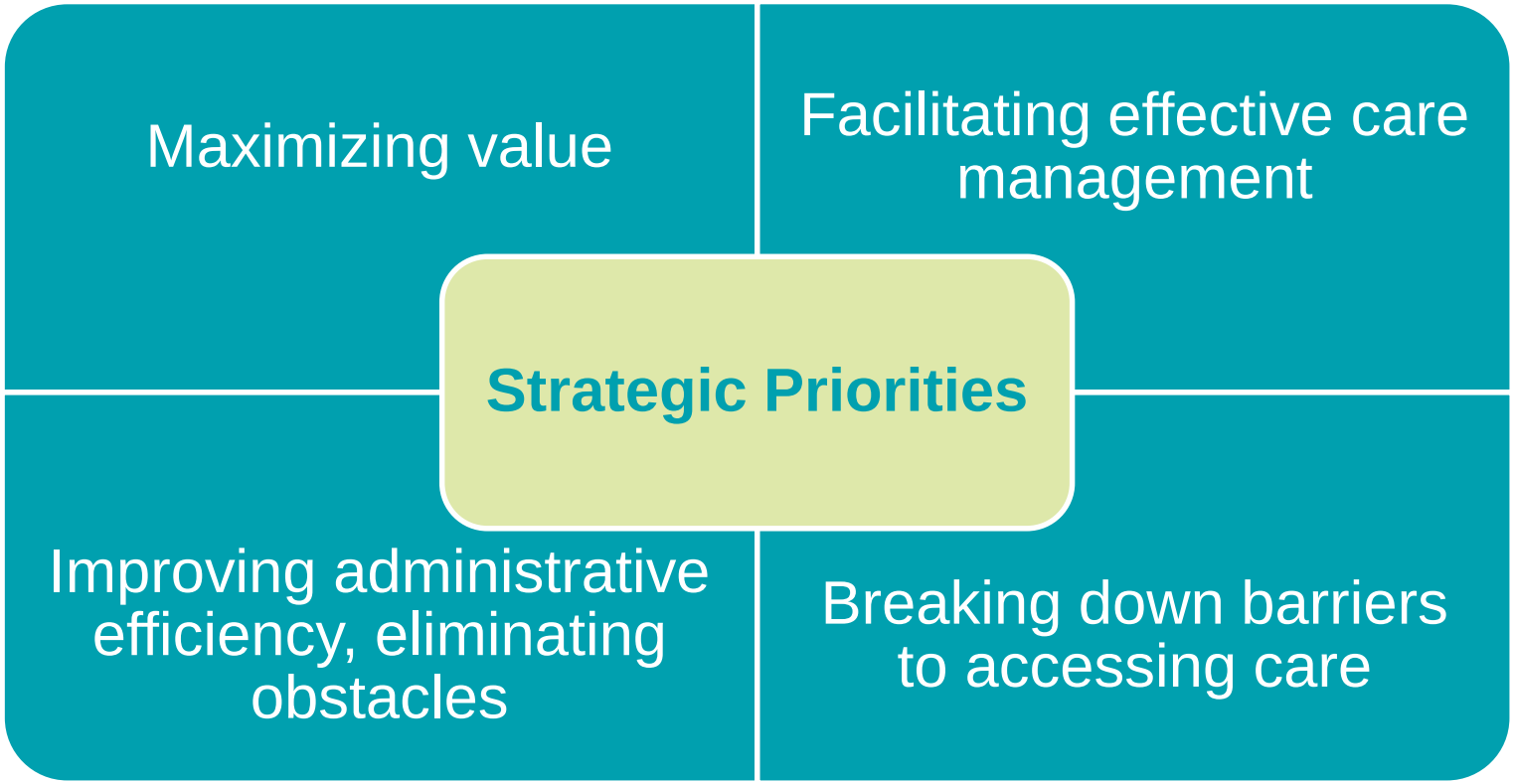


Recognized for Quality, Innovation and Success

- ✓ Molina Healthcare plans have been ranked among America's top Medicaid plans by U.S. News & World Report.
- ✓ FORTUNE 500 Company by Fortune Magazine
- ✓ Business Ethics magazine 100 Best Corporate Citizens.
- ✓ Alfred P. Sloan Award for Business Excellence in Workplace Flexibility in 2011.
- ✓ 11 of our 13 plans have earned the Multicultural Health Care Distinction from Robert Wood Johnson Foundation, for organizations that meet or exceed its rigorous requirements for providing care in a culturally-sensitive manner.
- ✓ Molina Healthcare is a leader in quality with the majority of its health plans accredited and rated by the National Committee for Quality Assurance (NCQA).

Strategic Priorities

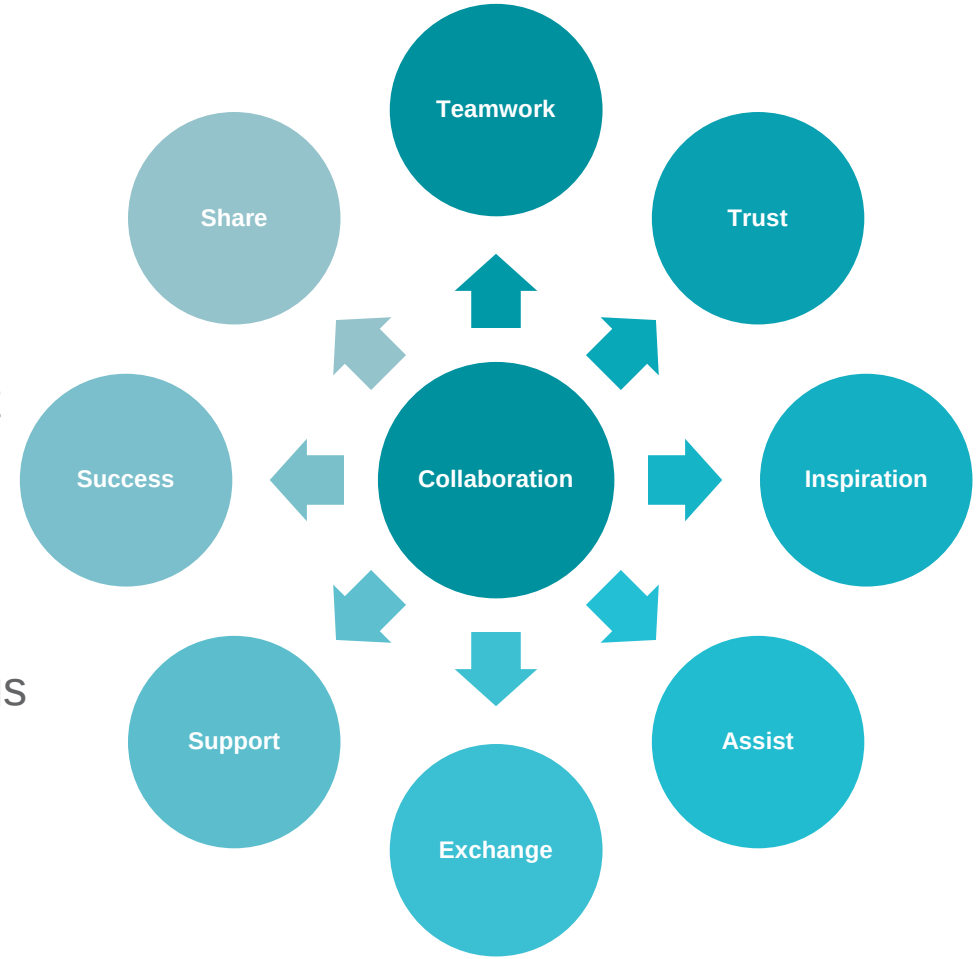
In all that we do, we will stay true to our mission, vision and values by delivering on four strategic priorities:



Strategic Priorities

Establish a Collaborative Approach

- Excellence begins with understanding
- Establish a relationship
  - Successful implementation
    - System load (benefits, contract terms, demographics)
    - FFS and DOM rules testing
  - Commitment to communication
    - Scheduled and ad hoc meetings
    - Growth through positive initiatives
    - Removal of unnecessary barriers



Provider Contact Center

We are here to help you. Additionally, we offer self-service options for the following services and more:

- Calling about an authorization
- Verifying Eligibility
- Checking on Benefits
- Network Status
- Claim Status
- Call us at **(844) 826-4335** Monday through Friday from 7:30 am to 5:30 pm

Provider Contact Center

Enhancing your experience – The Provider Services Contact Center is always happy to help you.

Having the following information available will save you time and help us give you the right information in a convenient and efficient way:

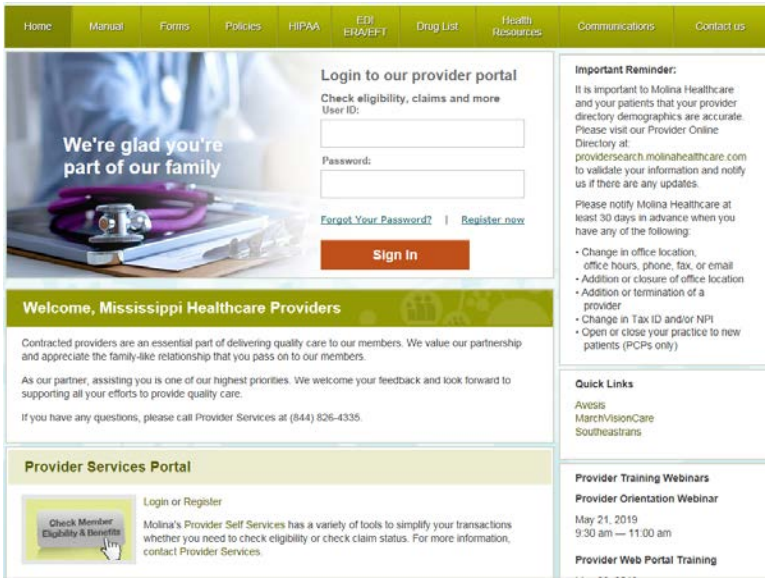
- Tax ID or NPI
- Name associated to either of these numbers
- CPT codes or HCPCS
- Member ID number
- County where your facility is located

Provider Website

Available to you 24/7!

https://www.molinahealthcare.com/providers

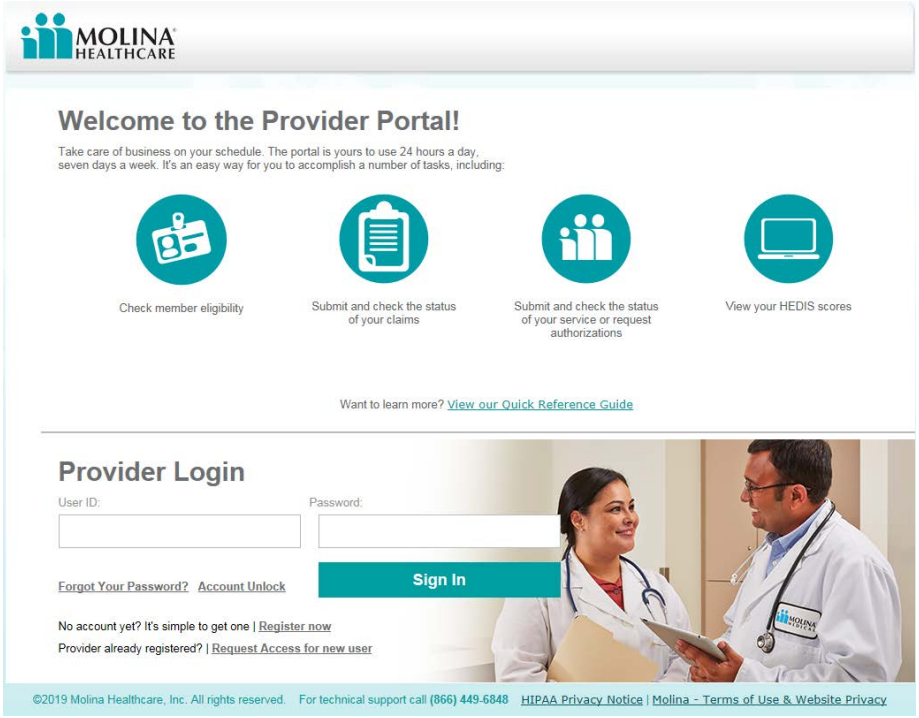
- Clinical Practice and Preventive Health Guidelines
- Health Management Programs for Asthma, Diabetes, Hypertension, CAD, CHF & Pregnancy
- Quality Improvement Programs
- Member Rights & Responsibilities
- Privacy Notices
- Provider News
- Provider Training
- Claims/Denials Decision Information
- Provider Manual
- Current Preferred Drug List & Updates
- Pharmaceutical Management Procedures
- UM Affirmative Statement (re: non-incentive for under-utilization)
- How to Obtain Copies of UM Criteria
- How to Contact UM Staff & Medical Reviewer
- New Technology
- How to access language services
- And more!



Provider Web Portal

Available to you 24/7!

https://provider.molinahealthcare.com/provider/login



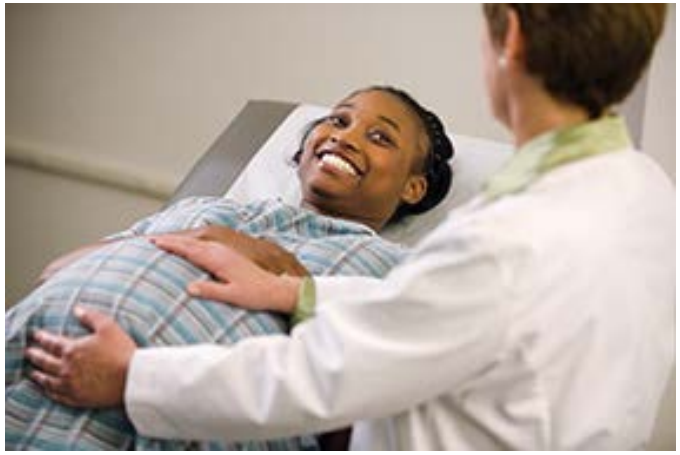
- Check Member Eligibility
- Submit and Check Claim Status
- Submit and Check PA Authorizations
- View your HEDIS scores
- And More!

Provider Contracting and Credentialing

All out-of-network providers must obtain a PA prior to rendering services. All Non-Par Providers require authorization regardless of services or codes.

To join our network, please complete the Contract Request Form found on our website at **https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx** and follow the instructions given.

After completing, a representative from our Provider Contracting Department will reach out to you regarding the enrollment and credentialing process.



For additional information, email **MHMSProviderContracting@Molinahealthcare.com**

Re-credentialing

- Re-credentialing occurs every 36 months
- Providers will receive notification 6 months in advance
- Molina Healthcare follows NCQA guidelines for re-credentialing
- For additional information, email **MHMSProviderContracting@Molinahealthcare.com**

Prior Authorizations Submissions

We require that all PA submissions to Molina include:

- Member demographic information,
- Facility information,
- Date of admission or Date Span of Services
- Clinical information sufficient to document the Medical Necessity of the admission or procedure.

Prior Authorizations Submissions

Prior Authorization is required for all outpatient surgery and identified procedures, non-emergent inpatient admissions, Home Health, some durable medical equipment and Out-of-Network Professional Services.

Molina requires notification of all emergent inpatient admissions within twenty-four (24) hours of admission or by the close of the next business day when emergent admissions occur on weekends or holidays.

