Mississippi Division Of Medicaid

Provider Workshops

2019

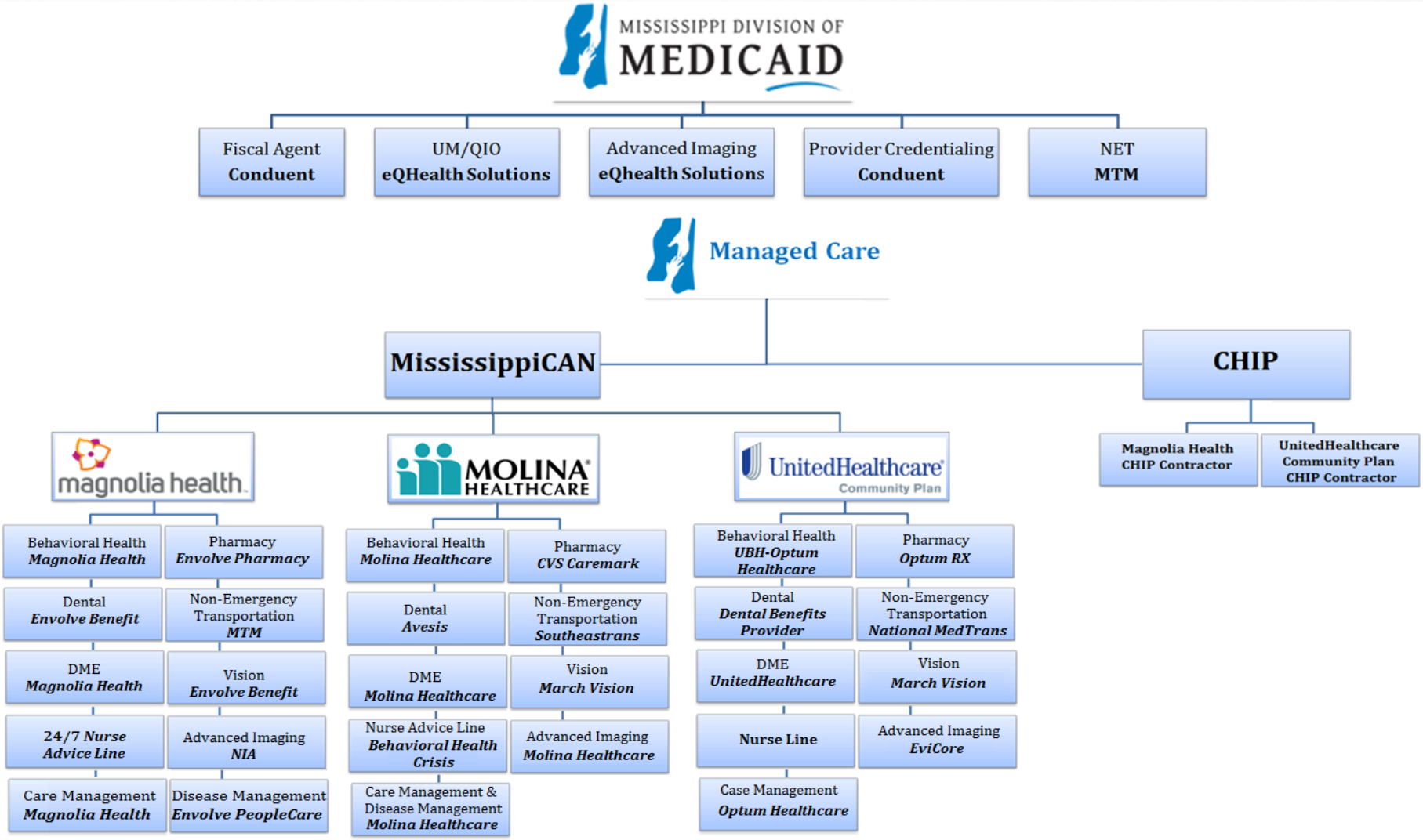
MISSISSIPPI DIVISION OF MEDICAID

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.	**Managed Care Overview** **Prior Authorizations** **Claims Review** **Retro Reviews**
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

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

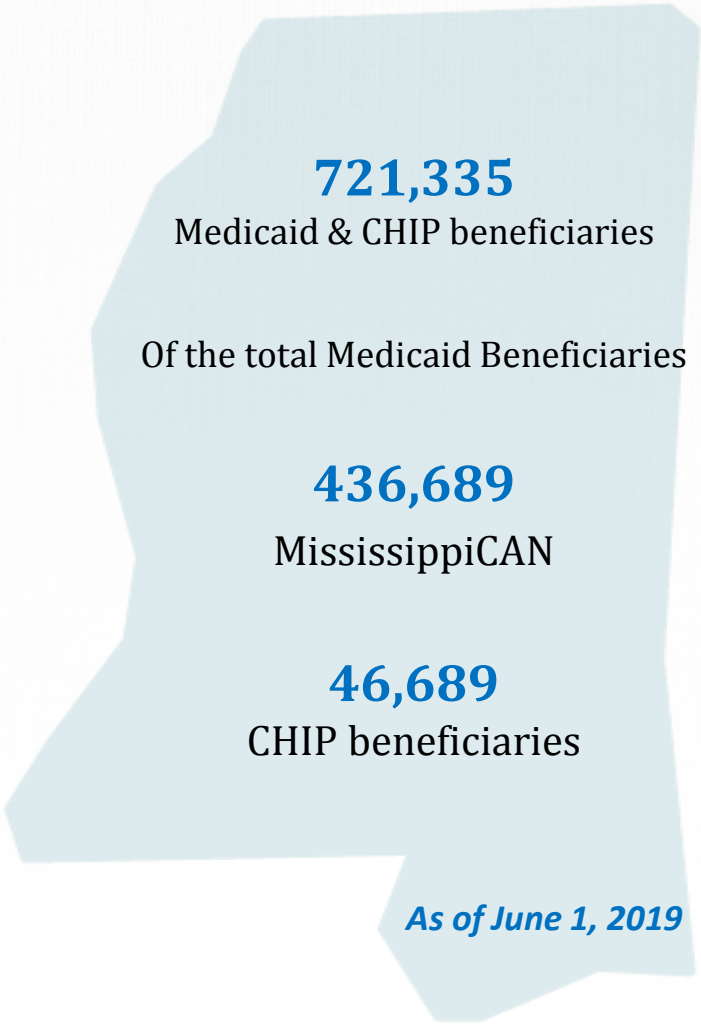
Managed Care Inquiries and Complaints	
Date	
Provider Name	
Provider ID Number	
Facility Name	
Contact Person	
Telephone Number	
Fax Number	
Beneficiary Name	
Beneficiary ID Number	
Telephone Number	
PLEASE PROVIDE DETAILED QUESTIONS AND/OR COMPLAINTS	

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.

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.

ALLIANT HEALTH SOLUTIONS

MS Medicaid UM/QIO Services

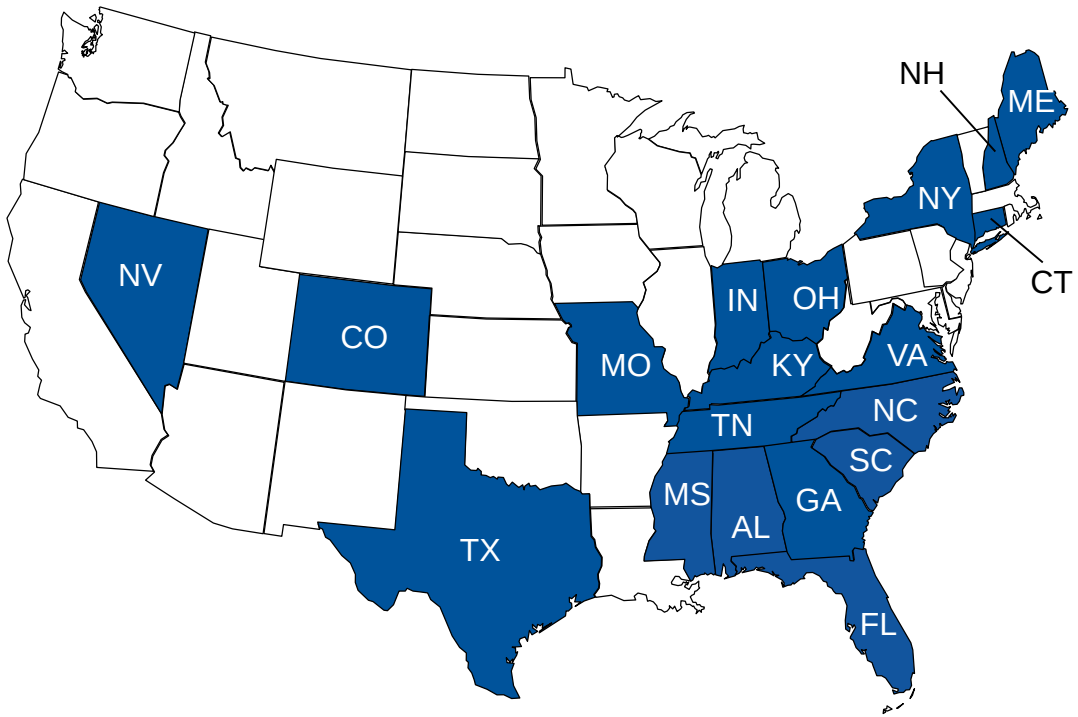
Presented by:

Denise Morgan , RN, BSN, MSN

Company Overview

- Nonprofit with 45+ years public sector experience
- More than 200 employees supported by practicing clinical consultants from 70 specialties
- Clinically led and data/systems driven
- Quality in all we do…
  - Medicare QIO/PRO Since 1984
  - ISO 9001:2015 Quality Management System
  - URAC Health Utilization Management
- Serving public and private partners to increase the value, effectiveness, and accessibility of health care
  - Utilization Management
  - Quality Management and Improvement
  - Compliance and Program Integrity

Markets Served by Alliant
(as of June 1, 2019)



- Alliant serves customers in 20 states
  - State programs in 9 states, including Medicaid MCOs
  - Federal programs in 8 states
  - Commercial health plans in 10 states

ALLIANT HEALTH SOLUTIONS

MS Medicaid UM/QIO Services

- Medical Services Utilization Management (UM)
- Behavioral Health Services UM
- Dental Services UM
- Peer Review Services
- Quality Improvement Services – Quality Reviews
- Care Management Services

UM/QIO Transition Schedule

- Effective August 1, 2019, Alliant will begin performing prior authorizations for new requests
- Prior authorizations submitted on or before July 31 will be completed by eQHealth Solutions (eQHS)
  - For requests to eQHS pended for additional information, providers will submit related inquiries and requested information to eQHS
- UM/QIO transition applies to all prior authorizations currently reviewed by eQHS, except advanced imaging
- Prior authorizations for beneficiaries enrolled in MississippiCAN will continue to be handled by the respective Coordinated Care Organizations (CCOs)

Prior Authorization Process

- What's changing?
- A focus on administrative simplification
  - Less forms, more focus on specific information needed for processing requests
- Dynamic prior authorization portal, including a dedicated provider workspace:
  - Real-time access to all prior authorization functions
  - Secure messaging with Alliant's clinical team
  - Quickly view last 10 PA requests; last 10 decision notices; and last 10 provider messages
  - Provider education and training services module: training materials and videos; reference guides; and user manuals

https://ms.allianthealth.org

ALLIANT HEALTH SOLUTIONS

MS Medicaid Provider Portal

Prior Authorization Web Portal

Alerts / Messages

Effective August 1, 2019, Alliant Health Solutions will begin performing prior authorization reviews for new requests as the Mississippi Division of Medicaid (DOM) transitions to a new Utilization Management / Quality Improvement Organization (UM/QIO) vendor. All prior authorization reviews in process before August 1, will be completed by eQHealth Solutions as part of the transition to Alliant Health Solutions. Therefore any requests submitted on or before July 31 that are pended for additional information will be handled by eQHealth Solutions and providers will submit related inquiries and requested information/documentation to eQHealth Solutions during the month of August. This UM/QIO transition applies to all prior authorization services currently reviewed by eQHealth Solutions, except advanced imaging services, which will continue to be handled by eQHealth Solutions.

Mississippi Prior Authorization Web Portal Overview

Alliant Health Solutions is URAC accredited in Health Utilization Management and has over 25 years of experience providing utilization review and quality improvement services for Medicaid populations in several states.

The Mississippi Medicaid Prior Authorization Web Portal serves as the primary web portal for Medicaid providers to interact with Alliant Health Solutions as the UM/QIO vendor for the Division of Medicaid. The Prior Authorization web portal provides timely communications, data exchange and self-service tools for providers with both secure and public access areas.

Members of the public can obtain general information about UM/QIO prior authorizations and learn more about various UM/QIO interactions.

Medical Assistance Plan Providers can access a wealth of information including notices, forms, training and more. Providers can also register as a Prior Authorization web portal user to gain access to the provider workspace for submission of authorization requests, checking the status of requests, secure communications, and additional provider-specfic information.

Provider Information / Login

Provider Login

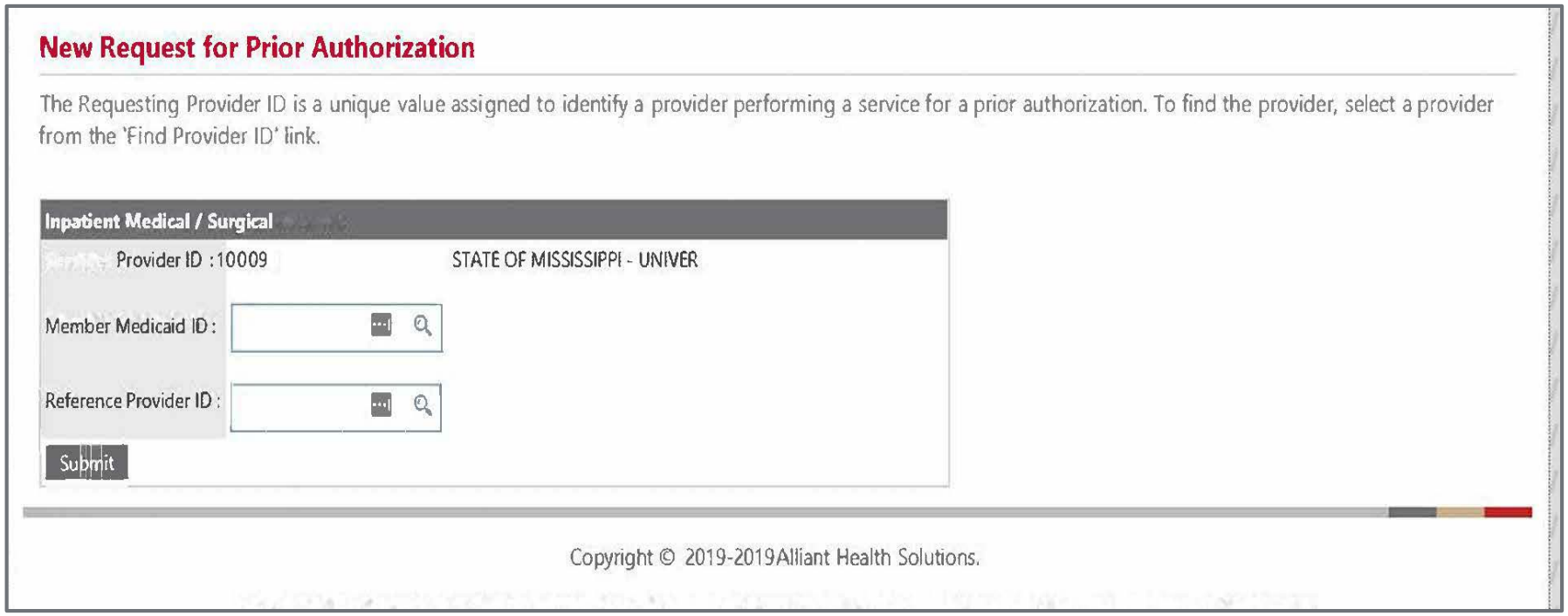
Scheduled Site Maintenance

Monday - Tuesday	1:00 AM - 2:00 AM
Wednesday	1:00 AM - 2:00 AM and 7:00 PM - 10:00 PM
Thursday - Saturday	1:00 AM - 2:00 AM
Sunday	12:00 AM - 7:00 AM

https://ms.allianthealth.org

ALLIANT HEALTH SOLUTIONS

Submitting a New PA Request



ALLIANT HEALTH SOLUTIONS

Hospital PA Request

Hospital Admissions and Outpatient Procedures (Form PA-81/100)

Please verify that the member name represents the correct member for this request. If not, please select under Prior Authorization the 'Submit/View' link to re-enter the correct information. If you need assistance please select under Contact Information the 'Contact Us' link, or call the Provider Contact Center at 1-800-xxx-xxxx.

Please provide the required information for this request. When you have completed entering data for this request, select the 'Review Request' link at the bottom of the page.

Prior authorization or pre-certification does not guarantee payment, approval of service or member benefit eligibility for the service.

Member Details

Member ID	Last Name	First Name	MI	Suffix	DOB	Gender
111111111	Beneficiary	Mister	J		12/20/1920	M

Service Provider Information

Provider ID	Name and Address	Phone	Taxonomy (Specialty)
10009	STATE OF MISSISSIPPI - UNIVER 1500 SW ANY STREET JACKSON, MS 39216	601-555-1212	Family Practice

Reference Provider Information

Physician ID	Name and Address	Phone	Taxonomy (Specialty)
11109	SMITH DOCTOR B MD 1400 112TH AVENUE SUITE X ANYWHERE, MS 39216	601-555-1212	Internal Medicine

Contact Information

* Contact Name :

* Contact Email :

* Contact Phone : 601-555-1212 Ext.

* Contact Fax : - -

ALLIANT HEALTH SOLUTIONS

Hospital PA Request (cont.)

Request Information

* Admit Date :	04/24/2019	Discharge Date :	MM/dd/yyyy	Targeted Discharge Date :	05/10/2019
Admission Type :	Emergency	Place of Service :	Inpatient Hospital		

*** Diagnosis**

ICD Code	Diagnosis Description	Date	Primary	Admission	
E08.620	DIABETES DUE TO UNDERLYING CONDITION W DIABETIC DERMATITIS	04/24/2019	Yes	No	EDIT DELETE
		MM/dd/yyyy			ADD

Supporting Information

*** Clinical Data to Support Request :**

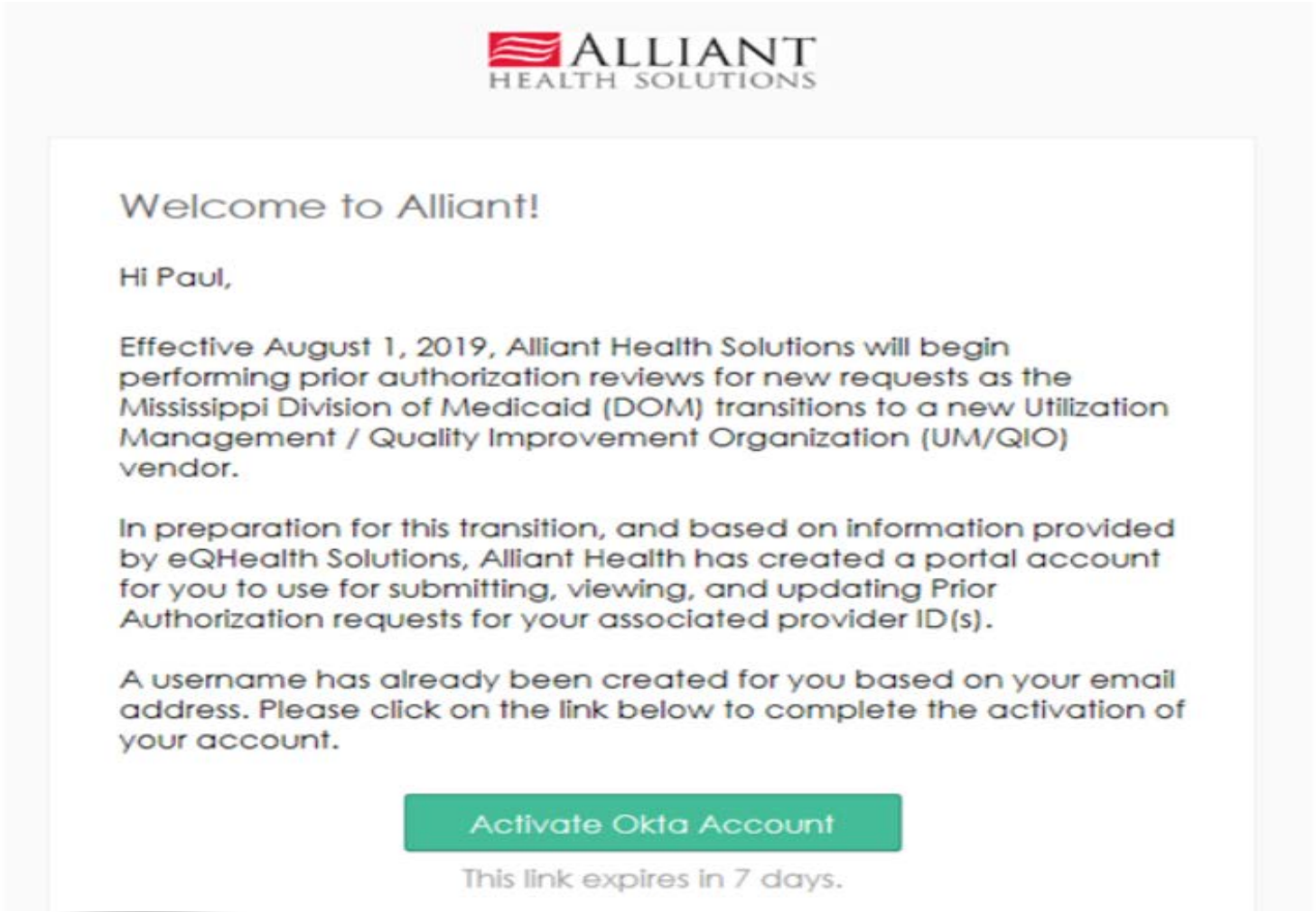
Include vital signs, history and physical, lab reports, X-rays, signs/symptoms, whether the patient was treated on an outpatient basis for 48 hours prior to admission

*** Admitting Treatment Plan :**

Describe the services to be provided, i.e., IV fluids, medications, complex wound care and other treatments.

ALLIANT HEALTH SOLUTIONS

Portal Sign-up Outreach



https://ms.allianthealth.org

ALLIANT
HEALTH SOLUTIONS

Prior Authorizations

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

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

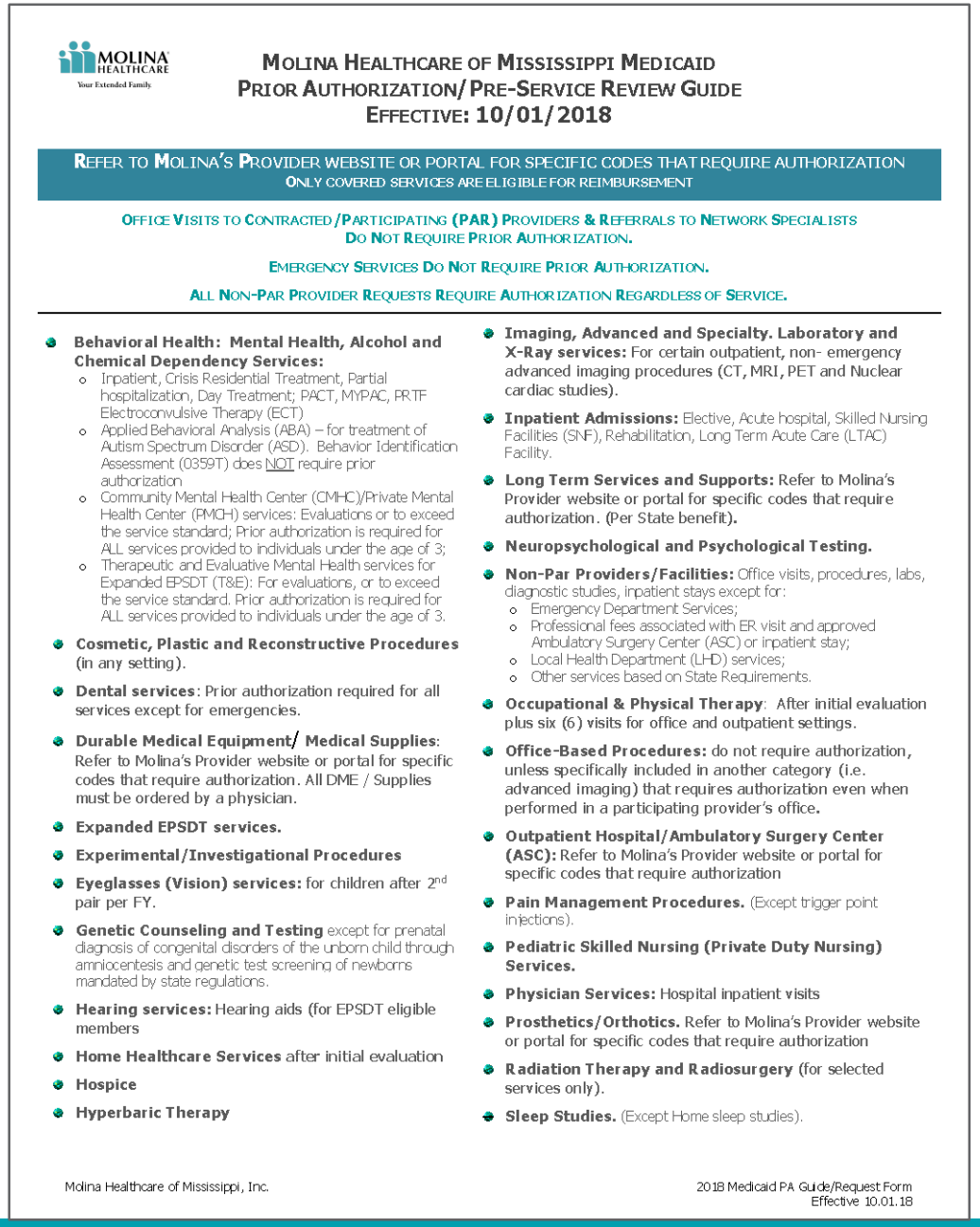
Behavioral Health Authorizations:
Phone: 1 (844) 826-4335
Inpatient Requests Fax: 1 (844) 207-1622
All Non-Inpatient Fax: 1 (844) 206-4006

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
Your Extended Family

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

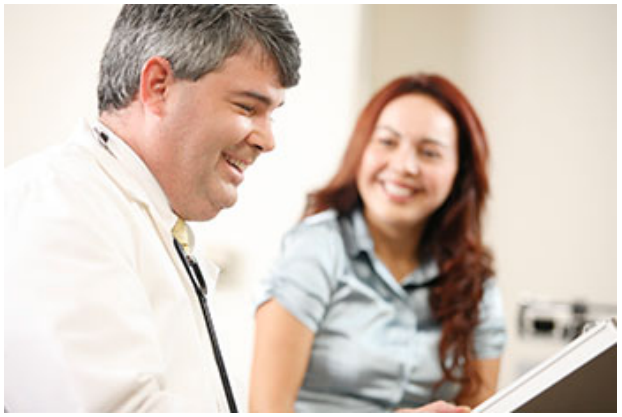
- Requests for authorization not meeting criteria must be reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate) 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.