- For emergency admissions, notification of the admission shall occur once the patient has been stabilized in the emergency department.
- Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate inpatient review and discharge planning.
- Emergent inpatient admission services performed without meeting notification and Medical Necessity requirements or failure to include all of the needed documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient admission.

Requests for services listed on the Molina Healthcare Prior Authorization Guide are evaluated by licensed nurses and clinicians that have the authority to approve services.

Prior Authorizations and Referrals

Prior Authorization is a request for prospective review. It is designed to:

- Assist in benefit determination
- Prevent unanticipated denials of coverage
- Create a collaborative approach to determining the appropriate level of care for Members receiving services
- Identify Case Management and Disease Management opportunities
- Improve coordination of care

Referrals are made when medically necessary services are beyond the scope of the PCP's practice. Most referrals to in-network specialists do not require an authorization from Molina. Information is to be exchanged between the PCP and Specialist to coordinate care of the patient.

Requests for services listed on the Molina Healthcare Prior Authorization Guide are evaluated by licensed nurses and clinicians that have the authority to approve services.

A list of services and procedures that require prior authorization is included in our Provider Manual and also posted on our website at **MolinaHealthcare.com**

Request Submissions

Web Portal: https://eportal.molinahealthcare.com/Provider/Login

Phone: (844) 826-4335. Please follow the prompts for prior authorization.

Note: *For telephonically submitted requests, it may be necessary to submit additional documentation before the authorization can be processed.*

Fax: Prior authorization requests may be faxed to the Healthcare Services Department using the Molina Healthcare Service Request Form which is available on our website at: **MolinaHealthcare.com.**

Prior Authorizations:
Phone: 1 (844) 826-4335
Inpatient Requests Fax: 1 (844) 207-1622
All Non-Inpatient Fax: 1 (844) 207-1620

Behavioral Health Authorizations:
Phone: 1 (844) 826-4335
Inpatient Requests Fax: 1 (844) 207-1622
All Non-Inpatient Fax: 1 (844) 206-4006

Note: *Please indicate on the fax if the request is non-urgent or expedited/urgent. Please see the MHMS Provider Manual for definition of expedited/urgent.*

Mail:
188 East Capital Street
Suite 700
Jackson, MS 39201

Prior Authorization Review Guide

https://www.molinahealthcare.com/providers/ms/PDF/Medicaid/PA-Guide-Request-Form.pdf

MOLINA HEALTHCARE

MOLINA HEALTHCARE OF MISSISSIPPI MEDICAID
PRIOR AUTHORIZATION/PRE-SERVICE REVIEW GUIDE
EFFECTIVE: 10/01/2018

REFER TO MOLINA'S PROVIDER WEBSITE OR PORTAL FOR SPECIFIC CODES THAT REQUIRE AUTHORIZATION
ONLY COVERED SERVICES ARE ELIGIBLE FOR REIMBURSEMENT

OFFICE VISITS TO CONTRACTED/PARTICIPATING (PAR) PROVIDERS & REFERRALS TO NETWORK SPECIALISTS DO NOT REQUIRE PRIOR AUTHORIZATION.

EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

ALL NON-PAR PROVIDER REQUESTS REQUIRE AUTHORIZATION REGARDLESS OF SERVICE.

- **Behavioral Health: Mental Health, Alcohol and Chemical Dependency Services:**
  - Inpatient, Crisis Residential Treatment, Partial hospitalization, Day Treatment; PACT, MYPAC, PRTF Electroconvulsive Therapy (ECT)
  - Applied Behavioral Analysis (ABA) – for treatment of Autism Spectrum Disorder (ASD). Behavior Identification Assessment (0359T) does NOT require prior authorization
  - Community Mental Health Center (CMHC)/Private Mental Health Center (PMCH) services: Evaluations or to exceed the service standard; Prior authorization is required for ALL services provided to individuals under the age of 3;
  - Therapeutic and Evaluative Mental Health services for Expanded EPSDT (T&E): For evaluations, or to exceed the service standard. Prior authorization is required for ALL services provided to individuals under the age of 3.
- **Cosmetic, Plastic and Reconstructive Procedures** (in any setting).
- **Dental services**: Prior authorization required for all services except for emergencies.
- **Durable Medical Equipment/ Medical Supplies**: Refer to Molina's Provider website or portal for specific codes that require authorization. All DME / Supplies must be ordered by a physician.
- **Expanded EPSDT services.**
- **Experimental/Investigational Procedures**
- **Eyeglasses (Vision) services:** for children after 2nd pair per FY.
- **Genetic Counseling and Testing** except for prenatal diagnosis of congenital disorders of the unborn child through amniocentesis and genetic test screening of newborns mandated by state regulations.
- **Hearing services:** Hearing aids (for EPSDT eligible members
- **Home Healthcare Services** after initial evaluation
- **Hospice**
- **Hyperbaric Therapy**
- **Imaging, Advanced and Specialty. Laboratory and X-Ray services:** For certain outpatient, non- emergency advanced imaging procedures (CT, MRI, PET and Nuclear cardiac studies).
- **Inpatient Admissions:** Elective, Acute hospital, Skilled Nursing Facilities (SNF), Rehabilitation, Long Term Acute Care (LTAC) Facility.
- **Long Term Services and Supports:** Refer to Molina's Provider website or portal for specific codes that require authorization. (Per State benefit).
- **Neuropsychological and Psychological Testing.**
- **Non-Par Providers/Facilities:** Office visits, procedures, labs, diagnostic studies, inpatient stays except for:
  - Emergency Department Services;
  - Professional fees associated with ER visit and approved Ambulatory Surgery Center (ASC) or inpatient stay;
  - Local Health Department (LHD) services;
  - Other services based on State Requirements.
- **Occupational & Physical Therapy**: After initial evaluation plus six (6) visits for office and outpatient settings.
- **Office-Based Procedures:** do not require authorization, unless specifically included in another category (i.e. advanced imaging) that requires authorization even when performed in a participating provider's office.
- **Outpatient Hospital/Ambulatory Surgery Center (ASC):** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Pain Management Procedures.** (Except trigger point injections).
- **Pediatric Skilled Nursing (Private Duty Nursing) Services.**
- **Physician Services:** Hospital inpatient visits
- **Prosthetics/Orthotics.** Refer to Molina's Provider website or portal for specific codes that require authorization
- **Radiation Therapy and Radiosurgery** (for selected services only).
- **Sleep Studies.** (Except Home sleep studies).

Molina Healthcare of Mississippi, Inc.

2018 Medicaid PA Guide/Request Form
Effective 10.01.18

Pre-Service Review

Pre-service review defines the process, qualified personnel and timeframes for accepting, evaluating and replying to prior authorization requests.

- Pre-service review is required for all non-emergent inpatient admissions, outpatient surgery and identified procedures, Home Health, some durable medical equipment (DME) and Out-of-Network Professional Services. The pre-service review process assures the following:
  - Member eligibility;
  - Member covered benefits;
  - The service is not experimental or investigation in nature;
  - The service meets Medical Necessity criteria (according to accepted, nationally-recognized resources);
  - All covered services, e.g. test, procedure, are within the Provider's scope of practice;
  - The requested Provider can provide the service in a timely manner;
  - The receiving specialist(s) and/or hospital is/are provided the required medical information to evaluate a Member's condition;
  - The requested covered service is directed to the most appropriate contracted specialist, facility or vendor;
  - The service is provided at the appropriate level of care in the appropriate facility; e.g. outpatient versus inpatient or at appropriate level of inpatient care;
  - Continuity and coordination of care is maintained; and
  - The PCP is kept appraised of service requests and of the service provided to the Member by other Providers.

Post-Service Review

Post-Service Review applies when a Provider fails to seek authorization from Molina for services that require authorization.

- Failure to obtain authorization for an elective service that requires authorization may result in an administrative denial. Emergent services do not require authorization.
- Post service reviews related to retroactive eligibility are reviewed for medical necessity and will not be denied for failure to obtain prior authorization.
- Coverage of emergent services up to stabilization of the patient will be approved for payment. If the patient is subsequently admitted following emergent care services, authorization is required within one (1) business day or post stabilization stay will be denied
- Failure to obtain authorization when required will result in denial of payment for those services.
- The only potential exception for payment as a result of post-service review is if information is received indicating the provider did not know nor reasonably could have known that patient was a Molina member or in the case of an error by Molina, a medical necessity review will be performed.
- Decisions, in this circumstance, will be based on the following:
  - medical need; and
  - appropriateness of care guidelines defined by UM policies and criteria;
  - regulation and guidance; and
  - evidence based criteria sets.

Peer-to-Peer Review Process

- Peer-to-Peer review of an adverse determination may be requested if the Provider directing the Member's care wishes to provide additional information related to the authorization request.
- The requesting Provider has **five (5) business** days from the receipt of the denial notification to schedule the review.
- Requests can be made by contacting Molina at **(844) 826-4335**.

Concurrent Review

- Molina performs concurrent inpatient review in order to ensure patient safety, Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans.

- Molina will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission.

This information is due from the inpatient facility within twenty-four (24) hours of the request.

Prior Authorization – Appeals

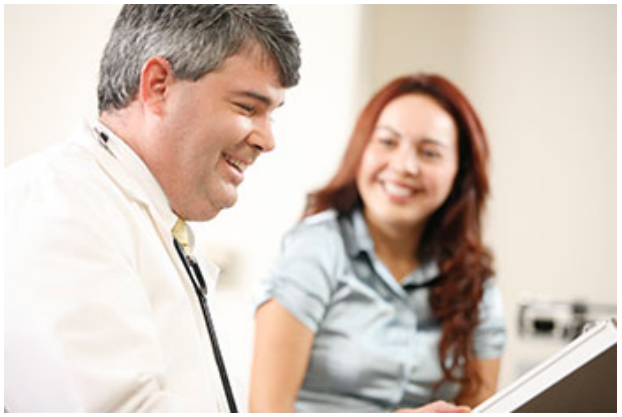
- Requests for authorization not meeting criteria must be reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate) may determine to delay, modify or deny services to a Member for reasons of Medical Necessity.

- Board certified licensed Providers from appropriate specialty areas must be utilized to assist in making determinations of Medical Necessity, as appropriate. All utilization decisions must be made in a timely manner to accommodate the clinical urgency of the situation, in accordance with regulatory requirements and NCQA standards.

- Providers can contact Molina's Healthcare Services Utilization Management team at **(844) 826-4335** to obtain Molina's UM Criteria.

Prior Authorization – Appeals

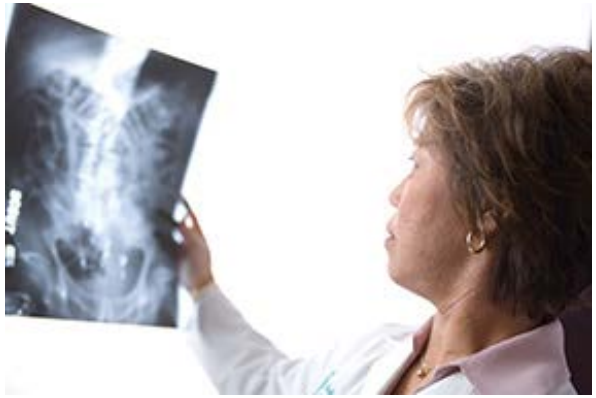
- A Provider may file a formal Appeal orally or in writing, requesting Molina to review an Adverse Benefit Determination related to a Provider.
- Appeals must be filed within thirty (30) calendar days from the Adverse Benefit Determination or denial. A written acknowledgement letter must be sent within ten (10) calendar days of receipt of the Appeal. Appeals must be resolved as expeditiously as possible, and no later than thirty (30) calendar days from receipt.
- For decisions not resolved wholly in the Provider's favor, Providers have the right to request a State Administrative Hearing from the Division of Medicaid.



Coordination of Care and Services

There are two (2) main coordination of care process for Molina Members.

1. First occurs when new Members enrolls in Molina and needs transition medical care to care to Molina contracted Providers.
    - Member and Provider Contact Center will provide assistance in obtaining auths, transferring to contacted DME Vendors, receiving approval for RX medications, etc.
2. The second coordination of care process occurs when a Molina Member benefits will be ending and they need assistance in transitioning to other care.



Coordination of Care and Services

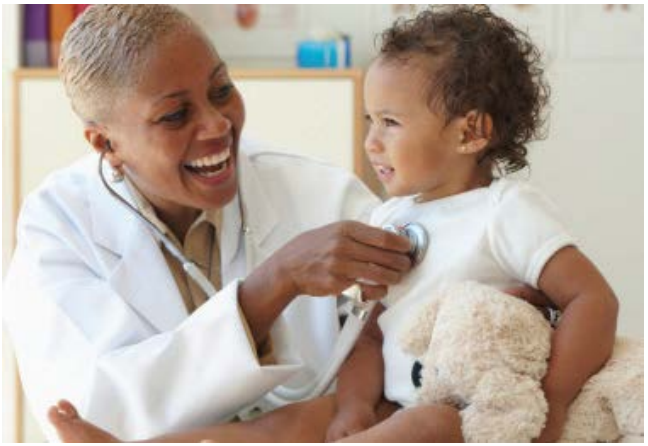
It is Molina's Policy to provide Members with advance notice when a Provider they will no longer be in Network. The Provider leaving the Network shall provide all appropriate information related to the course of treatment.

Acute Conditions or Serious Conditions
Following termination the Terminated provider will continue to provide Covered Services to the member for 90 Days or longer if necessary for safe transfer of care.

High Risk of Second or Third Trimester Pregnancy
The Terminated provider will continue to provide services following termination until postpartum services related to delivery are completed.

Claims Reconsideration

A Claims Reconsideration is written communication advising of the disagreement or dissatisfaction of claim determination.



Reconsideration must be accompanied by the following:

- Member demographic information,
- Supporting documentation outlining the specifics regarding the reason for the request.
- Refer to Molina Provider Manual for additional information

Claims Reconsideration

All reconsiderations must be received within ninety (90) days of the date on the Remittance Advice. Molina will respond to your request, in writing, within thirty (30) calendar days. Molina offers the following submission options:

Submit requests directly to Molina Healthcare of Mississippi via the Provider Portal at **provider.molinahealthcare.com**

Submit requests directly to Molina Healthcare of Mississippi by faxing to **1-844-808-2409**

Claims Reconsiderations, Disputes, and Appeals – Important Definitions

Adverse Benefit Determination
The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized services; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Division of Medicaid.

Provider appeal
Request for Molina to review an Adverse Benefit Determination related to a Provider; which may include, but is not limited to, for cause termination by Molina, or delay or non-payment for Covered Services.

Documentation needed for submission of Reconsiderations, Disputes, or Appeals

- All Claim Reconsiderations, Disputes or Appeals must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Molina's Provider website and the Provider Portal.
- The form must be filled out completely in order to be processed.
- Any documentation to support the reconsideration, dispute or appeal must be included, e.g. include Medical Records, copy of Explanation of Payment, copy of Authorization Form.
- If submitting voluminous Medical Records, please indicate where Molina can find pertinent information to support the medical necessity for the service.

Appeals Quick Reference

Molina Healthcare Member Resolution Team (MRT) and Provider Resolution Team (PRT) are working together to re-route any misdirected requests. However, participating providers sending disputes/appeal requests to the wrong department could delay response times.

Pre-Service Appeals

For providers seeking to appeal a denied Prior Authorization (PA) on behalf of a member only, fax Member Appeals at **(844) 808-2407**.