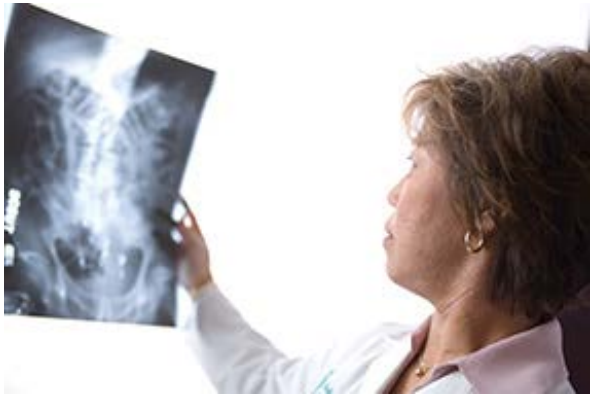
Coordination of Care and Services

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.

Top 5 Reasons for Delay in PA Request

Our #1Goal is to get your PA request correct and returned to the you as soon as possible

- Incorrect Fax number on the Submitted PA request
- Not enough clinical information to make a medical determination
- Call to UM department to change dates or service or add CPT codes
- Unreadable PA request or insufficient information(i.e. NPI #, CPT codes, TIN#)
- Incorrect use of URGENT/STANDARD PA request type

The lack of critical information can create multiple phone calls or outreach attempts that can cause delays in getting an Prior Authorization number back.

Behavioral Health Prior Authorizations

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

Behavioral Health Prior Authorizations

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.

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.

Behavioral Health Prior Authorizations

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.

The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Molina prior authorization documents are updated annually, or more frequently as appropriate, and the current documents are posted on the Molina website at MolinaHealthcare.com

Request for Prior Authorizations

Our goal is to ensure our members are receiving the right services at the right time AND in the right place. Providers can help meet these goals by sending all appropriate information that supports the member's need for Services when they send us the authorization request.

- 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

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**

Prior Authorization

Prior Authorization:

Peer to Peer, Concurrent Review, and Appeals

UnitedHealthcare

Peer to Peer

- A **Peer to Peer** may be scheduled with a Medical Director if the provider disagrees with the prior authorization determination within 14 calendar days of the adverse determination.

Concurrent Review

- A **Concurrent Review** requires your cooperation and is a review of an extension of previously approved, ongoing course of treatment during an inpatient or ongoing ambulatory care.
  - Provide all requested clinical information and/or documents within 24 hours of receipt of our request.

Appeal

- Timeframe - Within thirty (30) calendar days from notice of adverse action
- Acknowledgement Letter - UHC will send an acknowledgment letter within ten (10) calendar days of receipt
- Resolution Letter - Once determination has been made, UHC will send an Appeal Resolution letter within thirty (30) calendar days
- Expedited appeals require resolution within seventy-two (72) hours
- A State Administrative Hearing through the Division of Medicaid must be requested within thirty (30) calendar days of UHC final determination

Authorization, Prior Authorization & Notification

- An **Authorization** is defined as an UHC administrative or clinical review of an ***inpatient*** admission stay, as well as ***outpatient*** procedures or services. The basic elements of an authorization review include eligibility verification, benefit interpretation, medical necessity review, and appropriateness of care for making accurate utilization determinations.

- A **Prior Authorization (PA)** is defined as a UHC administrative or clinical review conducted ***prior to*** an elective or non-emergent inpatient admission stay, as well as outpatient procedures or services. The basic elements of a PA review include eligibility verification, benefit interpretation, medical necessity review, and appropriateness of care for making utilization determinations.

Authorization, Prior Authorization & Notification

- A **Notification** is a process by which a hospital notifies United of all urgent/emergent hospital admissions and provides clinical information to United to support all inpatient days beyond the day of admission.

Prior Authorization:
Documentation/Coordination/Denials/Recourse

UnitedHealthcare

Documentation

- Provider/Facility Demographics
  - Requesting and Rendering
- Member Demographics
- Requested Date of Service
- Requested Procedure Codes
- Diagnoses
- Supporting Documentation as Needed

Coordination of PAs

Continuity of Care for medically necessary services up to 90 calendar days.

May require PA - medical necessity review for continuation after 30 days.

Request PA following standard procedures

Provide documentation of prior PA approval upon PA request submission; indicate continuity of care.

https://www.uhcprovider.com/en/prior-auth-advance-notification/prior-auth-app.html

PA Denials

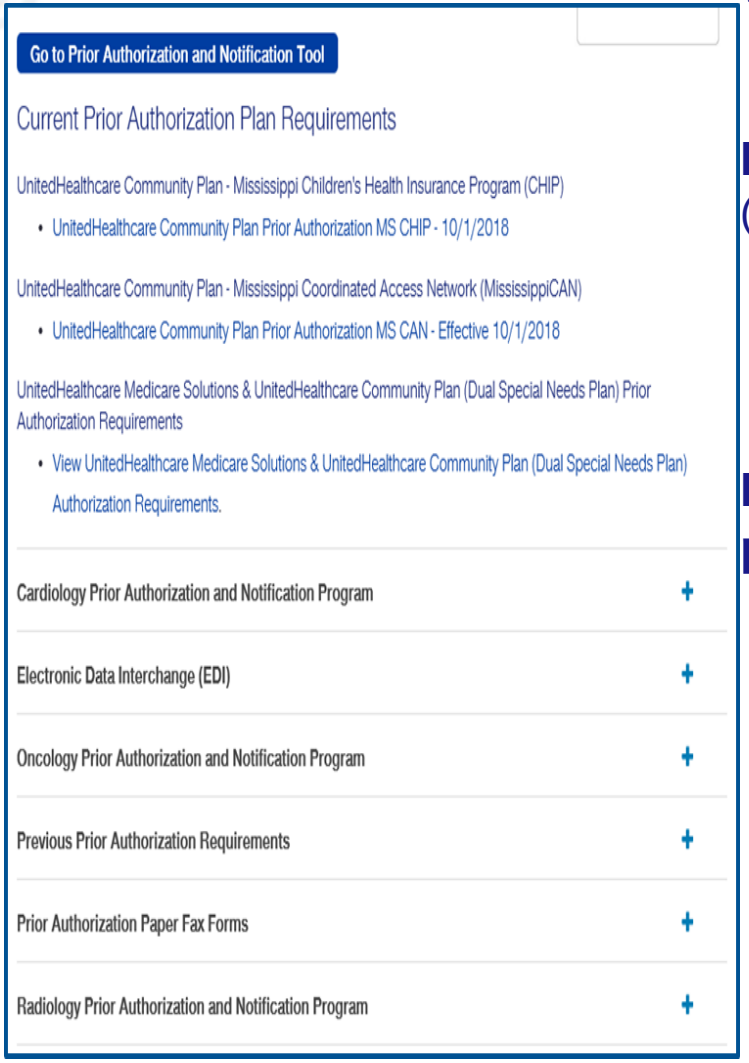
- Medical necessity
- Lack of information

Recourse

- Written notice, explaining actions to take, provided to member and a copy sent to requesting provider.
- Peer-to-Peer within 14 calendar days.
- Appeal within 30 calendar days from notice of adverse action.
- State Administrative Hearing through Division of Medicaid within 30 calendar days of UHC appeal final determination.

https://www.uhcprovider.com/en/prior-auth-advance-notification/prior-auth-app.html

Prior Authorization:
Request Submissions



Website

UHCprovider.com

List of services requiring prior authorization (updated quarterly)

UHCProvider.com > Health Plans by State > Mississippi > Medicaid (Community Plan) > Prior Authorization and Notification

Request prior authorization online, or by phone or fax:

Online: Prior Authorization and Notification app on Link

Phone: 866-604-3267 (Mon-Fri, 8am-5pm; or 24/7 for emergencies)

Fax: 888-310-6858; fax form is available at UHCProvider.com > Health Plans by State > Mississippi > Prior Authorization and Notification > PA Paper Fax Forms

Prior Authorization:

Request Submissions Continued

- **Radiology / Cardiology / Outpatient Oncology**
  UHCProvider.com > Health Plans by State > Mississippi > Medicaid (Community Plan) > Prior Authorization

- **Request prior authorization online, or by phone or fax:**
  Online: Prior Authorization and Notification app on Link
  Phone: 866-889-8054 (Mon-Fri, 7a – 7p)
  Fax: 866-889-8061

- **Prior authorization is not required for emergency or urgent care.**

- **Referrals**

  Out-of-network physicians, facilities and other health care providers must request prior authorization for all procedures and services, excluding emergent or urgent care.

  Only in-network care providers may initiate prior authorizations.

  Authorization for out-of-network services should be initiated by the in-network PCP or specialists.

Prior Authorization:
Pre and Post Review

Pre-Service Review

- A **Prior Authorization (PA)** is defined as a UHC administrative or clinical review conducted ***prior to*** an elective or non-emergent inpatient admission stay, as well as outpatient procedures or services. The basic elements of a PA review include eligibility verification, benefit interpretation, medical necessity review, and appropriateness of care for making utilization determinations.

Post-Service Review

- A **Retrospective Review** is conducted after services are provided to a member due to retro-eligibility or extenuating circumstances related to the member as in unconsciousness upon presentation and acts of nature. The care provider must have not submitted a claim. The request must include a reason and be submitted within 60 days of the service date. For retrospective review request:
  - Call: 866-604-3267, Mon-Fri, 8a – 5p
  - Fax: 888-310-6858
  - **Not conducted for**: elective ambulatory or inpatient services on the UHC advance notification list for which PA did not occur prior to providing the service; emergency inpatient service when notification requirements no met; services not requiring PA; reconsideration and/or review of an adverse benefit determination; previously submitted claim.

magnolia health™

Prior Authorization

8/7/2019

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.

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)

Magnolia Health Plan
Prior Authorization Timeframes

Type of Admission	Authorization Request Submission Requirement
Elective/Prescheduled	At least 14 days before but no later than 5 days prior to admission
Urgent Admission (not OB delivery or routine well baby newborn care)	Within two (2) business days of admission
Urgent Admission (OB delivery or routine well baby newborn care)	See Newborn enrollment for instructions
Emergent/Urgent/Post-Stabilization Care (less than 8 hrs. that does not result in inpatient stay)	No Authorization needed
Emergent/Urgent Care (that results in an inpatient stay)	Within two (2) business days of admission

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.

Behavioral Health Authorizations

8/7/2019

Prior Authorization Documentation

The following information should be considered when completing outpatient treatment requests:

- Are you using the most current OTR(outpatient treatment request) form?
  - Forms may be found here: https://www.magnoliahealthplan.com/providers/resources/behavioral-health.html
- Did you complete the entire OTR?
  - Ensure that there are no blank sections on the form. Common areas left blank include primary diagnosis, the requested authorization section such as frequency of sessions or estimated number of sessions etc.
- Have you updated the clinical information on the OTR?
  - Updated clinical must be submitted and should reflect information from the last 30 days. While we understand that there will be members who have little or no change in their condition during an authorization period due to the severity of their presenting problems, we must be assured that the clinical data being reviewed is current at the time the OTR is submitted. Please note that additional attachments (assessments, treatment plans) are encouraged to be submitted along with OTR via fax or provider portal.

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.

- 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

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.

- Inpatient Concurrent reviews are done after a patient reaches their 19 day DRG and still remains inpatient. Clinical is sent via fax or email and is reviewed for medical necessity. If Medical necessity is met, a concurrent will be done every two days after.

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

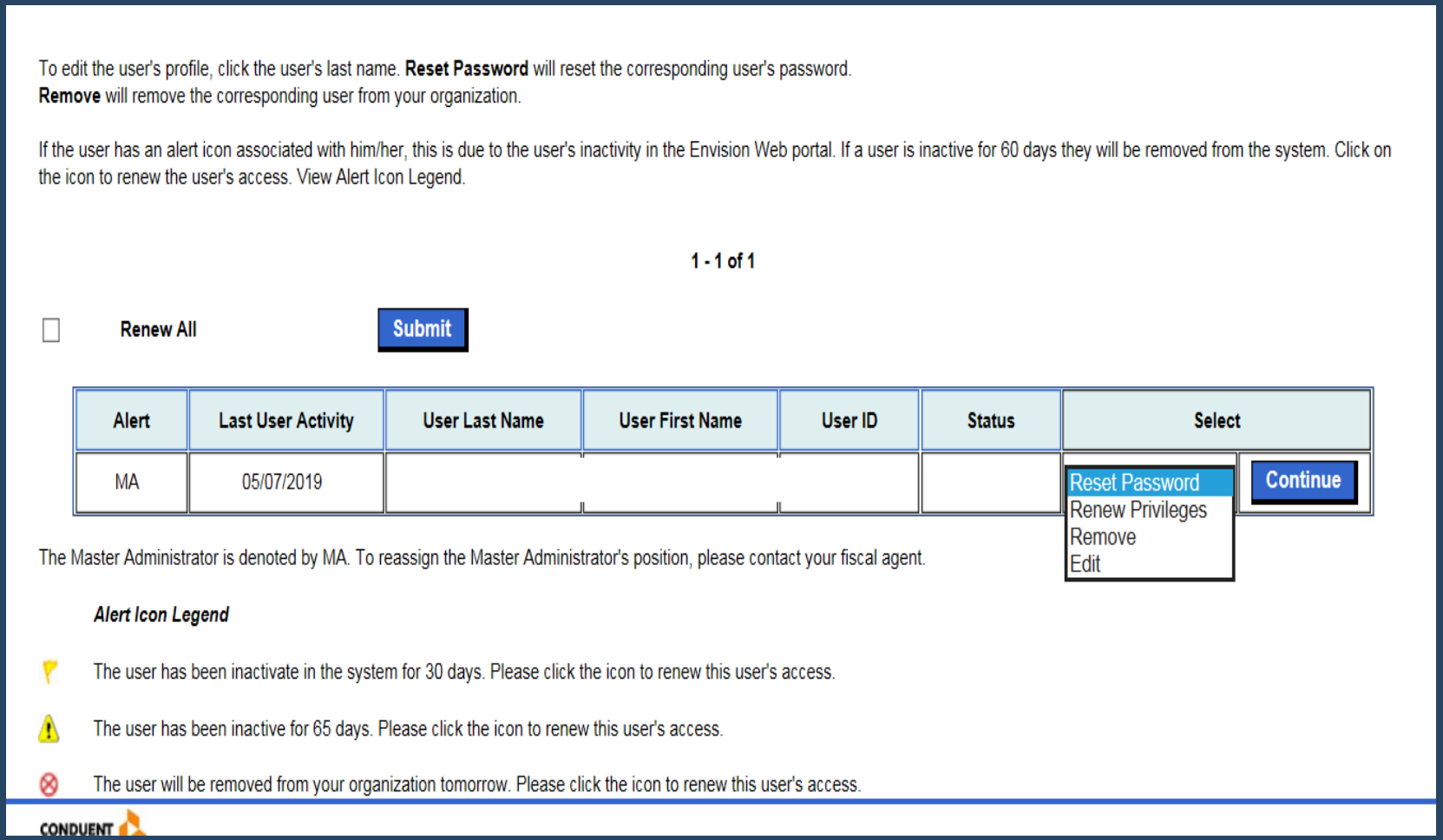
- Requests to speak to a physician after the determination has been made via notes.

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.

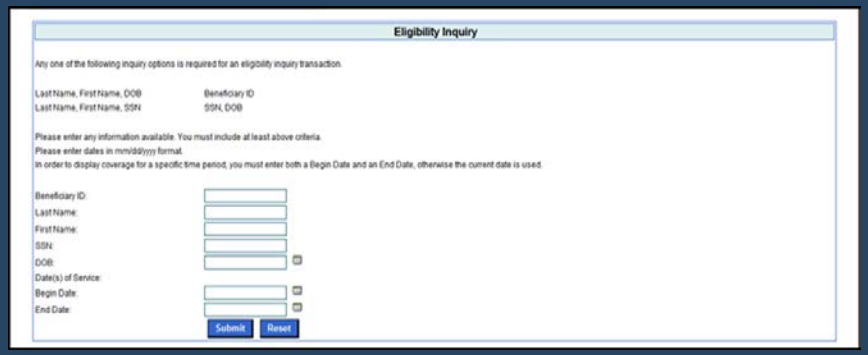
The user has been inactive for 65 days. Please click the icon to renew this user's access.

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

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

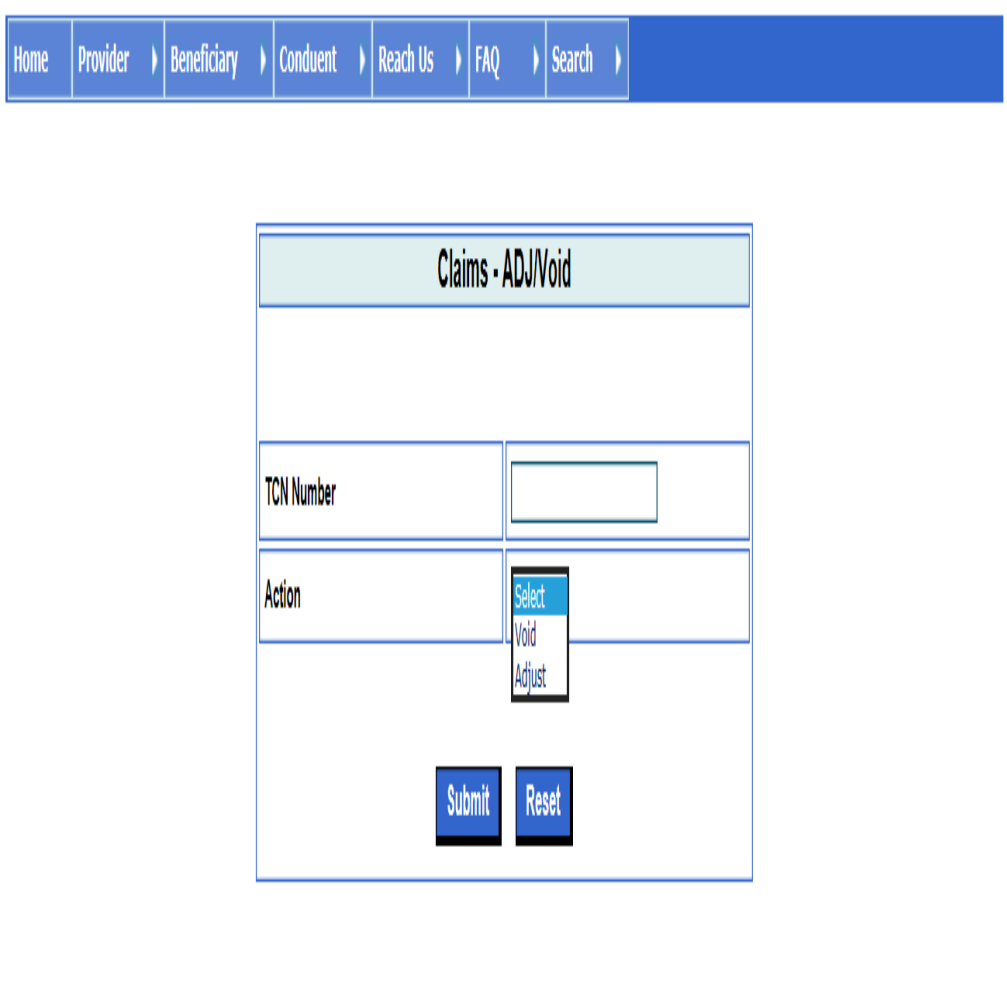


- You may check a Beneficiary's eligibility status by entering the following options:
  - Beneficiary ID or
  - SSN or
  - Beneficiary's name (*first name, last name*) and DOB

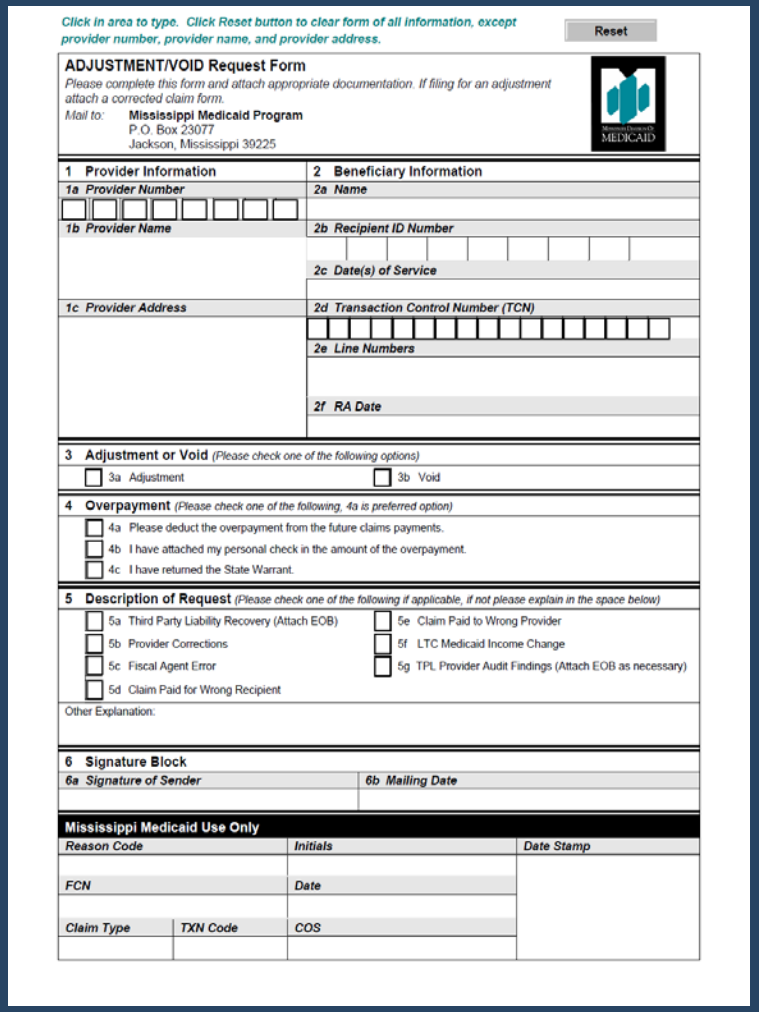
Adjusting and Voiding Claims

- **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

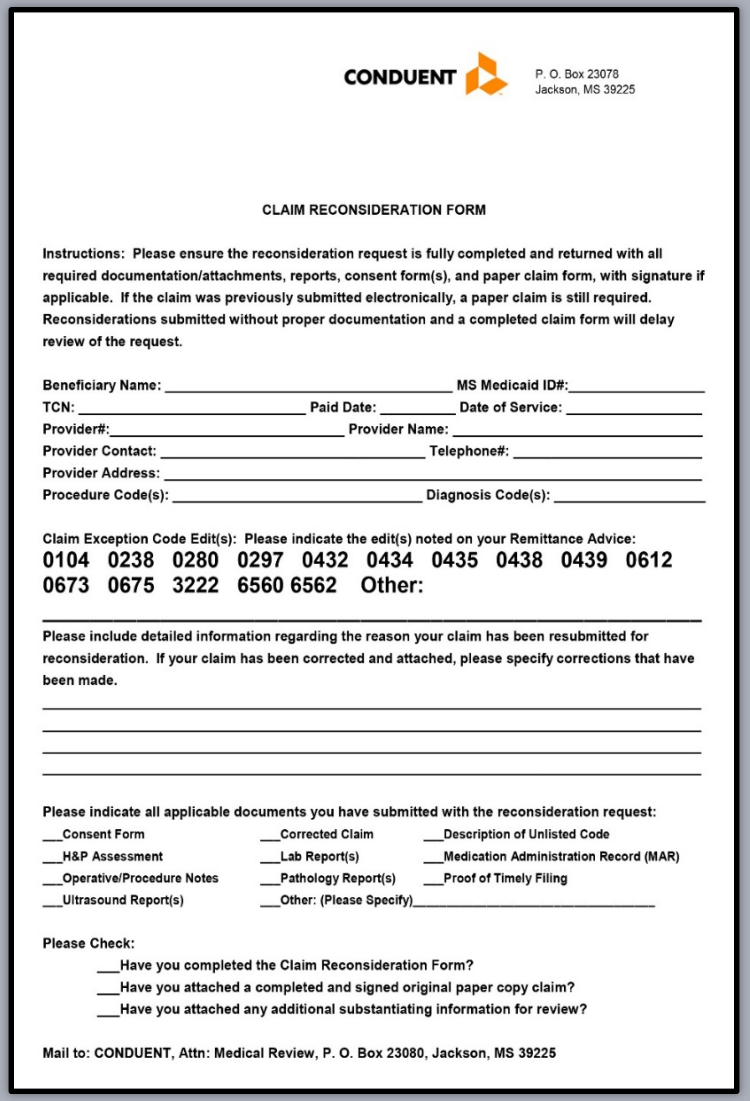
- Submit a RFI or request for public records in writing, by:
- You can submit a RFI or request for public records in writing by contact the Mississippi Division of Medicaid (DOM) multiple ways as listed below, including postal mail, fax and email. It is advised that you do not email forms or submit online 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