Post-Service Appeals

For providers seeking to appeal a denied claim only, fax Provider Claim Disputes/Appeals at **(844) 808-2409**.

If a provider rendered services without getting an approved PA first, providers must submit the claim and wait for a decision on the claim first before submitting a dispute/appeal to Molina.

How to File a Claim Reconsideration, Dispute or Appeal

Preferred Method – online via Molina's Provider Portal:
https://provider.MolinaHealthcare.com/provider/login

Fax: (844) 808-2409

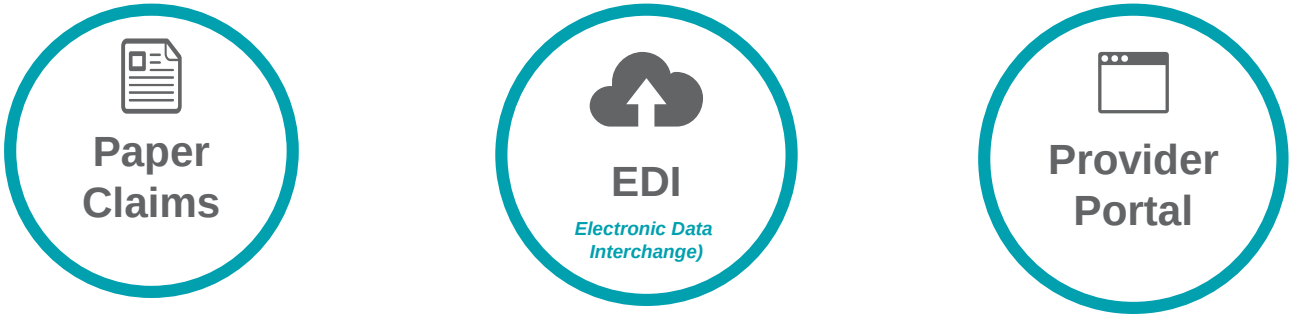
Mail:

Molina Healthcare of Mississippi, Inc.
Attention: Provider Grievance & Appeals
P.O Box 40309
North Charleston, SC 29423-0309

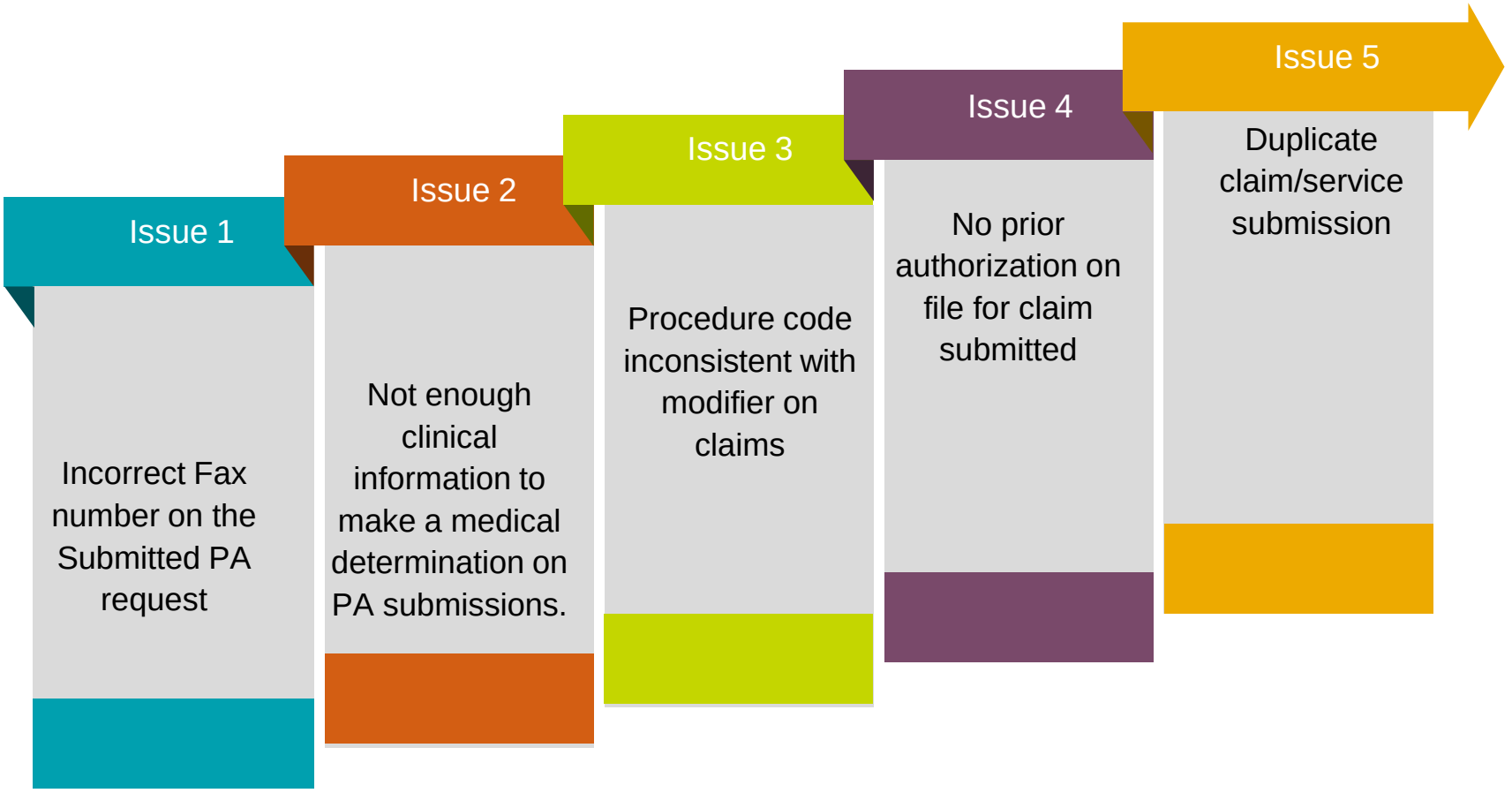
Corrected Claims

A corrected claim is a claim that has already been processed, whether paid or denied, and is resubmitted with additional charges, different procedure or diagnosis codes or any information that would change the way the claim originally processed. Claims returned requesting additional information or documentation should not be submitted as corrected claims. Corrected claims are treated as new claims.

Providers can submit corrected claims by the following:



Top 5 Issues


Issue 1
Incorrect Fax number on the Submitted PA request
Issue 2
Not enough clinical information to make a medical determination on PA submissions.
Issue 3
Procedure code inconsistent with modifier on claims
Issue 4
No prior authorization on file for claim submitted
Issue 5
Duplicate claim/service submission

How to correct the top 5 issues

Error	Resolution
Incorrect Fax number on the Submitted PA request	Provider should verify they have listed the correct fax number for Molina to submit a determination
Not enough clinical information to make a medical determination on PA submissions.	**Provider must submit the following with PA submissions:** • Current (up to 6 months), adequate patient history related to the requested services • Physical examination that addresses the problem • Lab or radiology results to support the request (Including previous MRI, CT, Lab or X-ray report/results) • PCP or Specialist progress notes or consultations • Any other information or data specific to the request
Duplicate claim/service submission	If a claim is in process, resubmitting duplicate claim will not speed up claim processing for payment
No prior authorization on file	For services that require authorization, provider should obtain authorization prior to submitting claim and/or rendering services
Procedure code inconsistent with modifier	To ensure that claims are as accurate as possible, cross-check with medical coding resources to ensure the correct code and modifier combination is being used

Contact Information

Molina Healthcare of Mississippi, Inc.
188 E. Capitol Street, Suite 700
Jackson, MS 39201

Phone Numbers

Main Line Toll Free	(844) 826-4333
Member Eligibility Verification	(844) 809-8438
Member Services	(844) 809-8438
Provider Services	(844) 826-4335
Behavioral Health Authorizations	(844) 826-4335
Pharmacy Authorizations	(844) 826-4335
Radiology/Transplant/NICU Auths	(855) 714-2415

Fax Numbers

Main Fax	(844) 303-5188
Prior Auth – Inpatient	(844) 207-1622
Prior Auth – All Non-Inpatient	(844) 207-1620
Behavioral Health - Inpatient	(844) 207-1622
Behavioral Health /All Non-Inpatient	(844) 206-4006
Pharmacy Authorizations	(844) 312-6371
Radiology Authorizations	(877) 731-7218
Transplant Authorizations	(877) 813-1206
NICU Authorizations	(877) 731-7220

Vendors

Avesis
Toll Free: (833) 282-2419
Toll Free: (844) 826-4335
www.avesis.com

Southeastrans
Toll Free: (855) 391-2355
Toll Free: (844) 826-4335
www.southeastrans.com/members/mississippi

CVS Caremark
Toll Free: (844) 826-4335
PA submissions Fax: (844) 312-6371

March Vision
Toll Free: (844) 606-2724
Toll Free: (844) 826-4335
www.marchvisioncare.com

UnitedHealthcare Community Plan of Mississippi, Inc.

2019 Division of Medicaid Provider Workshops

UnitedHealthcare®
Community Plan

UnitedHealthcare: Who We Are

UnitedHealthcare Community Plan

Our Mission

To help people live healthier lives and to help make the health system work better for everyone

Our Core Values

Integrity – Honor commitments & Never compromise ethics

Compassion – Walk in the shoes of people we serve and those with whom we work

Relationships – Build trust through collaboration

Innovation – Invent the future and learn from the past

Performance – demonstrate excellence in everything we do

Our Vision

To be the premier health care delivery organization in the eyes of our state partners, providing health plans that meet the unique needs of our Medicaid members as well as our members in other government-sponsored health care programs. And to be effective partners with physicians, hospitals and other health care professionals in serving their patients.

UnitedHealthcare: Who We Are

UnitedHealthcare Community Plan

UnitedHealth Group℠

OPTUM®

OptumHealth
OptumRx
OptumInsight

ACCREDITED NCQA HEALTH PLAN

DISTINCTION NCQA MULTICULTURAL HEALTH CARE

UnitedHealthcare

UnitedHealthcare Community & State
UnitedHealthcare Medicare & Retirement
UnitedHealthcare Employer & Individual
UnitedHealthcare Military & Veterans

FORTUNE WORLD'S MOST ADMIRED COMPANIES 2019

THE CIVIC 50

MILITARY FRIENDLY EMPLOYER MF'19 AWARD

5. UNITEDHEALTH GROUP

Number 5 on Fortune 500

Mission, Vision, & Values

UnitedHealthcare® Community Plan

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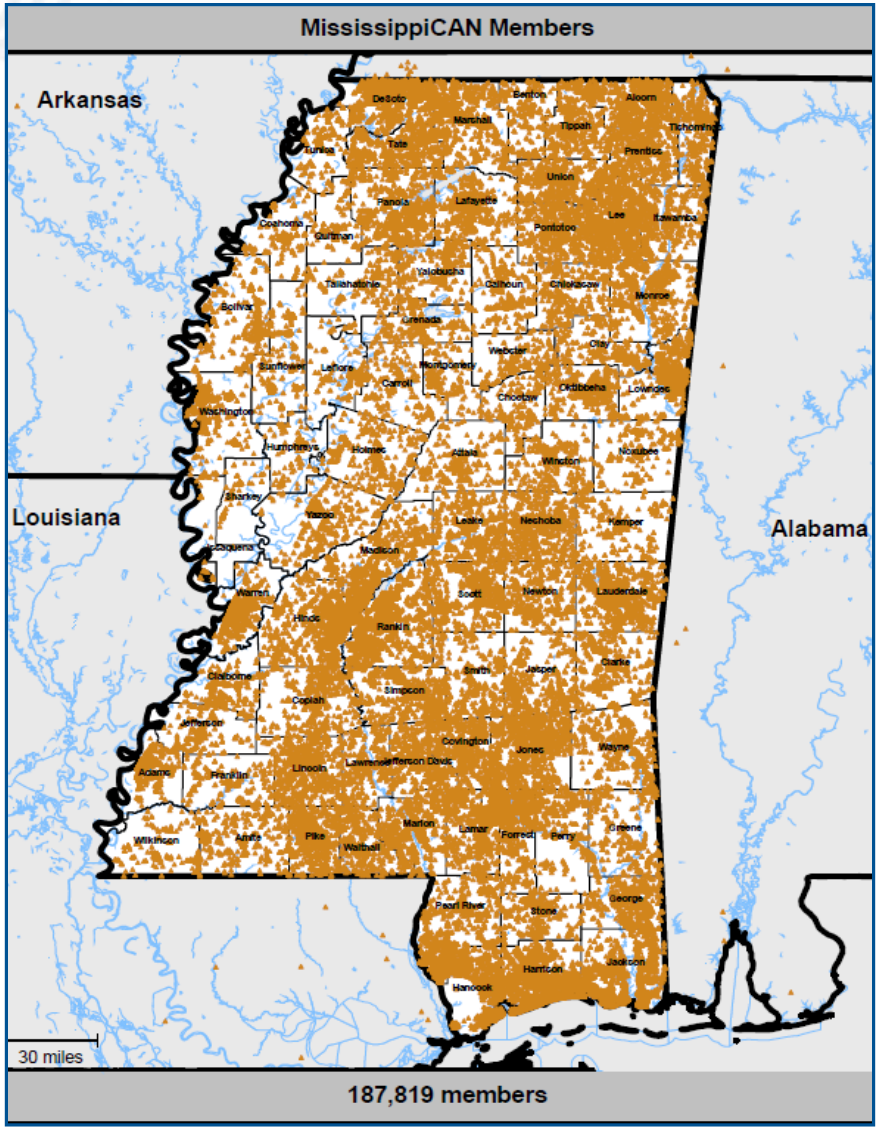
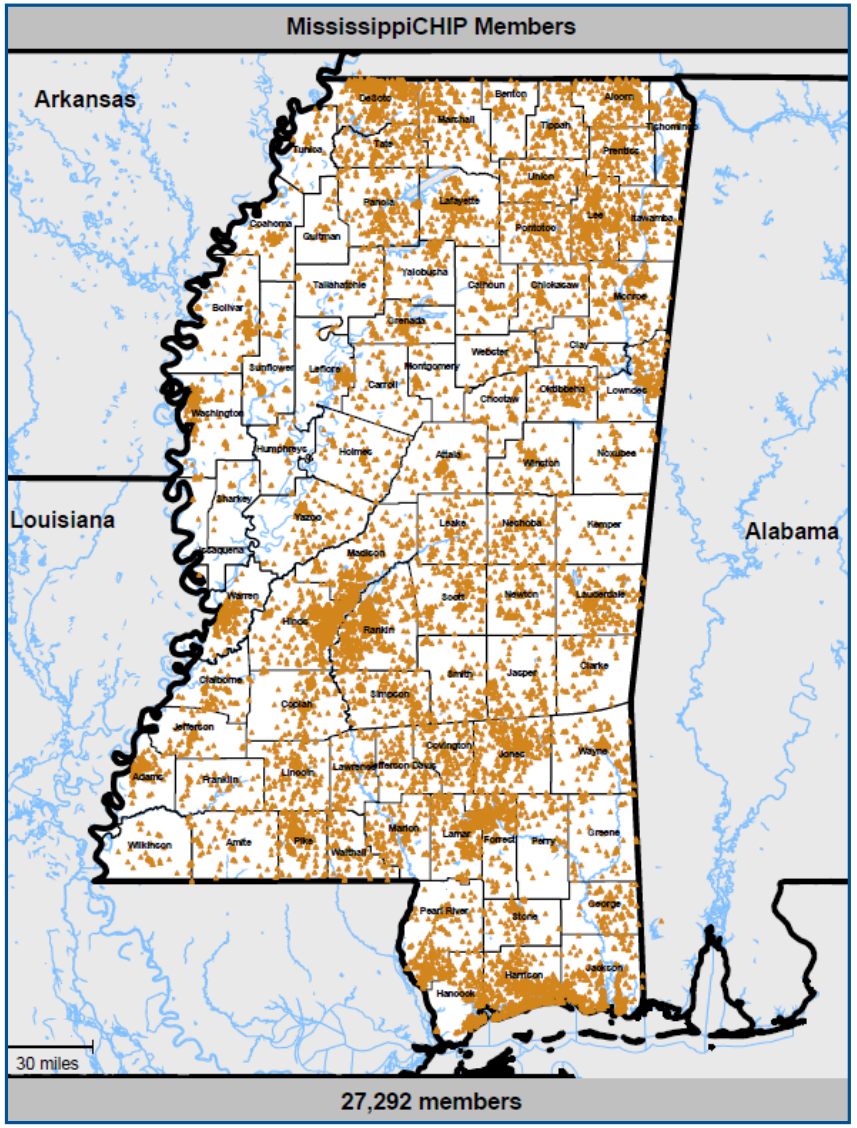
Membership

UnitedHealthcare® Community Plan





In the Community

UnitedHealthcare Community Plan

- Community-Based Health Fairs
- Farm to Fork: Food assistance program runs May-Sep
- Thanksgiving Turkey Giveaways
- 4-H Partnership: Eat-4-Health empowers youth to help improve the health of their peers, families, and communities
- Heart Smart Sisters: Promotes Heart Disease Awareness and provides weekly classes
- Sesame Workshop Partnership: Food for Thought, a bilingual initiative helping families make food choices that are affordable, nutritional, and help set lifelong healthy habits
- Maternal/Child Health: Healthy First Steps & Baby Building Blocks
- Local Schools: Supplies, backpacks, uniforms, shoes, etc.
- Pink Ribbon Funded sponsorship

Join Our Network

UnitedHealthcare® Community Plan

Step 1: Get Started

Submit your request for participation.