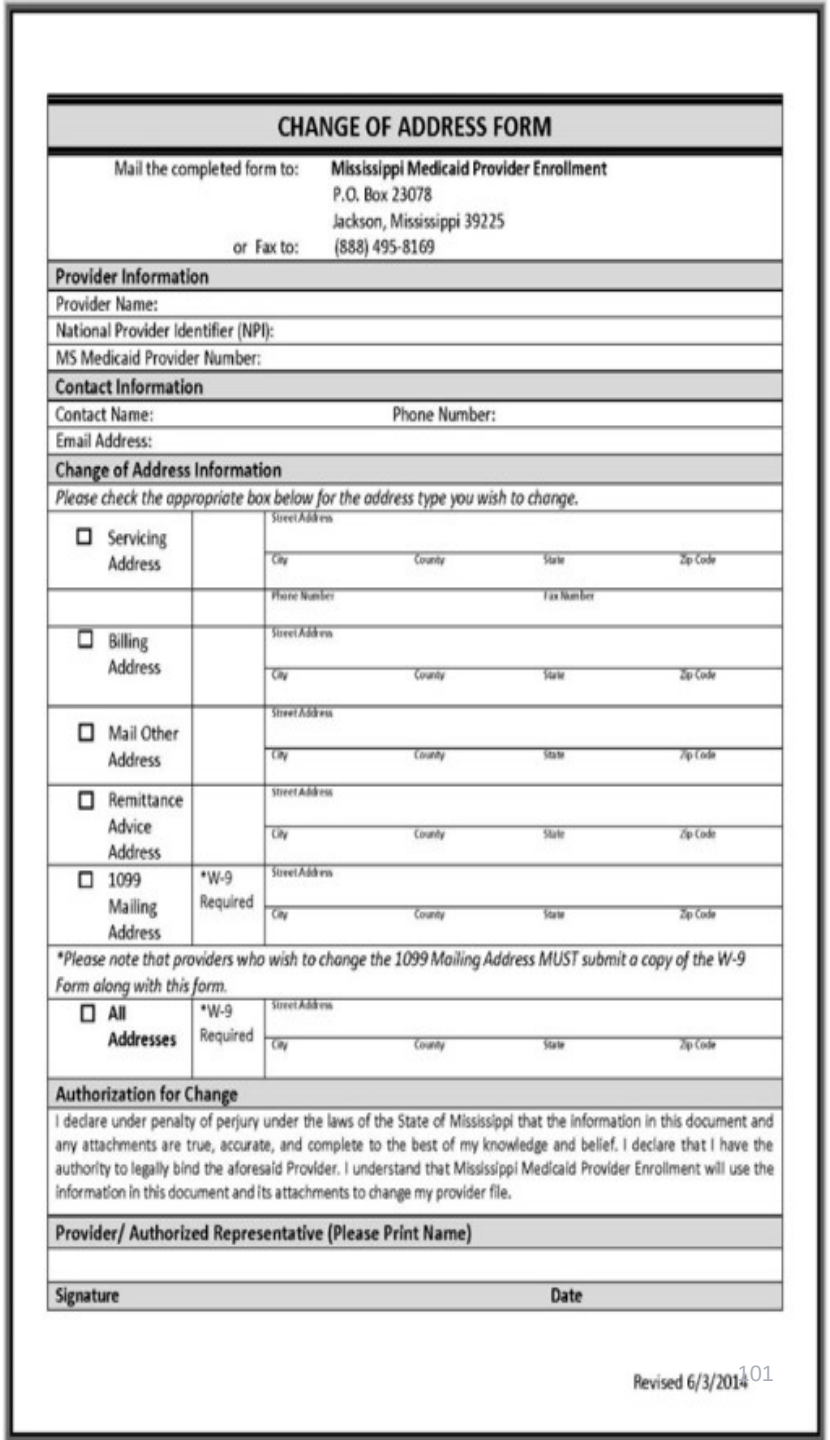
  Fax: 888-495-8169

- 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.

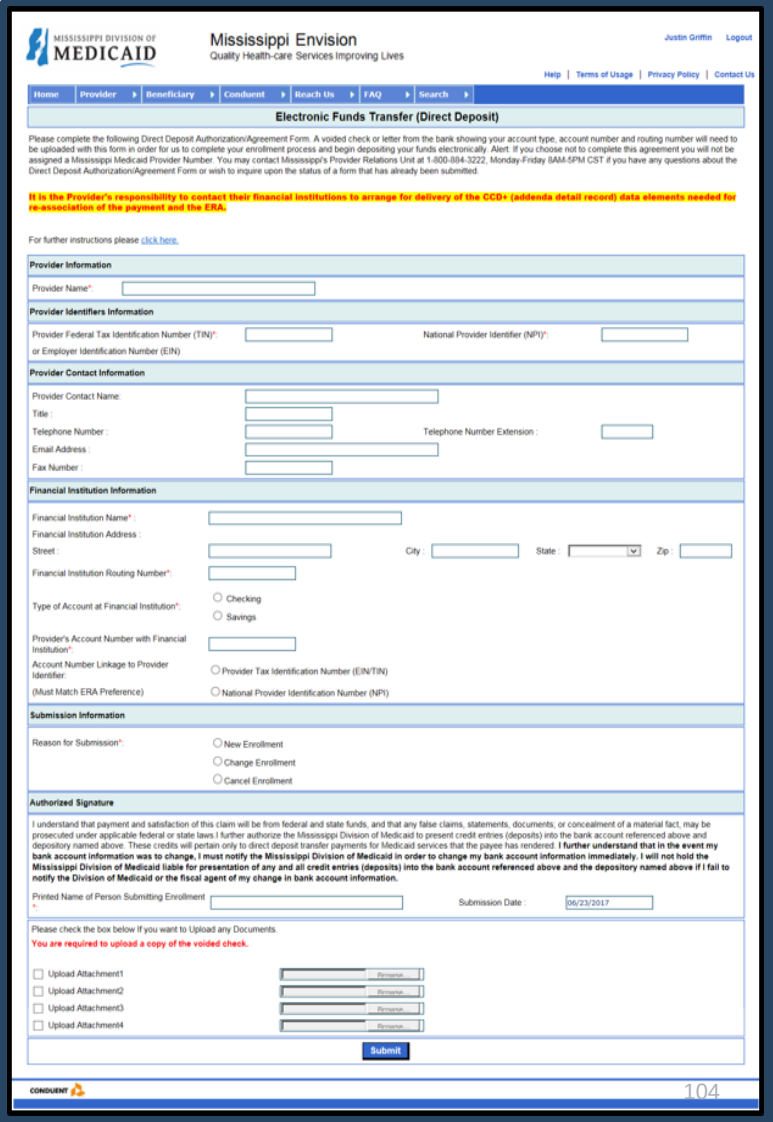
Banking (EFT) Form

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

Justin Griffin Logout

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Home | Provider | Beneficiary | Conduent | Reach Us | FAQ | Search

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 :
Telephone Number Extension :
Email Address :
Fax Number :

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?

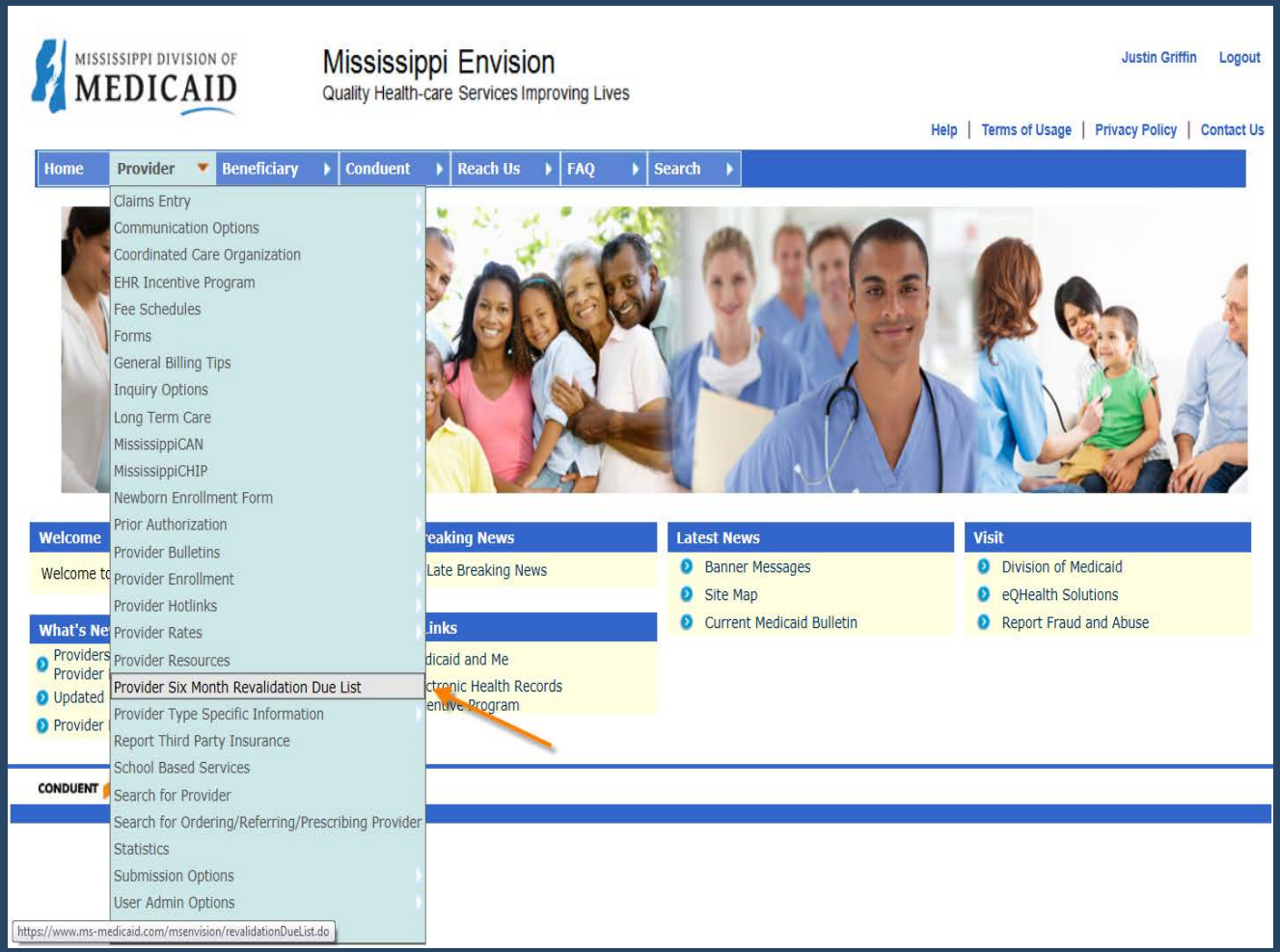
Provider Revalidation – a CMS requirement that mandates that providers who have been enrolled in Medicaid, regardless of provider type, must revalidate at least every five (5) years. Providers will need to verify that the information currently on his/her provider file is accurate and up-to-date in order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

What if I Fail to Revalidate

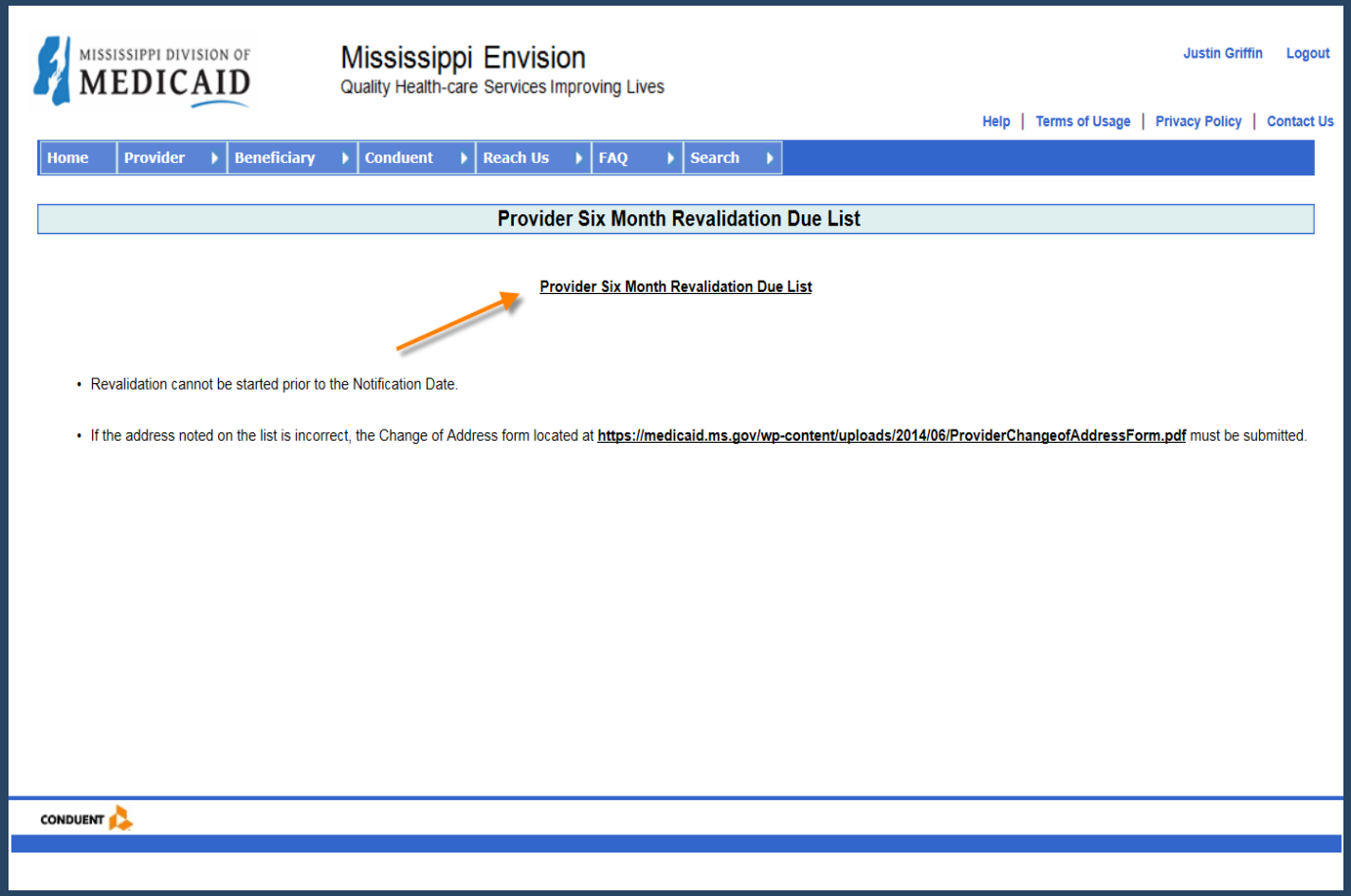
- Providers that fail to revalidate by the deadline will be terminated and required to re-enroll.
- If your Mississippi Medicaid Provider Number is termed due to failure to complete revalidation, your participation with the CCOs (Magnolia and United Healthcare and Molina Healthcare) will be termed as 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

	A	B	C	D	E	F	G	H	I	J	K	L
1	As of Date	Provider ID	NPI	Provider Name	Address Type	Address Line 1	Address Line 2	City	State	Zip	Revalidation Due Date	Revalidation Notificatio
2	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
3	07/16/2017	00120812	1689766008	WILLIAM O COOPER MD	Mail Other	2146 BELCOURT AVENUE		NASHVILLE	TN	37232-8792	07/28/2017	06/13/2017
4	07/16/2017	00120887	1366451387	AMY B HOLLMAN M.D.	Mail Other	308 CORPORATE DR		RIDGELAND	MS	39157	07/15/2017	05/31/2017
5	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
6	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
7	07/16/2017	00010791	1790709079	GEORGE L CAIN JR MD	Mail Other	506 ALCORN DRIVE		CORINTH	MS	38834	07/15/2017	05/31/2017
8	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
9	07/16/2017	00121210	1881753986	TAMBOLI KAIZAD P MD	Mail Other	PO BOX 1040		GULFPORT	MS	39502	08/05/2017	06/21/2017
10	07/16/2017	00121373	1124024922	SPECTRA EAST INC	Mail Other	8 KING ROAD		ROCKLEIGH	NJ	07647	08/11/2017	06/27/2017
11	07/16/2017	00121439	1376584920	JACKSON CHRISTOPHER L MD	Mail Other	2100 HWY 61 NORTH		VICKSBURG	MS	39183	08/05/2017	06/21/2017
12	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
13	07/16/2017	05280398	1235142878	MARLOW ALISHA PHD	Mail Other	P O BOX 2868		MERIDIAN	MS	39302	09/01/2017	
14	07/16/2017	00011647	1598762247	HILL JULIAN B	Mail Other	450 EAST PRESIDENT ST		TUPELO	MS	38801-5599	07/22/2017	06/07/2017
15	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
16	07/16/2017	00121649	1356318752	PILLAI REKHA MD	Mail Other	1211 UNION AVE, SUITE 400		MEMPHIS	TN	38104	07/22/2017	06/07/2017
17	07/16/2017	00121654	1508950502	KATHY D HILL CFNP	Mail Other	PO BOX 24116		JACKSON	MS	39345	07/28/2017	06/13/2017
18	07/16/2017	00121666	1548370745	MEMPHIS PATHOLOGY LABORATORY	Mail Other	1701 CENTURY CENTER COVE		MEMPHIS	TN	38134	08/11/2017	06/27/2017
19	07/16/2017	00121754	1811932064	BANKS MICHELLE D	Mail Other	1115 N. FRONTAGE RD.		VICKSBURG	MS	39180	07/15/2017	05/31/2017
20	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
21	07/16/2017	00121836	1316916844	TABB LESLIE C CFNP	Mail Other	803 1ST STREET		CLEVELAND	MS	38732	07/22/2017	06/07/2017
22	07/16/2017	00122148	1740331834	MITCHELL DORIS NP	Mail Other	P. O. BOX 427		MERIGOLD	MS	38759	07/22/2017	06/07/2017
23	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
24	07/16/2017	06202721	1992773535	JOHNSON KEVIN R DO	Mail Other	450 EAST PRESIDENT STREET		TUPELO	MS	38858	07/28/2017	06/13/2017
25	07/16/2017	06301045	1962481820	PROPATH SERVICES LLP	Mail Other	8267 ELMBROOK DRIVE, STE 100		DALLAS	TX	75247	09/01/2017	
26	07/16/2017	06687044	1164436838	SESSIONS SYLVIA C LCSW	Mail Other	48 OLD SETTLEMENT ROAD		TYLERTOWN	MS	39667	09/01/2017	
27	07/16/2017	00011817	1518925866	FLANDERSJAMESP	Mail Other	P O BOX 820666		VICKSBURG	MS	39182	07/22/2017	06/07/2017
28	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**

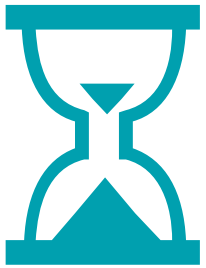
Claims & Retro Reviews

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

Claim Submission Timeframes

Claims Submission	Time Frame
Initial Claim	180 Days from the DOS/180 Days from the Date of Discharge
Reconsideration/ Correction/Adjustment	90 Days from the date of denial/EOP
COB	180 Days from the Primary Payer's EOP



Claim Submission

Electronic Claims

(preferred method)

The Provider Portal

(**https://provider.molinahealthcare.com**) is available free of charge and allows for attachments to be included.

Clearinghouse

- Providers may use the Clearinghouse of their choosing. *(Note that fees may apply).*
- ClaimsNet is Molina Healthcare's chosen clearinghouse. When submitting EDI Claims (via a clearinghouse) to Molina Healthcare, providers must use the applicable **payer ID # 77010**

Paper Claims

Claims Mailing Address

Molina Healthcare of Mississippi, Inc.
PO Box 22618
Long Beach, CA 90801

EDI Claims Submission Information

- Molina Healthcare of Mississippi uses ClaimsNet as its gateway clearinghouse. ClaimsNet has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

- Molina accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. In order to ensure that all data being submitted to our gateway is received properly your submitter must utilize the latest version of the 837 standard. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

- ClaimsNet Payer ID# 77010

EDI Frequently Asked Questions

- **Can I submit COB claims electronically?**
  Yes, Molina and our connected Clearinghouses fully support electronic COB.

- **Do I need to submit a certain volume of claims to send EDI?**
  No, any number of claims via EDI saves both time and money.

- **Which Clearinghouses are currently available to submit EDI claims to Molina?**
  https://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/Pages/chinfo.aspx

- **What claims transactions are currently accepted for EDI transmission?**
  837P (Professional claims), 837I (Institutional claims).

EDI Frequently Asked Questions

- **Where can I find more information on the HIPAA transactions?**
  https://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/Pages/guidanceinfo.aspx
- **How do I exchange the 270/271 Eligibility Inquiry?**
  Molina does not directly exchange the Eligibility transactions. The transactions may be sent to Molina's contracted clearinghouse Change Healthcare to verify Eligibility.
- **How do I exchange the 276/277 Claim Status Inquiry/Response?**
  Molina does not directly exchange the Claim Status transactions. The transactions may be sent to Molina's contracted clearinghouse Change Healthcare to verify Claim Status.

EDI Claims Submission Issues

Providers can call the EDI customer service line at **(866) 409-2935**; and/or

Submit an email to **EDI.Claims@molinahealthcare.com**.

EDI Claims Contact Information

For questions about any of the following areas, please select the appropriate link:

- **Submitting Electronic: Claims, Referral Certification and Authorization**
  1-866-409-2935
  Email Directly: EDI.Claims@MolinaHealthcare.com

- **Submitting Electronic: Encounters**
  1-866-409-2935
  Email Directly: EDI.Encounters@MolinaHealthcare.com

- **Receiving 835/ERAs**
  1-866-409-2935
  Email Directly: EDI.eraeft@MolinaHealthcare.com

Electronic Funds Transfer & Remittance Advice (EFT & ERA)

Contracted Providers are required to register for EFT within 30 days of entering the Molina Network. Providers enrolled in EFT payments will automatically receive ERAs as well. Molina partners with Change Healthcare ProviderNet for EFT and ERA services. Additional information regarding EFTs and ERAs will be available under the "EDI, ERA/EFT" tab on the Molina website at **MolinaHealthcare.com/provider**.

Benefits of EFT/ERA:

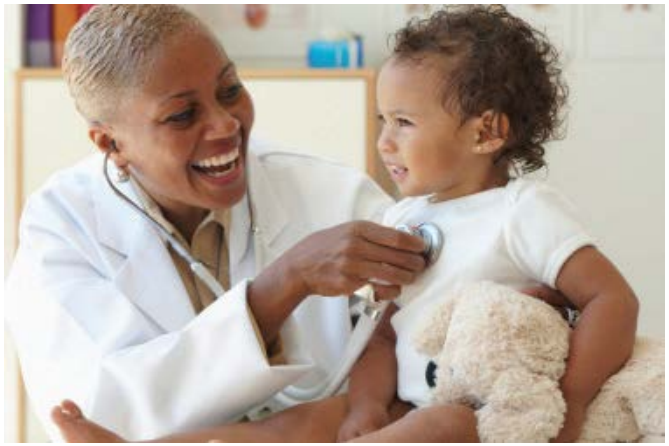
- Faster payment (as little as 3 days from the day the claim was electronically submitted)
- Search historical ERAs by claim number, member name, etc.
- View, print, download and save PDF ERAs for easy reference
- Providers can have files routed to their ftp and/or their associated clearinghouse

How to Enroll:

- To register for EFT/ERAs with Change Healthcare go to: **https://providernet.adminisource.com/Start.aspx**
- Step-by-step registration instructions are available on Molina's website (**www.molinahealthcare.com/provider**) under the "EDI, ERA/EFT" tab.

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

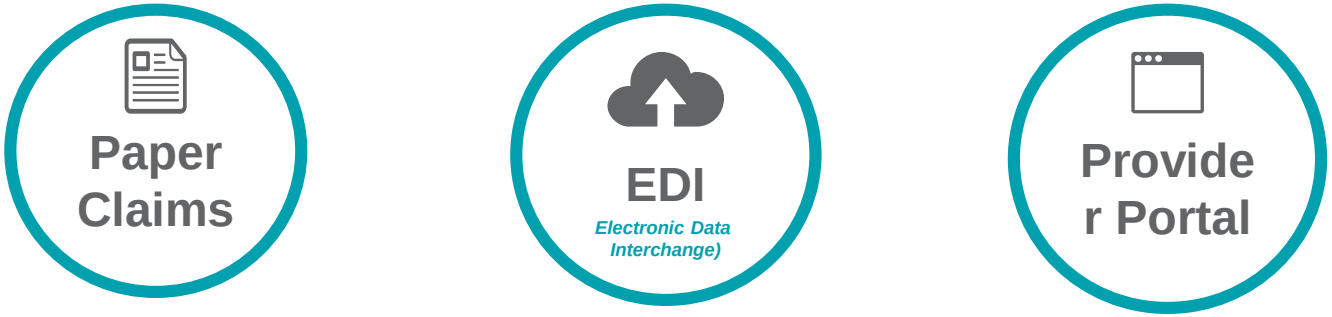
Mail:

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:



Balance Billing

Providers **may not** balance bill Molina Members for any reason for covered services. Detailed information regarding the billing requirements for non-covered services are available in the MHMS Provider Manual.

Your Provider Agreement with MHMS requires that your office verify eligibility prior to rendering any service and obtain approval for those services that require prior authorization.