Step 2: Get Credentialed

Verify your experience and expertise.

Step 3: Get Contracted

Review and sign your participation agreement.

Step 4: Get Connected

Set up your online tools, paperless options and complete your training.

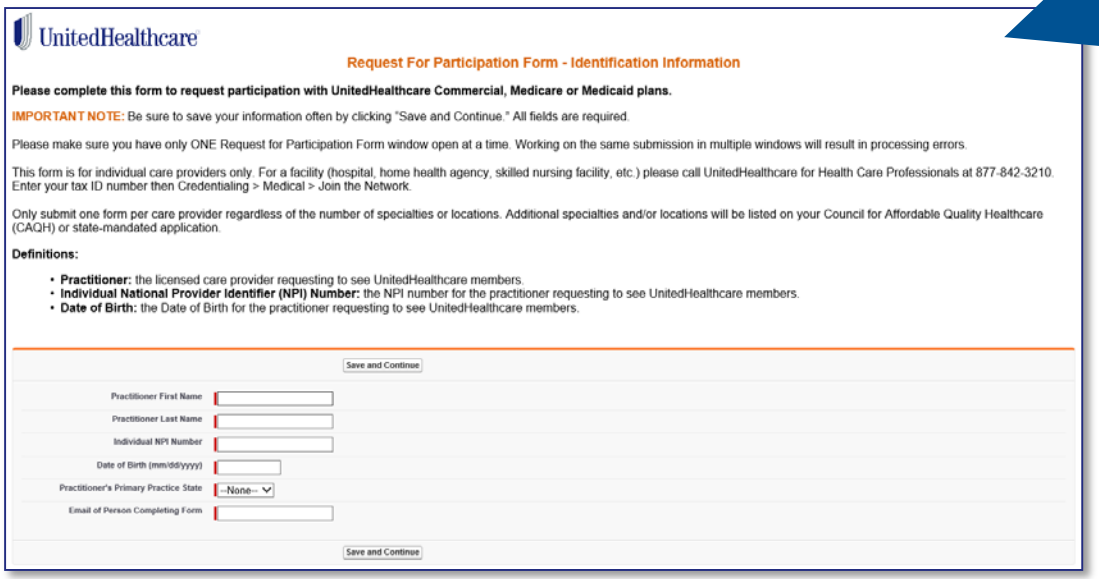
Join Our Network: 1) Get Started

UnitedHealthcare Community Plan

- Call 877-842-3210 8 AM to 5 PM CT, Mon-Fri
  - Enter your Tax ID then select
  - Credentialing > Medical > Join the Network

- Practitioners can submit through RFP portal:
  - ncc-optum.secure.force.com/rfp

Medical Practitioners & Facilities



UnitedHealthcare

Request For Participation Form - Identification Information

Please complete this form to request participation with UnitedHealthcare Commercial, Medicare or Medicaid plans.

IMPORTANT NOTE: Be sure to save your information often by clicking "Save and Continue." All fields are required.

Please make sure you have only ONE Request for Participation Form window open at a time. Working on the same submission in multiple windows will result in processing errors.

This form is for individual care providers only. For a facility (hospital, home health agency, skilled nursing facility, etc.) please call UnitedHealthcare for Health Care Professionals at 877-842-3210. Enter your tax ID number then Credentialing > Medical > Join the Network.

Only submit one form per care provider regardless of the number of specialties or locations. Additional specialties and/or locations will be listed on your Council for Affordable Quality Healthcare (CAQH) or state-mandated application.

Definitions:

- **Practitioner:** the licensed care provider requesting to see UnitedHealthcare members.
- **Individual National Provider Identifier (NPI) Number:** the NPI number for the practitioner requesting to see UnitedHealthcare members.
- **Date of Birth:** the Date of Birth for the practitioner requesting to see UnitedHealthcare members.

Save and Continue

Practitioner First Name
Practitioner Last Name
Individual NPI Number
Date of Birth (mm/dd/yyyy)
Practitioner's Primary Practice State --None--
Email of Person Completing Form

Save and Continue

Join Our Network: 1) Get Started

UnitedHealthcare Community Plan

- Physical Medicine Providers (PT/OT/ST & Chiro)
  - Credentialing and contracting conducted by Optum Physical Health
  - Go to MyOptumHealthPhysicalHealth.com or call 800-873-4575
- Behavioral Health Providers
  - Credentialing and contracting conducted by Optum Behavioral Health Solutions
  - Go to ProviderExpress.com (look under “Our Network” for specific instructions) or call 800-817-4705
- Dental Care Providers
  - Credentialing and contracting conducted by Dental Benefit Partners
  - Visit dbp.optum.com (look under “Join Our Network”) or call 800-822-5353
- Optometrists/Vision Care
  - Credentialing and contracting conducted by March Vision Care
  - Go to marchvisioncare.com and click “Become a Provider”

Join Network: 2) Get Credentialed

UnitedHealthcare Community Plan

During the credentialing process, we will verify qualifications, practice history, certifications, and registration to practice

Facilities must meet the following criteria to be considered for credentialing:

- Current required license(s)
- General/comprehensive liability insurance
- Errors and omissions (malpractice) insurance
- Proof of Medicare/Medicaid program participation eligibility
- Appropriate accreditation by a recognized agency, or satisfactory alternative
- Centers for Medicare & Medicaid Services (CMS) certification

Complete application on CAQH ProView

- Fast and easy way to enter credentialing information and securely submit to multiple health insurers at no cost to providers.
- Authorize UHC to access your data by either selecting global authorization or manually authorizing UnitedHealthcare
- proview.caqh.org or call the CAQH Help Desk at 888-599-1771

Check credentialing application status by calling 877-842-3210

Enter your Tax ID then select Credentialing > Medical > Get Status.

Recredentialing

UnitedHealthcare Community Plan

Required at least every 3 years by NCQA & CMS

- Helps make sure that health plans have the most accurate, up-to-date information.
- Allows providers to review practice locations and contact information used in provider directories that are made available to members.
- If recredentialing is not completed, network participation could be negatively impacted.

To complete recredentialing with UHC

- Attest to all the data in your CAQH ProView application every 120 days and maintain a complete and current application
- UnitedHealthcare retrieves your information from CAQH ProView to review for updates and changes.
- Multiple outreach attempts occur during the final 6 months of current cred cycle in attempt to prompt action

Join Network: 3) Get Contracted

UnitedHealthcare Community Plan

Contracting is a separate process from credentialing – but we start the contracting process while working through credentialing.

Joining Existing Group Contract?

- If you're joining a medical group that already has a participation agreement with UHC, you won't receive a contract directly. Instead, you'll be added to the group agreement once your credentialing application has been approved.

Signing a New Contract with UnitedHealthcare?

- Once we receive your credentialing application, we'll send you a contract (participation agreement), typically within 10 business days.
- If you've given us an email address, we'll send the contract through the secure DocuSign application. If not, we'll send it by U.S. mail.
- Review the Agreement, Sign, & Return
- We'll let you know once your agreement is fully set up and you're clear to begin seeing patients as a UnitedHealthcare network provider.

Join Network: 4) Get Connected

UnitedHealthcare Community Plan

Once credentialing is approved and the provider agreement is executed and loaded, you're ready to see patients as a UnitedHealthcare network care provider.

The next step is to get connected with our online systems and resources.

View the Get Connected Quick Start Guide checklist.
uhcprovider.com/en/resource-library/Join-Our-Network.html

- ✓ Step 1: Bookmark UHCprovider.com
- ✓ Step 2: Subscribe to Receive Network Bulletin
- ✓ Step 3: Setup Electronic Data Interchange (EDI) Connections
- ✓ Step 4: Create an Optum ID and Access Link
- ✓ Step 5: Set up Electronic Payments & Statements (EPS)
- ✓ Step 6: Verify Your Demographic and Tax ID Information
- ✓ Step 7: Tune in to UHC On Air
- ✓ Step 8: Learn About UnitedHealthcare Benefit Plans in Your State

Filing Claims

UnitedHealthcare Community Plan

1. **Review and copy both sides of the member's ID card**. This card contains information that helps you process claims accurately. These ID cards display claims address, copayment info (if applicable), and telephone numbers for member and provider services.

2. **Notify UHC of planned procedures and services** on the Prior Auth list.

3. **Prepare a complete and accurate electronic or paper claim**. Complete a CMS 1500 or CMS 1450 (UB-04) form.

4. **Submit claims electronically** to reduce costs, help ensure faster processing and reduce claim entry errors.
   - ❑ Use electronic payer ID 87726 to submit claims.
   - ❑ Contact your vendor or our EDI unit at 800-210-8315.
   - ❑ Mail completed paper claims to:

     UnitedHealthcare Community Plan
     PO Box 5032
     Kingston, NY 12402-5032

Complete Claims

UnitedHealthcare Community Plan

Follow CMS National Uniform Claim Committee (NUCC) Manual guidelines for placement of claim data.

- Member's name, date of birth, address and ID number.
- Name, signature, address and phone number of physician or care provider performing the service.
- National Provider Identifier (NPI) number.
- Physician's or care provider's tax ID number.
- CPT-4 and HCPCS procedure codes with modifiers where appropriate.
- ICD-10 diagnostic codes.
- Revenue codes (UB-04 only).
- Date of service(s), place of service(s) and number of services (units) rendered.
- Referring physician's name (if applicable).
- Information about other insurance coverage, including job related, auto or accident information, if available.

Reimbursement Policies

UnitedHealthcare Community Plan

Reimbursement policies are available online at:

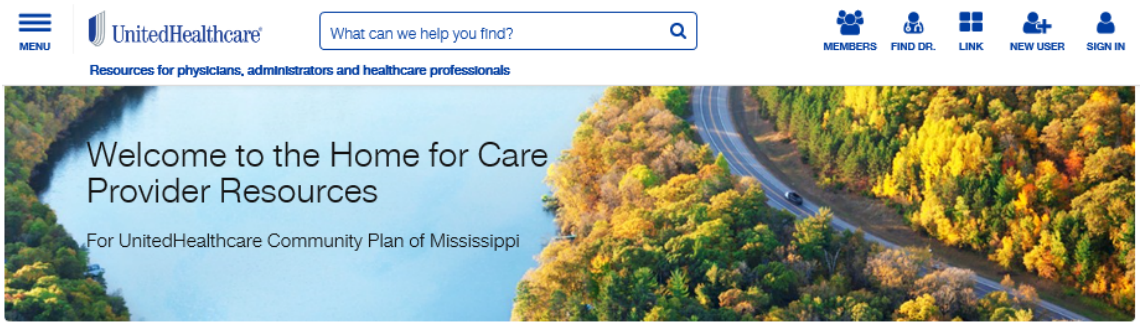
UHCprovider.com > Policies and Protocols > Community Plan Policies

Reimbursement policies are often based on external sources:

- CMS National CCI
- CMS National/Local Coverage Determinations (NCDs/LCDs)
- Current Procedural Terminology (CPT)
- Specialty Societies including:
  - American Society of Anesthesiologists (AMA)
  - American College of Cardiologists (ACC)
  - American College of Obstetrics and Gynecology (ACOG)
- National Physician Fee Schedule (NPFS)/Relative Value File

UHCProvider.com/MS

UnitedHealthcare Community Plan



LINK Self-Service Tools

UnitedHealthcare Community Plan

Comprehensive info and service tools available 24/7!

claimsLink

- View claims information for multiple UHC plans
- Access letters, remittance advice documents and reimbursement policies
- Submit additional information requested on pended claims
- Flag claims for future viewing
- Submit corrected claims or claim reconsideration requests
- Receive instant printable confirmation for your submissions

eligibilityLink

- Search for covered members
- Find member cost share, deductible or out-of-pocket responsibility
- View preventive care opportunities for some members
- View detailed benefits information for multiple plans
- See coverage details and limits specific to each benefit plan

LINK Self-Service Tools

UnitedHealthcare Community Plan

My Practice Profile

- View, update and attest to provider demographic information members see for your organization.
- Use the tool to make demographic changes and get those updates into our systems more quickly.

Prior Authorization and Notification Tool

- Determine if prior authorization or notification is required.
- Complete notification or prior authorization request.
- Upload medical notes or other attachments when required and add messages for the reviewer when attachments are required.
- Check status of your notification and prior authorization requests – including those made by phone.