In the event of a denial of payment, providers shall look solely to MHMS for compensation for services rendered, with the exception of any applicable cost sharing/co-payments.

- The date of claim receipt is the date as indicated by its data stamp on the claim.
- The date of claim payment is the date of the check or other form of payment.

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.

Rejected vs Denied Claim

Molina processes claims in an accurate and timely manner with minimal disturbances. Claim denials and rejections happen for a variety of reasons.

Rejected Claim
Claim does not meet basic claims processing requirements. A few examples of rejected claims include the use of an incorrect claim form, required fields are left blank or required information is printed outside the appropriate fields.

Denied Claim
The claim has been reviewed and was determined not to meet payment requirements. A few examples of reasons for denied claims include an invalid modifier, a missing: provider address, date of service or NPI and corrected claims indicator or original claim number.

Top Billing Errors

Error	Resolution
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
Missing/incomplete/invalid replacement claim information	Corrected Claim can be submitted via EDI or E-Portal
Procedure not covered when performed for reported diagnosis code	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

ClaimsNet Top Denials & Rejections

Error	Resolution
Baby claim submitted with mother's ID number	Claims must be submitted with member's own unique ID number
Claim for inpatient hospital care with POS 21 missing Date of Admission	For services that require authorization, provider should obtain authorization prior to submitting claim and/or rendering services
Patient Relationship to Insured not checked off as Self	Provider should validate all required fields are checked off and filled out correctly prior to submitting claim
Invalid/missing member ID	Member ID can be submitted with or without leading zero's. When leading zero's are added, it must only contain 5 leading zeros

Claims

Claim Filing

UnitedHealthcare

Electronic vs. Paper

- Electronic claims help reduce errors and shorten payment cycles
  - Learn more about electronic claims submission at:
    UHCprovider.com > Claims & Payments
    Link

- If a claim must be submitted on paper, use the following address:
  UnitedHealthcare
  P.O. Box 5032
  Kingston, NY 12402-5032

- Effective 10/1/2018 UHC validates physician NPI numbers for the following providers: Rendering, Billing, Attending and Operating. These NPIs are validated against the State's Provider file and may require the use of taxonomy codes to make a match.

Claim Filing

UnitedHealthcare

Format

- Claims must be submitted using the standard CMS-1500 for professional claims and CMS-1450 (UB04) for facility or institutional claims, or respective electronic format
- Include all appropriate secondary diagnosis codes for each line item

Timely Filing

- 180 days timely filing is now allowed for both MississippiCAN and CHIP

Inpatient

- The payer (CCO or DOM) on record on the **date of admission** should be billed for the entire inpatient stay.

Disagree With a Decision?

UnitedHealthcare®

Claims

Provider Services

1-877-743-8734

Website

UHCProvider.com > Link

Reconsideration

(when additional information is added)

Within 90 calendar days of determination

Corrected Claim

(when the provider wants to "try again" & disregard original claim)

Within 90 calendar days of determination)

UHCProvider.com > Claims & Payments > Claim Reconsideration

Appeal

Within 30 calendar days of determination

State Hearing (MSCAN)

Third Party Hearing (CHIP)

Within 30 calendar days of UHC appeal determination

Prior Auth/UM

Peer-to-peer (pre-service)

Outpatient: Within 14 calendar days of determination

Inpatient: Within 3 calendar days of determination

Concurrent Review

Within 14 calendar days of determination or 3 days post-discharge

Appeal

Within 30 calendar days of determination

State Hearing (MSCAN)

Third Party Hearing (CHIP)

Within 30 calendar days of UHC appeal determination

Appeals & Filing Timeframe

- Timeframe for Requesting an Appeal - Within thirty (30) calendar days from notice of adverse action
- Acknowledgement Letter - UHC will send an acknowledgment letter within ten (10) calendar days of receipt
- Resolution Letter - Once determination has been made, UHC will send an Appeal Resolution letter within thirty (30) calendar days
- Expedited appeals require resolution within seventy-two (72) hours
- A State Administrative Hearing through Division of Medicaid must be requested within thirty (30) calendar days of UHC final determination. Same timeline for third-party hearing for CHIP

Retrospective Review Process

A retrospective review is conducted after services are provided to a member. We perform these reviews for retro-eligibility or for extenuating circumstances related to the member:

The member is unconscious upon presentation, and the care provider has not previously submitted a claim for the member; or

Acts of nature impairing the facility's ability to verify a member's coverage/eligibility status. The request for retrospective review must include a reason and be submitted within 60 days of the service date.

Not providing a reason for the retrospective review request will result in a denial.

For a retrospective review request:

Call: 866-604-3267, Monday-Friday, 8 a.m. – 5 p.m. Central Time.

Emergency calls are accepted after hours.

Fax: 888-310-6858

A retrospective review is not conducted for:

Elective ambulatory or inpatient services on the UnitedHealthcare Community Plan advance notification list for which prior approval did not occur before providing the services.

Emergency inpatient services on the advance notification list that did not meet notification requirements. Notification of inpatient admission is required within one business day of the admission date.

Services not requiring prior approval

Reconsideration and/or review of an adverse benefit determination

Previously submitted claim

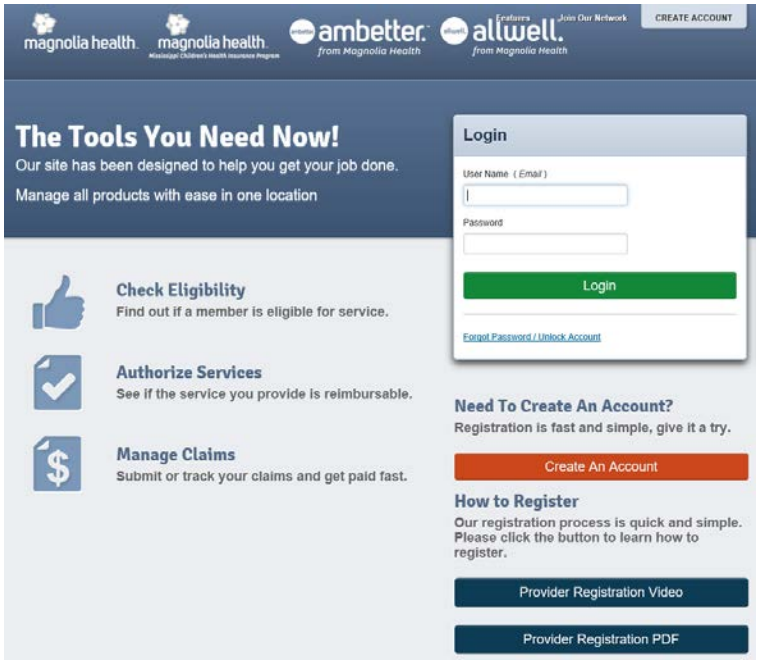
Claims Filling and Processing

8/7/2019

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



Paper Claims

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

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

- Please note NO 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.

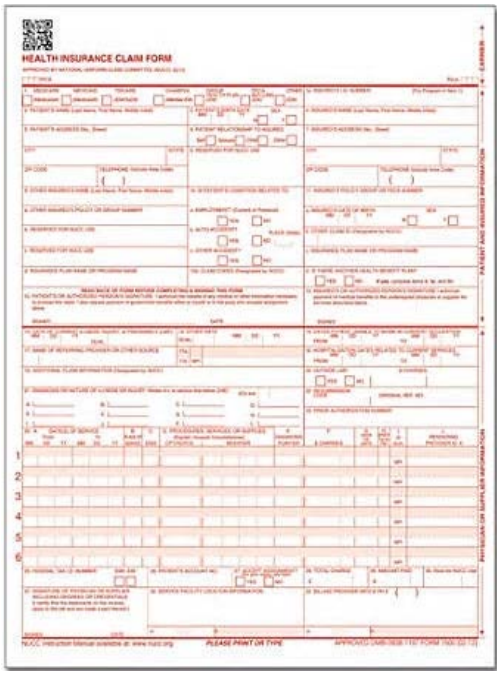
- Visit PaySpan's website for more information: www.payspanhealth.com

- 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

Inpatient Billing

- Every inpatient stay is assigned a single DRG that reflects the typical resource use of that case. Payments are based solely on the DRG billed for the patient's stay in the facility, regardless of length of stay or additional services rendered.

- Magnolia's DRG calculator is based off of the same metrics, including base rates, outlier methods and groupers, currently used by Mississippi Division of Medicaid (DOM). For more information, please visit the link below.

https://medicaid.ms.gov/providers/reimbursement

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

Billing the member

- Providers cannot balance bill a beneficiary for the provider's charge and the provider's contracted reimbursement rate.
- Providers cannot bill member's for claims that did not pay.
- A provider may only bill a Magnolia member if the following condition is met:

Prior to the service being rendered, the provider has obtained and kept a written member acknowledgement statement signed by the client.

Billing the member cont…

- There are limited circumstances in which a provider may bill a Magnolia member:
  - ❖Services not covered by Magnolia
  - ❖Services not authorized by Magnolia
  - ❖Services denied as not medically necessary
  - ❖Provider has proof that they attempted but failed to obtain member insurance ID information within sixty (60) calendar days of service.
  - ❖Services exceed program limitations

Question & Answer Session

Afternoon Agenda

1:30 p.m.	3:00 p.m.	**Hospital Services** **Newborns**
3:00 p.m.	3:30 p.m.	Question & Answer Session
3:30 p.m.	4:30 p.m.	Help Desk

Hospital Programs and Services (HPS)

Overview of HPS

Responsibilities:

- Outpatient Prospective Payment System (OPPS)
- Prepare policy recommendations
- FFS and MSCAN Encounter Claims Adjudication Validation
- Provide assistance to providers with claims reimbursement issues
- Monitor vendors to ensure contractual and regulatory compliance
- Provide support to all DOM offices

State Fiscal Year (SFY) 2019 Updates

All Patient Refined Diagnosis Related Groups (APR-DRG)

- APR-DRG grouper version and hospital-specific relative value (HSRV) weights remain on v.35
- DRG base price change from $6,585 to $6,574
- Cost outlier threshold increases to $47,000
- Cost to charge ratios (CCRs) will be updated on October 1, 2019

OPPS

- APC conversion factor is maintained at SFY18 - $64.714
- Fee schedule updates using January Addendum B
- OPPS Dental multiple procedure payment reduction policy

OPPS New Dental Policy

Effective March 1, 2019, DOM implemented a revised billing policy for medically necessary dental services performed in an outpatient hospital setting. The revised billing policy:

- Requires the dentist to obtain prior authorization for any dental procedures performed in the outpatient hospital setting,
- Allows coverage of more than one (1) unit per beneficiary per day with prior authorization,
- Requires each approved unit billed to be a separate line item and
- Applies multiple procedure payment reduction.

More information regarding this policy can be found at:

https://medicaid.ms.gov/

DOM Hospital Reimbursement Policies

Things to know . . .

Three-day window rule:

- Refers to outpatient hospital services provided to a beneficiary by the admitting hospital or by an entity wholly owned or operated by the admitting hospital*
    - Provided within 3 days prior to /including the admit date
    - Related to the inpatient stay
    - Includes diagnostic services and related therapeutic (non-Diagnostic) Services
    - Billed with inpatient claim and paid under APR-DRG

- Therapeutic services may be billed separately if unrelated to the inpatient stay using condition code 51 on the outpatient claim

Mississippi Medicaid Administrative Code Title 23 Part 202; Hospital Services, Rule 1.1C

DOM Hospital Reimbursement Policies

Things to know . . .

OPPS Span Billing rules

- Span billing services are outpatient hospital services furnished by a single provider, to a single beneficiary over a span of multiple dates.
- Outpatient hospital claims that span over multiple dates of services are denied unless they meet certain criteria and the date span is less than or equal to the threshold for that type of service
- DOM recognizes the following services for OPPS Span Billing

SERVICES	SERVICE CODES	THRESHOLD *
Physical Therapy	Revenue Codes 0420-0429	31 Days
Occupational Therapy	Revenue Codes 0430-0439	31 Days
Speech-Language Pathology	Revenue Codes 0440-0449	31 Days
Chemotherapy	Revenue Codes 0330-0339	31 Days
Observation	Procedure Code G0378	3 Days
Emergency Room	Revenue Code 0450 and any procedure code 99281-99285	2 Days
Recovery Room	Revenue Code 0710	2 Days

Days threshold are calculated using the submitted claim header dates.

MSCAN Reimbursement

Things to know . . .

Provider Status

- All Contractor Network Providers must:
  - Be enrolled in the Mississippi Medicaid Program.
  - Use the same National Provider Identifier (NPI) numbers and Mississippi Medicaid Provider Numbers with active enrollment segments.
  - Be enrolled as Group or Individual providers consistent with enrollment with the Division.

Example:

Claim submission with NPI and Taxonomy different than DOM's and /or CCO's enrollment records.

- XYZ Health Services, Inc. offer services for General Acute Care Hospital, Rural Health Clinics (RHC) and Physicians.
  - Hospital outpatient claim submitted to CCO with NPI of the RHC
  - Claim will be reimbursed by CCO using the RHC rate and not OPPS rates

MSCAN Reimbursement

Things to know . . .