Other Link tools include Document Vault, PreCheck MyScript, & UHC On Air

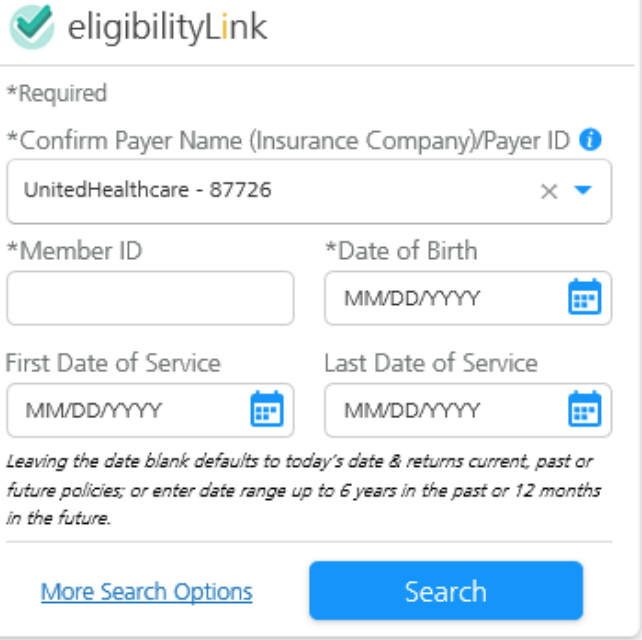
LINK Self-Service Tools

UnitedHealthcare® Community Plan

claimsLink

Prior Authorization and Notification

My Practice Profile



Electronic Payments & Statements

CAQH ProView™

UHC On Air

Hospital Benchmarks

Medical Billing Education

Optum Behavioral Provider Express Home

UnitedHealthcare Dental

Link Resource Library

Provider Appeals

UnitedHealthcare Community Plan

- You may appeal a denial or other adverse benefit determination within 30 calendar days from formal notice.
- To expedite the processing of Provider Appeals, use the Provider Appeal Form located at UHCprovider.com/claims.
- Completed appeal forms should be submitted to :

  P.O. Box 5032

  Kingston, NY 12402-5032
- Written acknowledgement confirming receipt of an appeal will be issued within 10 calendar days.
- Written determination provided within 30 calendar days.
- Upon receipt of notice of an appeal denial, you may request an Administrative State Hearing through the Division of Medicaid (MSCAN only).

Top Issues/Inquiries

UnitedHealthcare Community Plan

Mississippi CAN	Mississippi CHIP
Claims	
Inactive Member	Service Not Covered
Duplicate Claim	Bundled Pmt/Included in Chg
Timely Filing	Inactive Member
Send Primary Carriers EOB	Duplicate Claim
CLIA ID/Addr missing/invalid	Timely Filing
Bundled Pmt/Included in Chg	Send Primary Carriers EOB
	CLIA ID/Addr missing/invalid
Call Center	
Check Claim Status	Medical Benefit Info
Member Benefit Info	Prior Authorization Request
Prior Authorization Request	COB Info
Request an Adjustment	Check Claim Status
COB Information	Request an Adjustment

Avoid Common Claim Errors/Delays

UnitedHealthcare Community Plan

- Verify member eligibility via Link or Envision
- File NPIs and other provider information in alignment with state Medicaid enrollment (MSCAN only)
- Remember timely filing requirements (6 months from date of service MSCAN/CHIP)
- Request prior authorization when applicable (check UHCprovider.com/ms)
- Notify UHC of all inpatient admissions
- Investigate other coverage and file primary insurance payments
- Follow complete claim filing principles (all patient info, provider info, dx codes, CPT/HCPCS codes, Revenue codes, correct modifier use, unit accuracy, other insurance, COB info)

Contact Information

UnitedHealthcare Community Plan

Provider Services: 877-743-8734

- Please have NPI, Tax ID, and/or Member ID ready
- Provider call services is available to:
  - Answer general questions
  - Verify member eligibility
  - Check claim status
  - Advise on participation status
  - Receive demographic changes

Prior Authorization, Notification, Hospital Inpatient, Concurrent Review: 866-604-3267

- FAX: 888-310-6858
- UHCprovider.com

Pharmacy Services:
877-305-8952

Behavioral Health Services:
866-673-6315

Dental Services:
800-508-4862

Vision Services:
844-606-2724

Transportation:
844-525-2331

Question & Answer Session

Afternoon Agenda

1:30 p.m.	3:00 p.m.	Non- Emergency Transportation Third Party Liability Program Integrity
3:00 p.m.	3:30 p.m.	Question & Answer Session
3:30 p.m.	4:30 p.m.	Help Desk

Non-Emergency Transportation (NET)

(Administrative Code: Title 23: Part 201; Chapter 2; Rule 2.1 – 2.7)

NET Broker Responsibilities

The NET Broker is responsible for administering and operating the NET program in accordance with the Division of Medicaid's policy including, but not limited to, the authorization, coordination, scheduling, management, and reimbursement of NET services.

Non-Emergency Transportation Contact information

Fee For Service	To schedule a ride	1-866-331-6004
	If Your Ride is late or a no show	1-886-334-3794
	Complaints about transportation	1-866-436-0457
Magnolia Healthcare	To schedule a ride	1-866-331-6004
	If Your Ride is late or a no show	1-866-334-3794
	Complaints about transportation from the beneficiary(Member)	1-866-912-6285 Ext. 66400
	Complaints about transportation from a Healthcare provider.	1-866-912-6285 Ext. 66402
	Foster Care beneficiary services	1-866-869-7747
Molina Health Care	Schedule a trip, trip status or complaints	1-855-391-2355
United Healthcare	Schedule a trip, trip status or complaints	1-844-525-3085

2019 Division of Medicaid Provider Workshops

Non-Emergency Transportation (MTM)

8/7/2019

Modes of Transportation

- Public transit (bus)
- Sedan
- Public Motor Vehicle
- Multi-passenger Van
- Volunteer Driver
- Wheelchair Van
- Stretcher/Ambulance
- Air
- Gas mileage reimbursement (GMR)

How To Request Transportation

- Monday to Friday from 7 a.m. to 8 p.m.
- Reservation line: 1-866-331-6004
- You must call at least 3 business days prior to the appointment
- Full name, address, phone number, date of birth
- Medicaid ID number
- Confirm pick up address
- Date of the healthcare visit
- Name, address and phone number of the place member is going
- Medical reason for the visit

Things To Remember

- **Trip Reservations**:

  1-866-331-6004

  (*3 business days prior)

- **Where's My Ride:**

  1-866-334-3794

- **Hours of Operation**:

  M-F 7:00am-8:00pm

  Routine Appointments

  24/7/365

  Urgent Appointments

- **Community Outreach**

  CO-MS@mtm-inc.net

- **Support Team:**

  CM-Mississippi@mtm-inc.net

- **Compliance/Quality Team:**

  QM@mtm-inc.net

- **Complaints:**

  1-866-912-3285

www.mtm-inc.net/mississippi

Non-Emergency Transportation

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

Non-Emergent Transportation Subcontractor

Molina Healthcare has contracted with Southeastrans to manage all non-emergent transportation (NET) services for their MississippiCAN Members. Southeastrans is responsible for the following components of the Molina MS NET program:

- Establishing a network of NET providers throughout the State
- Quality assurance: timely, safe, comfortable transports
- Call center services and web portal for Members to request transportation
- Dispatch agents to coordinate return pickups for Members
- Technical Support for NET providers, members, and facilities using our portals
- Complaint management and resolution
- Pickup and Drop Off Address Verification
- Compliance monitoring and Data Management

Medical Provider Resources

SOUTHEASTRANS

As a medical facility, you may set up trips for your patients several ways.

- **Call us.** We have a staff of Special Service Representatives (SSRs) ready to take calls and handle requests directly from facilities.
  - You may reach them on the Facility Line at **1-888-822-6102**.
  - If you have members who come twice or more weekly, at the same times each week, our SSRs can send you a Standing Order Request. This will create an automatically generating trip for them.
- **Contact our agents** via email at **msssr@southeastrans.com** or fax at **601-991-9603**.
- **Our facility portal** is also a way to manage appointments and see who is coming and going from your facility.
  - When your patients complete their appointments, *call us directly* at **855-391-2355**. We will notify the transportation provider who brought them. They will then have up to 1 hour to return.

Contact Information

OUR HOURS

Mississippi Office
8:00 – 5:00 Mon – Fri

Urgent Trip Reservations are taken:
24 - 7 - 365

Routine Reservations are taken
Monday 7:30am - 8:00pm CST
Tuesday – Friday 7:30am – 5:30pm CST
The 2nd weekend of every month
8:00am – 5:00pm CST

Requests for routine reservations will not be accepted on national holidays (including New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving and Christmas)

Tammie Sanford, State Director
404-977-8666 mobile
769-209-4001 office
864-529-9880 fax
tsanford@southeastrans.com

Reservations / Where's My Ride
855-391-2355
Portal:
https://member.southeastrans.com/

NET Provider Assistance
888-822-6103
Portal:
https://provider.southeastrans.com/

Facility Assistance
888-822-6102 phone
MSSSR@southeastrans.com
601-991-9603 fax
Portal:
https://facility.southeastrans.com

Compliance Department / Officers
MSCompliance@southeastrans.com
Justin Owens, Compliance Manager
Jowens@southeastrans.com

Technical Support
isupport@southeastrans.com

Things to remember

- Trips should be scheduled at least 3 days in advance, but may be scheduled as far in advance as 30 days.
- Urgent trips may be scheduled as late as the day of the appointment, but should be scheduled as soon as you become aware of the need for transportation.
- Let us know at Southeastrans if you have an issue with pickup or drop-off. If you're communicating the issues to the NET provider, we are unaware and have no ability to control resolve the issue.
- Know the address and phone number of the pickup location as well as the name, address, and phone number of the drop off location when you schedule a trip to ensure a successful transport.
- Members should be on the lookout for drivers up to 15 minutes before the scheduled pickup.
- Drivers have up to 1 hour to return from the time Southeastrans receives the will-call.
- Although this is a multi load system, no member should be kept in a vehicle more than 45 minutes plus direct travel time.

UnitedHealthcare Community Plan of Mississippi, Inc.

2019 Division of Medicaid Provider Workshops

Non-Emergency Transportation

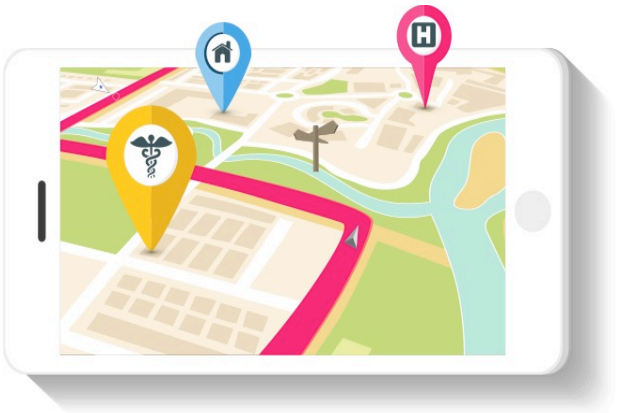
UnitedHealthcare®
Community Plan

Non-Emergency Transportation

UnitedHealthcare Community Plan

National MedTrans supplies resources for both members and providers to schedule transportation.

- **National MedTrans Member Reservations:** 844-525-3085 or
- **UHC Member Services:** 877-370-4009
- **Facilities and Providers:** 844-525-2331



Or request transportation online at:

https://nationalmedtrans.com/request-a-ride/

Things to Remember:

- Be sure to schedule 3 business days in advance
- Have member info on hand (Name, Phone#, Address, DOB, Member ID#.)
- Name and Address of Pick-up/Drop-off Locations

Members and Providers should not reach out to the drivers directly. All communication and dispatch is handled by National MedTrans representatives through their call centers and scheduling platform.

Non-Emergency Transportation

UnitedHealthcare Community Plan

- UHC is currently working to transition to a new subcontracted vendor to administer the Non-Emergent Medical Transportation benefit.

- MTM will replace National MedTrans as administrator of the NEMT program for UHC MSCAN members.
  - The anticipated date for this change is August 1, 2019. UHC member services **844-445-3245** and provider services **877-743-8734** are available to assist during this time of transition.

Third Party Liability (TPL)

(Administrative Code - Title 23; Part 306; Chapter 1, Rule 1.1 – Rule 1.7)

Overview

Third party liability (TPL) refers to the legal obligation of health care sources (third party sources) to pay for all or part of a medical claim of a Medicaid beneficiary.

TPL may include health insurance, casualty coverage resulting from an accidental injury or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the healthcare of a Medicaid beneficiary.

By law, Medicaid is the payer of last resort.

TPL Provider Recoupment

- Federal regulations require that DOM recover its payments when a liable third party is identified. The Division of Medicaid has contracted with Health Management Systems (HMS) to identify third party liability resources or supplemental medical benefits including private and governmental insurance coverage for Medicaid beneficiaries.

- The TPL Provider Recoupment process consists of HMS sending a notice and a listing of claims in which a third party insurance should have been primary. After 60 days from the date of the notice, DOM may automatically recoup (from a future remittance due your facility) the total dollar amount indicated on the listing unless documentation is received to refute the recoupment. Detail instructions are provided in the notice.

- HMS also conducts Credit Balance and LTC audits. Based on the audit findings, providers submit overpayments due back to Medicaid.

Primary or Secondary Payer - MEDICAID

- Medicaid is **always** the payer of last resort. This simply means that Medicaid always pays last where other health insurance plans are present. Recipients are required to keep Medicaid informed of any health insurance information. Providers are also responsible for notifying Medicaid of third-party insurance they find out about as well as informing Medicaid of any third party payments they receive on behalf of the recipient.

- Question: What happens if recipient has third party insurance on file with Medicaid?
  Answer: Provider files claim. Claim denies for TPL.

- Question: What should Provider do?
  Answer: Provider should file claim with third party insurance and resubmit claim to Medicaid indicating third party payment. Medicaid will pay claim up to Medicaid's allowed amount.

Third Party Claims Payment Flow

Primary = Aetna ⟷ **Secondary = Medicaid**

Primary = Medicare ⟷ **Secondary = Medicaid**

Primary = Aetna ⟷ **Secondary = Medicare** ⟷ **Tertiary = Medicaid**

Contact for Updating TPL Information

If the Beneficiary (member) is enrolled in the MSCAN Program call:

- United Healthcare 1-877-743-8731
- Magnolia Health Plan 1-866-912-6285
- Molina Healthcare 1-844-809-8438

For all other Beneficiaries (members) call:

- Office of Recovery 601-359-6095 or 800-421-2408

Callers must have the beneficiary's Medicaid ID Number available

magnolia health™

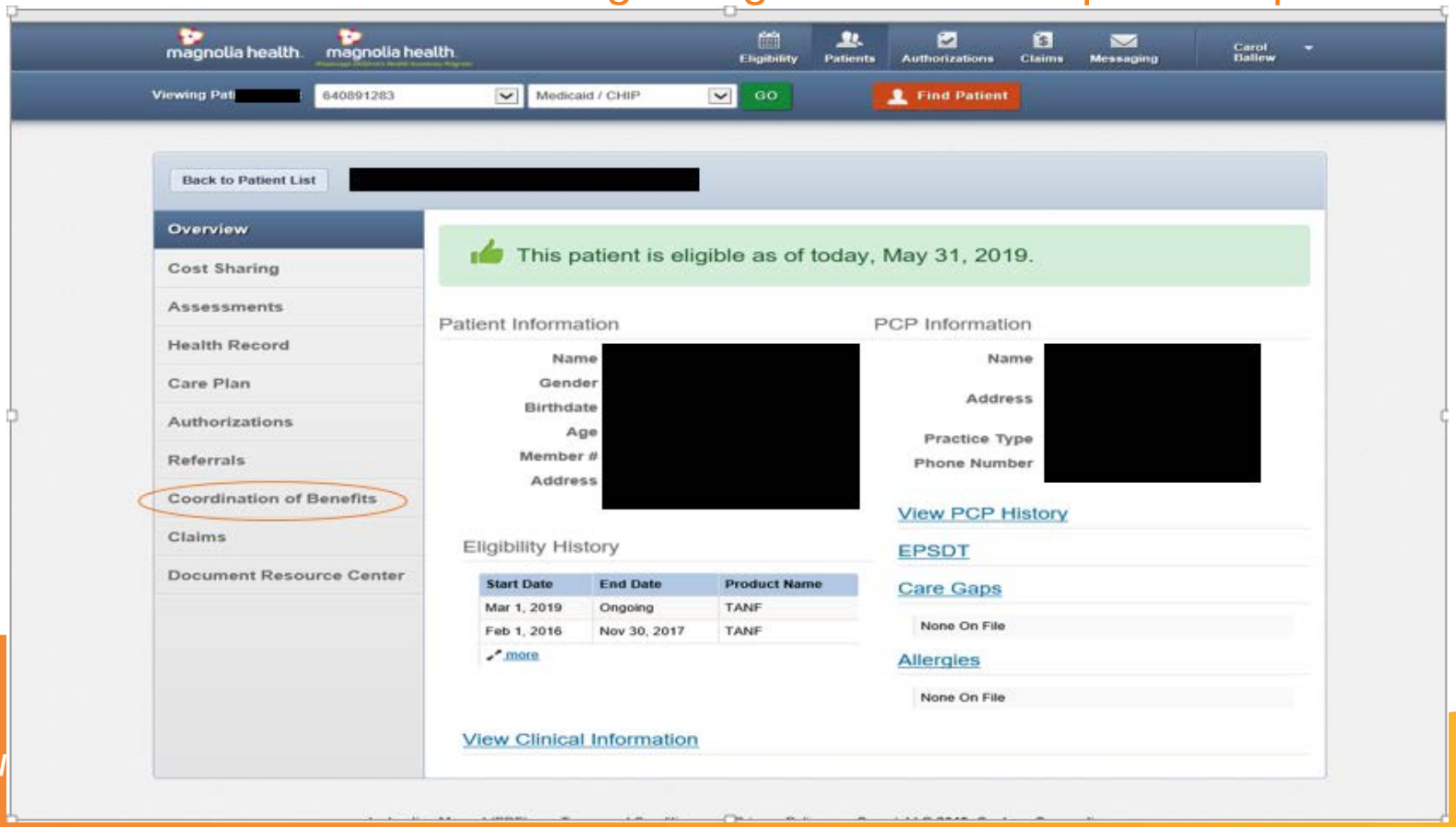
Third Party Liability

8/7/2019

Third Party Liability (TPL)

Third party liability - refers to any other health insurance plan or carrier or program that may be liable to pay all or part of healthcare expenses of the member.

TPL can be verified through Magnolia's secure provider portal



Third Partly Liability (TPL)

- Magnolia's providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Magnolia members. If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third party resources, the provider shall inform Magnolia that efforts have been unsuccessful. Magnolia will make every effort to work with the provider to determine liability coverage.

- If third party liability coverage is determined after services are rendered, Magnolia will coordinate with DOM on eligibility requirements for members identified to have another carrier, which could impact member's eligibility for Magnolia.

TPL

- Magnolia will reimburse a practitioner for certain covered services even when a third party source exists. For these services, Magnolia is required to use the pay and chase method of payment. This means that Magnolia will reimburse the practitioner for specific covered services and pursue recovery from the third party. Some of the services that fall under the pay and chase method are:

  - Pregnancy related services for women (prenatal, labor and delivery, and post-partum)
  - Preventative pediatric services (including ESPDT services)

TPL

- When Magnolia is the secondary payer, you must submit the claim within three hundred and sixty five (365) calendar days of the final determination of the primary payer

- If you have any questions regarding TPL, please contact Provider Services at 1-866-912-6285.

What to do if you receive a request for recoupment

- ✓ Read the request for recoupment completely including supplemental documentation within the letter.
  - Letter will include: affected claims, recoupment amount, and appeal/repayment options

- ✓ Provider have options:
  - If you do not agree with the determination, you may appeal by following the process outlined in the letter. All appeal request must be submitted within the timeframe specified on the notification.
  - If you would like to repay the funds, you may send a check to the address provided within the letter.
  - Do nothing and the funds will be recouped from future remits until balance is exhausted.

What you need to know about TPL

- You may contact Magnolia's call center at 866-912-6285 for assistance with TPL.
- Providers can verify Magnolia members TPL information on the secure portal.
- Look back period for TPL is 18 months.
- Providers must submit claim to the member's primary payer first and then submit explanation of payment to Magnolia as secondary payer.

Third Party Liability (TPL) Remittance Advice Denials

Denial Code	Denial Reason
EX23	Charges have been paid by another party- coordination of benefits
EX8Z	Coordination of benefits must be billed
EXEI	Other coordination of benefits and member has other coverage indicated

Third Party Liability (TPL)

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

TPL Process

Third Party Liability refers to the legal obligation of third parties to pay part or all of the expenditures for medical assistance furnished under a State plan.

Molina's claims processing system tracks all primary coverage, e.g. commercial or Medicare coverage, for each member via the Coordination of Benefits (COB) module.

Molina's member eligibility system will reflect when a member has been identified as having other coverage as an external enrollment segment.

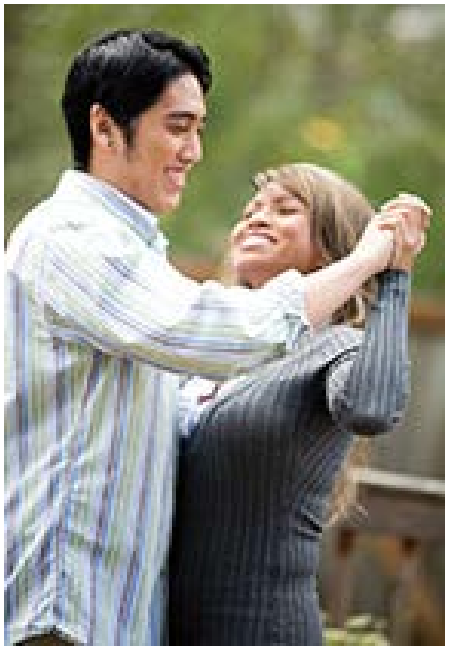
COB is validated with other commercial carriers monthly and reflected as COB segments in Molina's claim processing system.

It is the members responsibility to update DOM of other insurance coverage.

TPL Processes

Molina Healthcare of Mississippi is always the payer of last resort. However, Molina Healthcare is required to reimburse the practitioner for certain covered services prior to billing the third party source, and then pursue recovery of Medicaid payment. Those services include:

1. pregnancy related services for women (prenatal, labor and delivery, and postpartum),
2. preventive pediatric services (including EPSDT services), and
3. covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program.



TPL Recovery

Per the Deficit Reduction Act 2005, the Medicaid program is the payer of last resort. Molina coordinates benefits on claim payments accordingly and utilizes vendors, to seek reimbursement on Molina's behalf from the other carriers.

Molina also independently identifies and/or receive overpayments as a result of TPL. Recovery identified with a total recovery amount of $5 or less will not be requested from the provider so that the administrative cost to recover does exceed the amount of the overpayment.

Recovery letters are sent within the State's regulatory requirements.

All recovery activities are tracked with Molina's Recovery.Net application including requests for refunds, provider refunds and/or recoupments from future claims.

TPL Frequently Asked Questions

Is there a contact number for TPL cost avoidance or TPL recoveries?
Providers must send TPL recoveries to the Molina's Recovery team as instructed on the recovery letter.

TPL cost avoidance can be submitted to our contact center. The contact center will enter the information in our systems. This information is then validated and updated accordingly with Molina enrollment.

Where can I find Molina Member TPL information?
Providers can check member eligibility and benefits using MS Envision or by calling Molina Healthcare Provider Contact Center.

How do I a file claim with TPL?
Providers can submit TPL claims with an EOB using the following methods:

- Molina Provider Portal
- Mail
- EDI

TPL RA denials

Remit Code	Description
MA001	Paying the maximum allowable
N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
N480	Incomplete/Invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).
OC001	COB payment exceeds Plans maximum allowable.

Contact Information

Molina Healthcare of Mississippi, Inc.

188 E. Capitol Street, Suite 700
Jackson, MS 39201

Phone Numbers

Main Line Toll Free	(844) 826-4333
Member Eligibility Verification	(844) 809-8438
Member Services	(844) 809-8438
Provider Services	(844) 826-4335
Behavioral Health Authorizations	(844) 826-4335
Pharmacy Authorizations	(844) 826-4335
Radiology/Transplant/NICU Auths	(855) 714-2415

Fax Numbers

Main Fax	(844) 303-5188
Prior Auth – Inpatient	(844) 207-1622
Prior Auth – All Non-Inpatient	(844) 207-1620
Behavioral Health - Inpatient	(844) 207-1622
Behavioral Health /All Non-Inpatient	(844) 206-4006
Pharmacy Authorizations	(844) 312-6371
Radiology Authorizations	(877) 731-7218
Transplant Authorizations	(877) 813-1206
NICU Authorizations	(877) 731-7220

Vendors

Avesis
Toll Free: (833) 282-2419
Toll Free: (844) 826-4335
www.avesis.com

Southeastrans
Toll Free: (855) 391-2355
Toll Free: (844) 826-4335
www.southeastrans.com/members/mississippi

CVS Caremark
Toll Free: (844) 826-4335
PA submissions Fax: (844) 312-6371

March Vision
Toll Free: (844) 606-2724
Toll Free: (844) 826-4335
www.marchvisioncare.com

UnitedHealthcare Community Plan of Mississippi, Inc.

Third-Party Liability (TPL) & Coordination of Benefits (COB)

UnitedHealthcare Community Plan

Third-Party Liability (TPL) & Coordination of Benefits (COB)

UnitedHealthcare Community Plan

- Always check eligibility and potential TPL
- View eligibility and any other insurance on file for the member through the UHC *LINK* provider portal

  UHCProvider.com > Link > Eligibility

- If you detect a discrepancy, please notify us

  1-877-743-8734 or SWProviderservices@uhc.com

How to file TPL/COB claims

UnitedHealthcare Community Plan

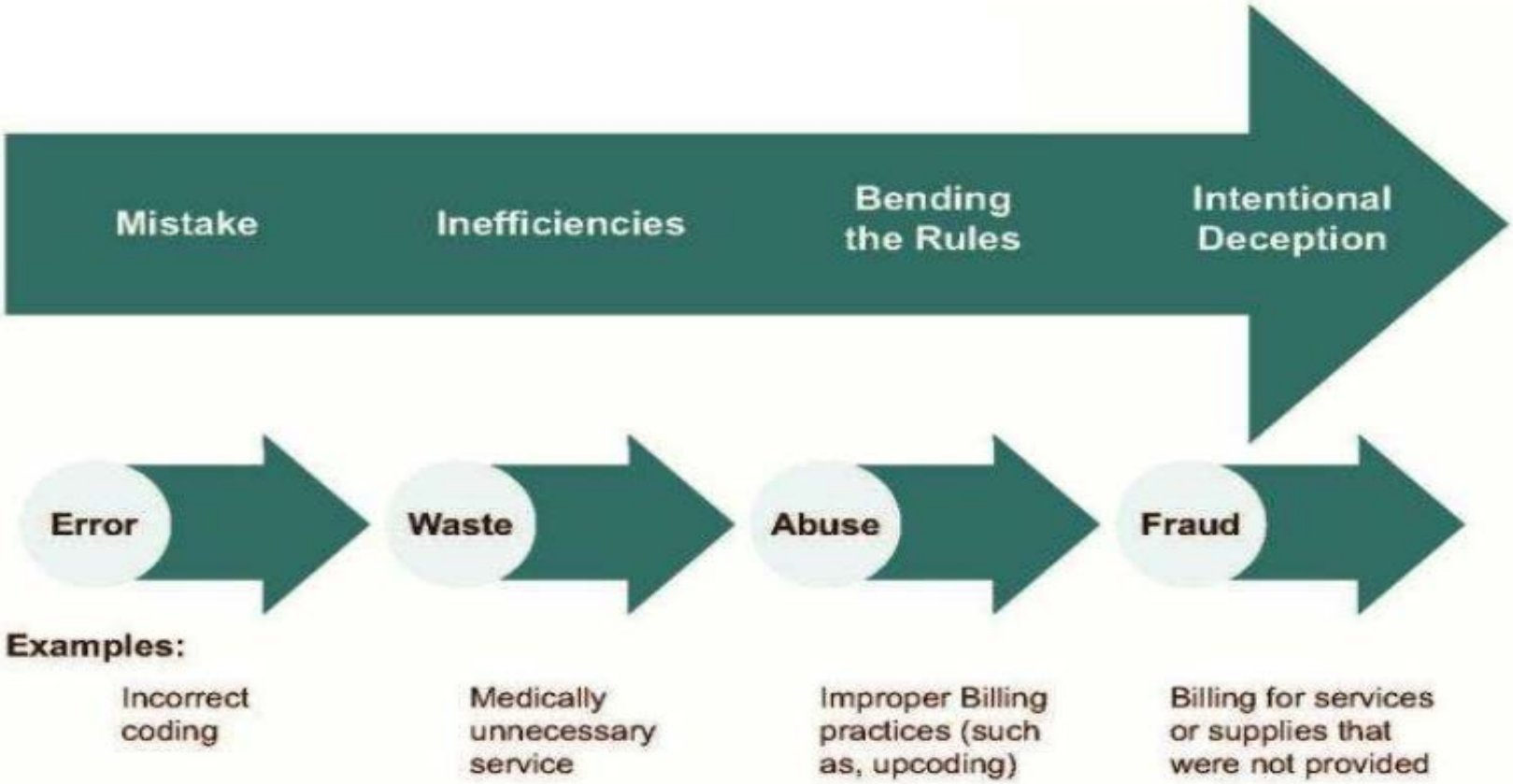
- When UHC is primary: submit directly to us
- When UHC is secondary: submit to primary carrier first, then submit EOB with the claim to UHC for consideration.
- Certain services will allow claim submission to UHC as primary even though there is another primary insurance available (*Pay & Chase*)
  1. Pregnancy related services for women (prenatal, delivery, post-partum, etc.)
     In-patient services are excluded from Pay and Chase and must be coordinated for pregnancy
  2. Preventive pediatric services (including EPSDT services)
  3. Covered services for an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program

Program Integrity

Importance of Program Integrity

- Reduce and eliminate fraud, waste and abuse
- Ensure Medicaid provides high quality care for our most vulnerable people
- Ensure provider payments are made in the correct amount and for appropriate services
- Ensure services provided to enrollees are medically necessary and appropriate
- Ensure compliance with federal and state rules and regulations

Program Integrity – Key Terms



Program Integrity Audits

The Office of Program Integrity conducts retrospective audits of MS Medicaid providers to evaluate and document patterns of healthcare provided to members.

The audits are designed to:

- Ensure compliance with MS Medicaid guidelines
- Recover any overpayments

Audit Process

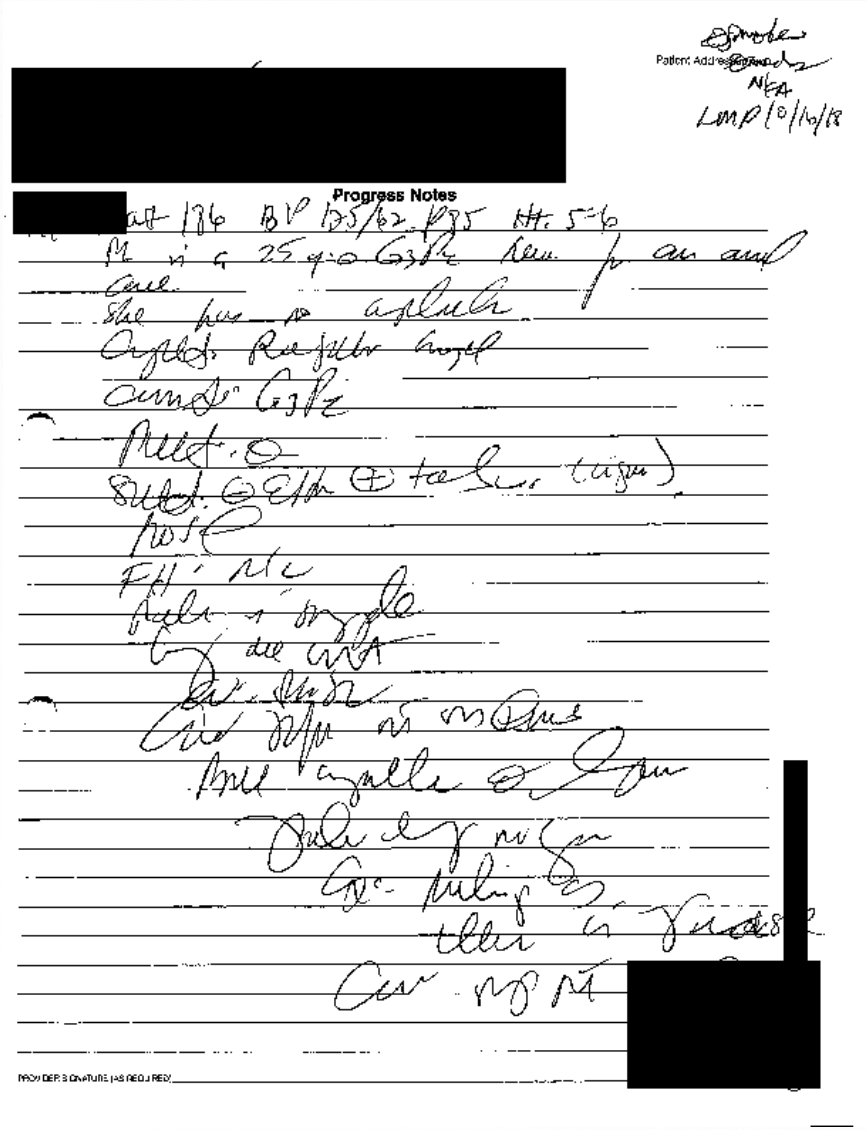
1. Preliminary review of provider, billing, payment and audit history
2. Request of medical records from provider
3. Onsite or in-house medical record audit
4. Draft audit findings letters of preliminary audit results
5. Additional documentation review
6. Demand Letter
7. Administrative hearing process
8. Recoupment of overpayment

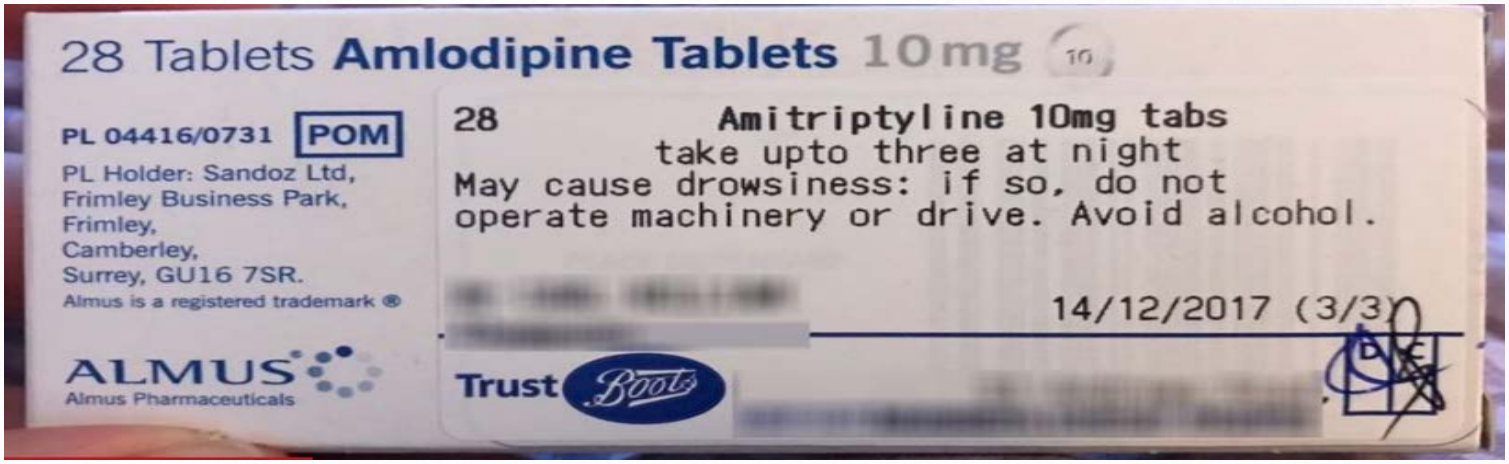
Documentation Standards

- A medical record is a legal document and illegal to tamper with or falsify.
- Documentation must be complete and legible.
- All information must be written and/or compiled on appropriate provider documentation forms.
- All entries must be made in a permanent form.
- Never use corrective tape, corrective liquid, erasers or other obliteration methods to remove or change information.

Examples of Improper Documentation

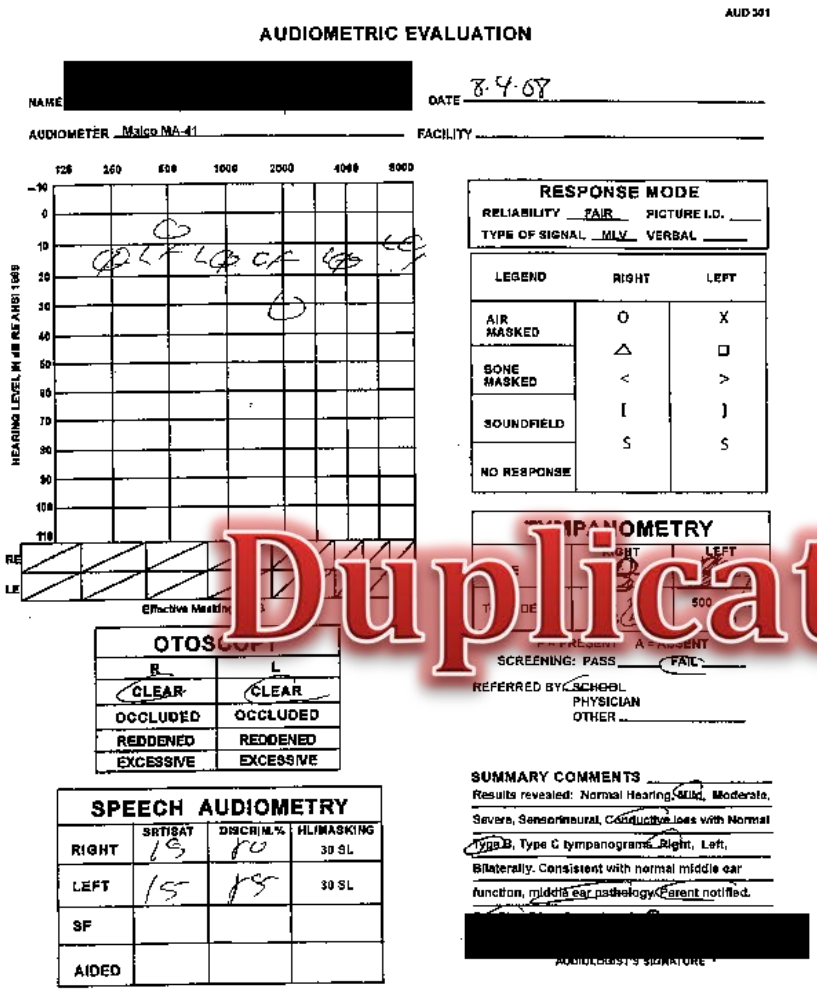
Illegible





Look-alike And Sound-alike Drug Names

Accupril®	Accutane®
Alprazolam	Lorazepam
Cardene®	Cardura®
Flomax®	Fosamax®
Lamisil®	Lomotil®
Nizoral®	Neoral®
Plendil®	Prilosec®
Zantac®	Zyrtec®



AUD 301

AUDIOMETRIC EVALUATION

NAME [redacted] DATE 8.4.08

AUDIOMETER Maico MA-41 FACILITY

125 250 500 1000 2000 4000 8000

HEARING LEVEL IN dB RE ANSI 1969

RESPONSE MODE

RELIABILITY FAIR PICTURE I.D.

TYPE OF SIGNAL MLV VERBAL

LEGEND	RIGHT	LEFT
AIR MASKED	O	X
	△	□
BONE MASKED	<	>
SOUNDFIELD	[	]
NO RESPONSE	S	S

TYMPANOMETRY

	RIGHT	LEFT
TYPE	B	A
	500, 1000 P, A	500, 1000 P, A

A = ABSENT

SCREENING: PASS FAIL

REFERRED BY: SCHOOL PHYSICIAN OTHER

OTOSCOPY

R	L
CLEAR	CLEAR
OCCLUDED	OCCLUDED
REDDENED	REDDENED
EXCESSIVE	EXCESSIVE

SPEECH AUDIOMETRY

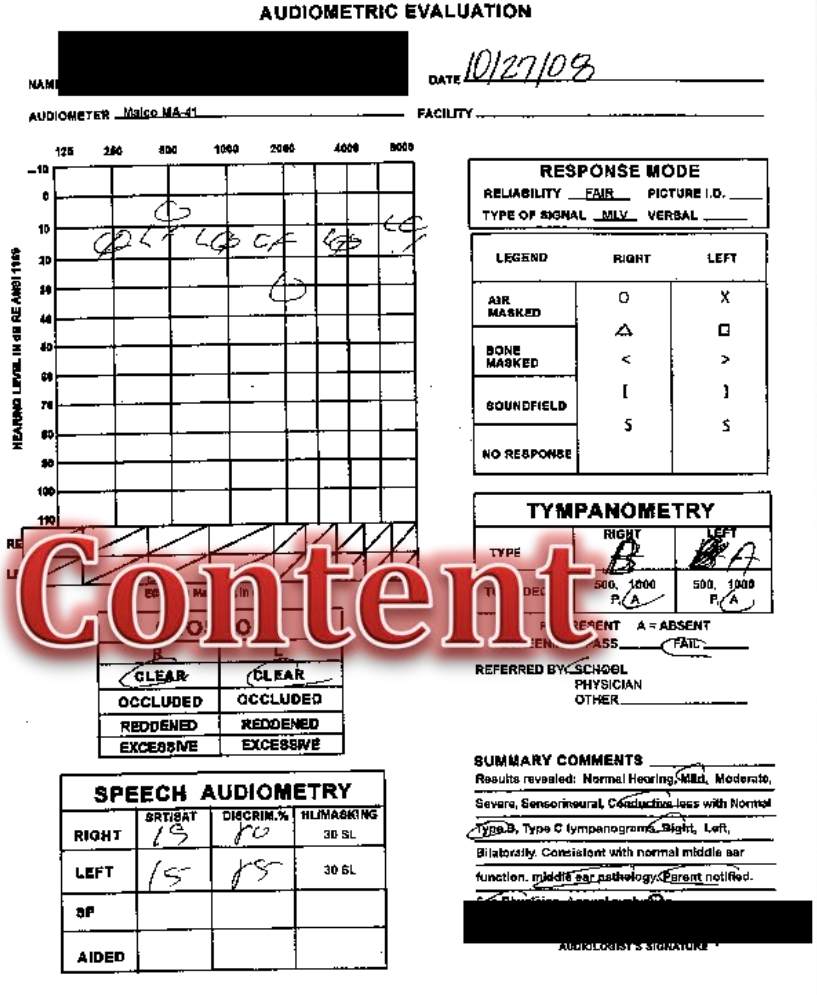
	SRTSAT	DISCRIM.%	HL/MASKING
RIGHT	15	20	30 SL
LEFT	15	15	30 SL
SF			
AIDED			

SUMMARY COMMENTS

Results revealed: Normal Hearing, Mild, Moderate, Severe, Sensorineural, Conductive loss with Normal Type B, Type C tympanograms, Right, Left, Bilaterally. Consistent with normal middle ear function, middle ear pathology. Parent notified.

[redacted]

AUDIOLOGIST'S SIGNATURE



AUD 301

AUDIOMETRIC EVALUATION

NAME [redacted] DATE 10/27/08

AUDIOMETER Maico MA-41 FACILITY

125 250 500 1000 2000 4000 8000

HEARING LEVEL IN dB RE ANSI 1969

RESPONSE MODE

RELIABILITY FAIR PICTURE I.D.

TYPE OF SIGNAL MLV VERBAL

LEGEND	RIGHT	LEFT
AIR MASKED	O	X
	△	□
BONE MASKED	<	>
SOUNDFIELD	[	]
NO RESPONSE	S	S

TYMPANOMETRY

	RIGHT	LEFT
TYPE	B	A
	500, 1000 P, A	500, 1000 P, A

A = ABSENT

FAIL

REFERRED BY: SCHOOL PHYSICIAN OTHER

OTOSCOPY

R	L
CLEAR	CLEAR
OCCLUDED	OCCLUDED
REDDENED	REDDENED
EXCESSIVE	EXCESSIVE

SPEECH AUDIOMETRY

	SRTSAT	DISCRIM.%	HL/MASKING
RIGHT	15	20	30 SL
LEFT	15	15	30 SL
SF			
AIDED			

SUMMARY COMMENTS

Results revealed: Normal Hearing, Mild, Moderate, Severe, Sensorineural, Conductive loss with Normal Type B, Type C tympanograms, Right, Left, Bilaterally. Consistent with normal middle ear function, middle ear pathology. Parent notified.

[redacted]

AUDIOLOGIST'S SIGNATURE

Best Practices

- Follow all federal and state statutes, rules, regulations, policies and procedures and make changes as a provider to meet them
- Good Standard to adopt:
  - **WIDE** (**W**rite **I**t **D**own **E**veryday)
  - Document all services at the time of service
  - Double check all documentation to ensure it is complete and complies with all standards
- Institute a quality assurance plan or committee to review monthly or quarterly for accuracy.
- Ensure that services provided are medically necessary or otherwise authorized under Medicaid.
- Promptly refund any identified overpayments.

Program Integrity Audit Myths

- The MS Medicaid Office of Program Integrity cannot audit managed care claims.
- The Division of Medicaid has to pay for medical record requests.
- Providers do not have to allow investigators onsite to audit.

Program Integrity Resources

Report Fraud and Abuse

Program Integrity investigates activities relating to the prevention, detection and investigation of alleged provider and beneficiary fraud and/or abuse in the Medicaid program.

Every dollar lost to the misuse of Medicaid benefits, is one less dollar available to fund programs providing essential medical services for vulnerable Mississippians. If we don't work together to help stop fraud and abuse, the system might not be available for those whom the program was created to help.

You can contact the Mississippi Division of Medicaid (DOM) multiple ways as listed below, including by phone, postal mail, fax and online forms. It is advised that you do not email forms or submit online forms with protected health information or personally identifiable information, to protect confidentiality in accordance with the Health Insurance Portability and Accountability Act of 1996.

- Toll-free: 800-880-5920
- Phone: 601-576-4162
- Fax: 601-576-4161
- Mailing address: 550 High Street, Suite 1000, Jackson, MS 39201
- Report fraud and abuse by submitting a fraud and abuse complaint form

Provider Terminations

The Mississippi Division of Medicaid maintains a list of providers whose Medicaid provider agreement has been terminated. Refer to the Miss. Code Ann. §43-13-121 and the Code of Federal Regulations (CFR) §455.416 for the reasons a provider's enrollment may be denied or revoked. The following list contains individuals or entities whose participation in the Medicaid program has been terminated for cause. Excluded individuals and entities are not allowed to receive reimbursement for providing Medicare and Medicaid services in any capacity, even if they are not on this listing.

The Affordable Care Act (ACA) requires that all physicians or other professionals who order or refer services for which a claim will be submitted to the Medicaid program must be enrolled as participating providers (see 42 CFR §455.410 (b)). Therefore, any un-enrolled provider, including any provider who is terminated from the Medicaid program for any reason, is not allowed to furnish, order, prescribe, or make referrals for services for which claims to the Medicaid program will be generated. Use of this list will help providers avoid submitting claims for medical care, services, and/or supplies that are ordered or prescribed by individuals or entities who are not authorized to submit such orders. Providers are responsible for screening all employees and contractors to identify excluded individuals and are responsible for searching the Office of Inspector General website, the System for Award Management (SAM) and the Mississippi Medicaid Sanction Provider List monthly to capture exclusions and reinstatements.

The Office of the Inspector General maintains a national list of all individuals who are excluded from receiving reimbursement from Medicare and Medicaid. For a comprehensive list of all individuals, go to http://oig.hhs.gov/fraud/exclusions.asp.

The files below contain providers who have been terminated from participation in the Mississippi Medicaid Program.

- Sanctioned provider list

Recovery Audit Contractor (RAC) Program

Current Audit Concepts – May 1, 2018

Add On Codes
Purpose of Audit: To validate claims coded and billed by providers and paid by DOM are not being overpaid for add-on codes when the required primary procedure either was not reported or was not paid.

New Patient Visits
Purpose of Audit: To validate claims coded and billed by providers and paid by DOM are correct for new patient visits; to identify incorrect payments associated with the same provider or provider group with the same specialty and subspecialty billing more than one new patient Evaluation and Management code within a 3 year time period.

3-Day Rule
Purpose of Audit: To validate that the claims coded and billed by the providers and paid by DOM are correct under the "3-day payment window." Under the payment window policy, a hospital (or an entity that is wholly owned or wholly operated by the hospital) must include on the claim for a beneficiary's inpatient stay, the diagnoses, procedures, and charges for all outpatient diagnostic services and admission-related outpatient non-diagnostic services that are furnished to the beneficiary during the 3-day payment window.

2019 Division of Medicaid Provider Workshops

Program Integrity

8/7/2019

Special Investigations Unit (SIU)

Reporting Waste, Abuse & Fraud:

WAF Helpline – 1-866-685-8665

- Available 24 hours a day
- Callers not required to give their names
- All calls will be investigated
- All calls remain ***CONFIDENTIAL***

Local Contact: Will Simpson, Vice-President, Compliance

601-863-3352

William.M.Simpson@CENTENE.COM

Cc: JACCompliance@centene.com

Special Investigations Unit (SIU)

Investigating Waste, Abuse & Fraud

Magnolia's SIU team investigates ***ALL*** reported WAF issues:

- Members
- Providers
- Facilities – hospitals, mental health programs, etc.
- DME providers
- Pharmacy
- Ancillary services – diagnostic, therapeutic, labs, custodial, etc.

Special Investigations Unit (SIU)

Investigating Waste, Abuse & Fraud: Prevention, Detection, and Investigation

- Magnolia takes the detection, investigation and prosecution of WAF seriously and has WAF program that complies with Mississippi state and federal laws
- Claims editing software performs systematic audits during the claims payment process – outliers are reported to SIU
- Referrals are made to SIU via WAF Helpline, the MS DOM, providers, provider employees, members, family members, facilities, pharmacies and data mining
- Magnolia's SIU team performs prepay and retrospective audits to ensure compliance with billing regulations and quality of care

Special Investigations Unit (SIU)

What You as a Provider need to Know:

- ***SIU will deny*** payment on prepay services found to be unsupported via peer review*
- ***SIU will recoup*** overpayments found in retrospective reviews via peer review*
- ***SIU will report*** Credible Allegations of Fraud (CAF) to the MS DOM who will report CAF to the Mississippi Attorney General's Office/ Medicaid Control Fraud Unit (MFCU)
- ***SIU will cooperate*** with MFCU

***The findings can be appealed. All steps for appeal and appeal rights will be stated in your letter.**

Program Integrity

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

Fraud, Waste and Abuse

Molina Healthcare of Mississippi, Inc. (Molina) is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. Accordingly, Molina has established a comprehensive Fraud, Waste, and Abuse Plan, also referred to as the “FWA Plan.”

The FWA Plan has been instituted in accordance with federal and state statutes regulations. Molina also complies with the Centers for Medicare and Medicaid Services Medicaid Integrity Program.

The FWA Plan has been developed to comply with all standards set forth by the regulations and laws of the United States Department of Health and Human Services Centers for Medicare and Medicaid Services and the State of Mississippi Division of Medicaid Office of Program Integrity. The FWA Plan is reviewed annually.

Confidential Reporting of Suspected Fraud, Waste, and Abuse

Molina utilizes several mechanisms to encourage anonymous, confidential and private, good faith reporting of instances of suspected fraud, waste, and abuse. Molina maintains confidential reporting mechanisms that Molina employees, members, and providers can use to report suspected fraud, waste, and abuse.

The Molina Healthcare AlertLine is available 24/7 and can be reached at any time (day or night), over the weekend, or even on holidays.

To report an issue by telephone, call toll-free at **(866) 606-3889**. To report an issue online, visit **https://molinahealthcare.AlertLine.com**. In addition to the Molina Healthcare AlertLine, employees may still report issues of concern directly to their supervisor, any Compliance official, or the Legal department.

Compliance Officer

Molina's Compliance Officer is the individual within the organization who is responsible for ensuring the health plan is abiding by the FWA Plan. The Compliance Officer, along with the health plan's Special Investigation Unit (SIU) has the responsibility and authority to report all investigations resulting in a finding of fraud, waste, and abuse to the Division of Medicaid Office of Program Integrity.

Contact information for the Compliance Officer is as follows:

Jeremy Ketchum, Compliance Officer
Molina Healthcare of Mississippi, Inc.
188 E. Capitol Street, Suite 700, Jackson, MS 39232
Phone number: **(888) 562-5442, ext. 177994**
E-Mail: Jeremy.ketchum@molinahealthcare.com

If there are changes in staff responsible for carrying out the plan, Molina will provide the Division of Medicaid Office of Program Integrity updated information.

Special Investigation Unit (SIU)

Molina's SIU supports the health plan Compliance Officer in preventing, detecting, investigating, and reporting all suspect fraud, waste, and abuse to the Office of Program Integrity. Molina shall cooperate with the Office of Program Integrity and other state and federal regulatory and/or law enforcement agencies in investigations of suspected fraud, waste, and abuse as necessary. Molina will assist the Division in any investigation or prosecution of Fraud by providing the following:

1. access to and free copies of computerized data stored by Molina;
2. direct computer access to computerized data stored by Molina that is supplied without charge and in the form requested by the Division; and,
3. access to any information possessed or maintained by any Provider of service(s) under the Medicaid State Plan to which the Division and Molina are authorized to access.

In terms of Molina's SIU organizational arrangement, the SIU Director is responsible for SIU development, implementation, and oversight. The SIU Director's information is as follows:

Shane Tiernan, Director, FWA, Operations
Molina Healthcare, Inc., 200 Oceangate, Suite 100, Long Beach, CA 90802
Phone number: **(888) 562-5442, ext. 113158**
E-mail: Shane.Tiernan@molinahealthcare.com

Special Investigation Unit Strategies

Strategies employed by the Molina Special Investigation Unit (SIU) when conducting retrospective fraud, waste, and abuse investigations:

Molina employs processes that retrospectively detect/identify issues and address instances of FWA that may have already occurred
The SIU conducts post-payment reviews using a fraud analytics system that employs multiple algorithms to identify billing outliers and aberrant service patterns, potential areas of overutilization or underutilization, changes in billing behavior, and possible improper schemes
The FWA analytics system brings enhanced solutions in identifying suspect behavior, which includes thorough risk assessments, provider scoring, and machine learning capabilities via the proprietary data platform
Providers exceeding a certain risk score will be considered leads and reviewed. Steps involved include performing a conflict check on the provider, initiating work on a lead, reviewing the provider scorecard to determine risk score, ranking in the peer group, reviewing risk factors
All cases, either proactive or via the Molina AlertLine, go through a two-tier process for investigation, which includes a preliminary and extensive investigation (as applicable)

Pre-Payment Reviews

Special Investigation Unit initiated pre-payment reviews:

Our FWA activities begin with the corporate philosophy that *prevention* of fraudulent, wasteful and abusive events is the *most* efficient and effective way to combat FWA. We apply an extensive array of *prepayment review* measures. Our SIU has no minimum dollar thresholds associated with its preliminary investigations and risk assessments as small investigations may lead to significant FWA detection.

Prepayment reviews can be initiated based on a directive from a state regulator, a high-dollar coding outlier, or based on a information discovered in the course of an audit.

As part of the SIU directed prepayment review process, the provider is notified in writing they are under review and instructed that all claims must be accompanied by medical records and submitted via mail. A team of nurse auditors reviews all incoming records and allows payment accordingly.

In addition, all submitted claims are subjected to a dual pass pre-payment clinical and claim editing of HCPCS/CPT and diagnosis codes to identify frequent coding errors ensuring claims are coded appropriately according to state and federal guidelines.

UnitedHealthcare Community Plan of Mississippi, Inc.

Program Integrity

UnitedHealthcare Community Plan

Program Integrity

UnitedHealthcare Community Plan

- UnitedHealthcare maintains both prospective and retrospective processes to assure that medically necessary services are appropriately reimbursed.
- UnitedHealthcare also maintains algorithms and claims monitoring systems to assess feasibility and likelihood of services being rendered as billed
- These processes are managed by both UHC and Optum payment integrity teams.
- Providers should respond to all record requests within the requested timeframe.
- Standard dispute processes and appeal rights are extended to these activities

Payment Integrity Claim Processes

UnitedHealthcare Community Plan

- Claim Editing - the claim payment system recognizes a specific code and automatically applies claim edits that support accurate payment
  - Example: Submitted CPT code is found on the CMS CCI editing file along with the corresponding code which triggers bundling logic as appropriate
- Reimbursement Policies – payment accuracy and consistency based on correct coding rules and industry standards for HIPAA, state and federal regulations, medical and drug policies
- Post-Payment Claim Audit
  - Retrospective Review utilizes claims data to identify irregular or suspicious practices or billing patterns for services previously rendered. Providers' coding and billing practices are compared to peers to determine any patterns of inappropriate or irregular billing.
  - MedReview
    - DRG Review
    - Outlier Review
    - Readmission Review

Other Payment Integrity Processes

UnitedHealthcare Community Plan

- **High Dollar Audit** - pre-payment review of claims paying over a $9k threshold for Medical and over $5K for Hospital claims.
- **Contract Audit** - pulls in retrospective paid claim data to identify any variance between contract terms and system pricing. Upon identification of a variance, load correction and claim adjustments are completed.
- **Subrogation** - pursue and recover any payments for which another carriers is responsible due to accident or injury (i.e. workers comp, auto injury)
- **COB/TPL** - determines which plan has primary responsibility when a member is covered by more than one, and ensures accurate payment coordination.
- **Pharmacy**
  - Real time audits - pre-payment, concurrent claim review (CCR) systems which offer a unique method for auditing pharmacy claims timely post-adjudication and assists in reducing the number of erroneous claims, as well as detecting patterns of FWA.
  - Desktop and on-site auditing - Routine on-site (non-fraud) audits are also selected using a large set of algorithms, based on billing patterns and peer norms. Results are compiled and used to select pharmacies for onsite audit.
- **Fraud Investigations** - initiated upon receipt of credible allegation and may involve desktop auditing, member verifications, provider verifications, purchase reviews, on-site investigations, internal and external referrals.
- **Sanctions Monitoring** - monitors state and federal sources to ensure payment is denied for providers who have lost their license or have practice restrictions.

Reporting Fraud, Waste & Abuse

UnitedHealthcare Community Plan

- If you suspect another care provider or a member has committed fraud, waste or abuse, then you have a responsibility and a right to report it.

- Call the Anti-Fraud and Recovery Solutions (AFRS) unit at Optum to make anonymous reports and offer tips about suspected fraud, waste or abuse.

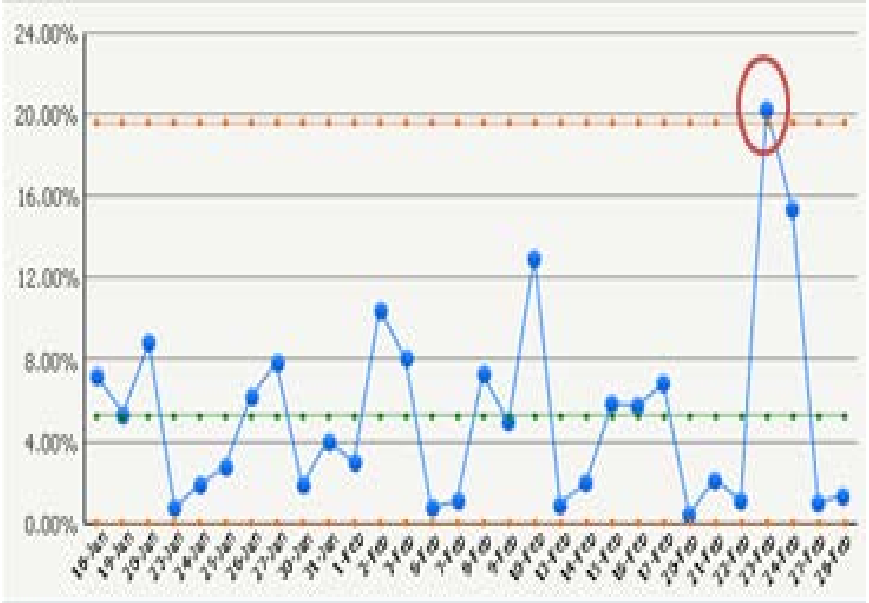
- 866-242-7727
  - Hours of operation: Monday-Friday, 8 AM - 4:30PM
  - This number is accessible to both providers and members.
  - After-hours calls have the option to leave a message and/or request a call back.

Program Integrity as a Provider Benefit

UnitedHealthcare Community Plan

CARE PROVIDER EARLY WARNING SYSTEM

Category: Overview
Volume: 1286
Denial Code: Claim Submitted after provider's timely filing limit.
Description: Reviewed claims and found provider is mass billing for same DOS after original claims were paid. Verified original claims were paid correctly and checked for provider selection and found no issues on history views of submission. Requested provider outreach to several providers to see why they are rebilling multiple times. The reach out shows provider does verify that claims were paid in history and not sure why additional submission occurred. Further research was submitted as there is suspect that there is a clearing house issue from the provider.



Question & Answer Session