Claim Payments

- Payment responsibility for beneficiary enrollment changes that occur during an inpatient stay.
  - The payor at the time of admit will be responsible for the inpatient hospital claim for the entire stay.
  - Related professional services must be split billed and submitted to the payor in effect on the date of service (DOS).

Example:

01/20/2019 – 02/15/2019 DOS of inpatient stay.
02/01/2019 Beneficiary enrollment changes from CCO to FFS

- The CCO at the time of admit will be responsible for reimbursement of the inpatient claim for the entire stay of 01/20/2019 – 02/15/2019.
- Related professional services must be split billed:
  - DOS 01/20/2019 – 01/31/2019 must be submitted to the CCO
  - DOS 02/01/2019 – 02/15/2019 must be submitted to FFS*

If a denial is received for edit 3341 – Claim Requires Prior Authorization, provider must submit the claim directly to the Office of Appeals.

HELPFUL RESOURCES

Division of Medicaid's website:

- https://medicaid.ms.gov/providers/reimbursement/
  - FAQ
  - Quick tip
  - Additional training material

- https://medicaid.ms.gov/providers/fee-schedules-and-rates/#
  - OPPS fee schedule (PDF and Excel)
  - Interactive Envision fee schedule
  - Provider Billing Handbook

- https://medicaid.ms.gov/about/state-plan/approved-state-plan-amendments/
  - Approved state plan amendments

Questions regarding Hospital Programs and Services should be directed to:

Zeddie Parker
Office Director
601-359-2562
zeddie.parker@medicaid.ms.gov

Michele Bates
Division Director
601-359-6146
rolonda.bates@medicaid.ms.gov

Prior Authorizations

How can providers obtain authorizations when members are transitioned to another payer (e.g. Medicaid FFS UM/QIO or MississippiCAN CCO)?

The Utilization Management divisions contracted with the Division of Medicaid will consider and review approved authorizations obtained by the other payers. However, providers must provide specified documentation for review, including but not limited to the following:

Member transitioned to Medicaid FFS UM/QIO from MississippiCAN CCO

- Providers may include the MSCAN authorization approval notice with their request to eQHealth/Alliant.
- The provider must still enter information through the authorization request process, which includes providing the necessary documentation supplied for the original authorization approval.
- Providers should be aware that the authorization information is not from the CCO, nor is it submitted from eQHealth/Alliant to the CCO.

Prior Authorizations

How can providers obtain authorizations when members are transitioned to another payer (e.g. Medicaid FFS UM/QIO or MississippiCAN CCO)?

The Utilization Management divisions contracted with the Division of Medicaid will consider and review approved authorizations obtained by the other payers. However, providers must provide specified documentation for review, including but not limited to the following:

Member transitioned to CCO Magnolia Health

- Magnolia only requires a copy of the authorization approval from the previous payer's Utilization Management (UM) division.

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Prior Authorizations

How can providers obtain authorizations when members are transitioned to another payer (e.g. Medicaid FFS UM/QIO or MississippiCAN CCO)?

The Utilization Management divisions contracted with the Division of Medicaid will consider and review approved authorizations obtained by the other payers. However, providers must provide specified documentation for review, including but not limited to the following:

Member transitioned to CCO Molina Healthcare of Mississippi

- Molina will accept a copy of the authorization approval.
- Molina will honor such PA from the previous health plan for up to 90 days, after which an updated authorization is required.
- Molina will contact the provider prior to that 90 day time frame to gather the clinical evidence appropriate for medical necessity justification.

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Prior Authorizations

How can providers obtain authorizations when members are transitioned to another payer (e.g. Medicaid FFS UM/QIO or MississippiCAN CCO)?

The Utilization Management divisions contracted with the Division of Medicaid will consider and review approved authorizations obtained by the other payers. However, providers must provide specified documentation for review, including but not limited to the following:

Member transitioned to CCO UnitedHealthcare of Mississippi

- Provider must indicate Request for Continuity of Care
- Provider must submit documentation of prior approval.
- Provider must submit supporting clinical documentation.

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Hospital Services

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

Inpatient Services – Management and Admissions

- For emergent inpatient admissions, notification to Molina must occur once the patient has been stabilized in the emergency department. Notification of admission is required to:
    - Verify member eligibility;
    - Authorize care, including level of care; and
    - Initiate inpatient review and discharge planning.

- Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the Medical Necessity of the admission.

- Hospital's are required to notify Molina within 24 hours or the first business day of any inpatient admission, including deliveries.

- Prior authorization is required for inpatient and outpatient surgeries and for all elective inpatient admissions to any facility.

Inpatient Services – Review and Status Determinations

- Molina performs concurrent review in order to ensure:
  - Patient safety;
  - Medical Necessity of ongoing inpatient services; and
  - Adequate progress of treatment and development of appropriate discharge plans.

- Performing these functions requires timely clinical information updates from the provider. We will request updated clinical records from the inpatient facility at regular intervals during the member's inpatient admission and ask that updates are provided within 24 hours of the request to better serve you and our members.

- Molina's Utilization Management staff determines if the collected medical records and requested clinical information are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and Medical Necessity requirements.

Emergency Services

- Emergency services encompass covered inpatient and outpatient services, inclusive of dialysis services, that are furnished by a Medicaid qualified provider and needed to evaluate or stabilize an Emergency Medical Condition.
- Emergency services do not require a prior authorization and will be reimbursed no less than the amount Medicaid reimburses Fee For Service Providers, regardless of the provider's network participation.
- Molina's goal is to ensure our members are accessing care in the appropriate setting. Our Care Management team will be actively involved with our members to assist them with how and where to seek treatment that best meets their needs.

Discharge Planning

- Discharge planning begins at admission, and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. The goal is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.
- Upon discharge, the provider must provide Molina with member demographic information, date of discharge, discharge plan and disposition.
- Inpatient Review Nurses work closely with the hospital discharge planners to determine the most appropriate discharge setting for the patient, as well as review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

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.

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

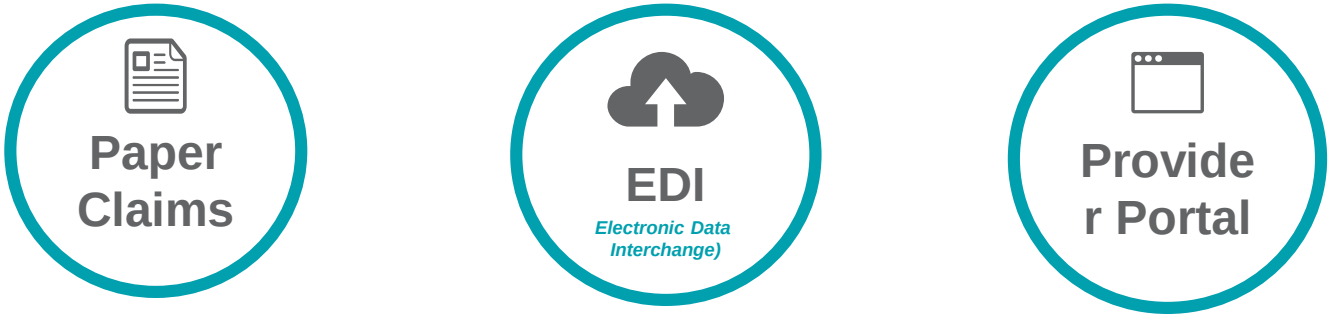
Mail:

Molina Healthcare of Mississippi, Inc.
Attention: Provider Grievance & Appeals
188 E. Capitol St. Suite 700
Jackson, MS 39201

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:



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

Hospital Services

Inpatient Management

UnitedHealthcare Community Plan

Verify Eligibility:

- Online
  - Medicaid Envision website: www.ms-medicaid.com/msenvision
  - Link Provider Portal: www.UHCProvider.com
- Call UHC Provider Services: 877-743-8734

Notify UHC Inpatient Utilization Management

- Call: 866-604-3267
- Fax: 888-310-6858

Notification Requirements and Prior Authorization:

- Urgent/emergent admissions and Post-stabilization care require notification within one (1) business day, even if occurring during the weekend or on a holiday.
- A Notification is a process by which a hospital notifies United of all urgent/emergent hospital admissions and provides clinical information to United to support all inpatient days beyond the day of admission.
- Elective admission require prior authorization

Concurrent reviews:

- Performed until medical services are no longer needed

Inpatient Management:
Determinations / Discharge Planning

UnitedHealthcare Community Plan

Determinations:

- Adverse Benefit Determinations
  - Written notice, explaining actions to take, provided to member and a copy sent to provider.
  - Peer to Peer – within 3 calendar days
  - Appeal – within 30 calendar days from notice of adverse action
  - State Administrative Hearing through the Division of Medicaid within 30 calendar days of UHC appeal final determination

Discharge Planning

- Begins on admission
- Coordination/communication with facility
- Discharge Care Managers
- Transitional Care Manager
- Multidisciplinary team
- Call: 877-743-8731

magnolia health™

Hospital Services

8/7/2019

Inpatient Services

- All hospital inpatient stays require notification within one (1) business day following the admission.
- Facilities are required to submit a request for authorization within two (2) business days following the date of inpatient admissions that are not planned or elective.

Outpatient Services

- Prior to rendering services, check our Pre-Auth Tool at www.magnoliahealthplan.com to verify if prior-authorization is required for the service being performed.
- Please initiate the Authorization process at least five (5) calendar days in advance for non-emergent outpatient services.

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)

Determinations

- Determinations for inpatient services will be made within 24 hours or 1 business of receipt of the request and all necessary information.
- Determinations for outpatient services will be made within 2 business or 3 calendar days of receipt of the request and all necessary information.

Emergency Services

- Prior Authorization is NOT required for emergent or urgent care services.
- If these services result in admission, Magnolia must be notified within one (1) business day and authorization must be requested within two (2) business days of admission.

Discharge Planning

- Concurrent review staff will work closely with hospital staff to ensure a comprehensive discharge plan is developed and in place prior to discharge.
- For members in Care Management, the Concurrent Review Nurse or designated staff will engage the member's Care Manager to ensure appropriate discharge planning and follow-up.

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.

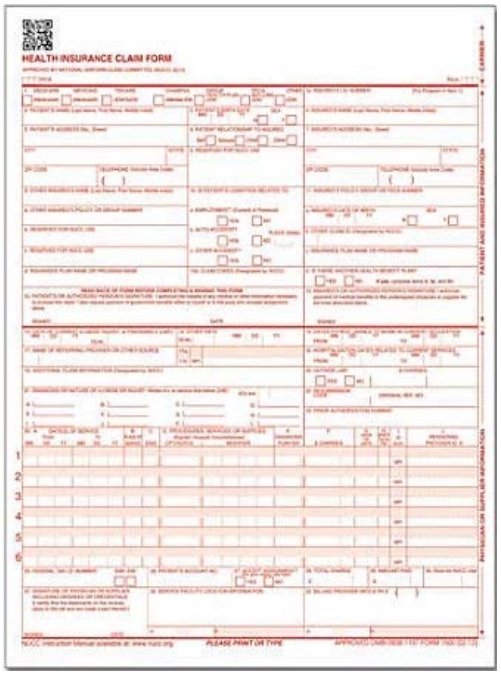
- Visit PaySpan's website for more information: www.payspanhealth.com

- 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

Electronic and Paper Claims

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

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

Payer Identification Numbers:
Behavioral Health – 68068
Medical - 68069

- **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.

Corrected Claim, Reconsideration, Claim Dispute

All Requests for corrected claims, reconsiderations or claim disputes must be received within **90 days** of the original Plan notification (ie. EOP). Original Plan determination will be upheld for requests received outside of the **90 day** timeframe, unless justification is provided to the Plan to consider

Corrected Claims

- Submit via Secure Web Portal
- Submit via an EDI Clearinghouse
- Submit via paper claim:
  - **Magnolia Health**
  - **PO BOX 3090**
  - **Farmington, MO 63640-3825**
  - **(Include original EOP)**

Reconsideration

- Written communication (i.e. letter) outlining disagreement of claim determination
- Indicate "Reconsideration of (original claim number)"
- Submit reconsider to:
  - **Magnolia Health**
  - **Attn: Reconsideration**
  - **PO BOX 3090**
  - **Farmington, MO 63640-3825**

Claim Dispute

- ONLY used when disputing determination of Reconsideration request
- Must complete Claim Dispute form located on **MagnoliaHealthPlan.com**
- Include original request for reconsideration letter and the Plan response
- Send Claim Dispute form and supporting documentation to:
- **Magnolia Health**
- **Attn: Claim Dispute**
- **PO BOX 3090**

Must be submitted within 90 days of adjudication

Provider Relations Contact Information

Provider inquires can be submitted the following ways:

- Contact Provider Services at 1-866-912-6285
- Send an email by logging in to the Secure Portal on the Magnolia Health Plan's website at https://provider.magnoliahealthplan.com

NEWBORN ENROLLMENT & PROCESSES

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*
Newborn Enrollment Form Submissions	**Lisa Willis- Smith** *Office of Eligibility* Telephone number: 601-576-4122 **Inquires for no Medicaid ID

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

MississippiCAN
Newborn Enrollment

Division of Medicaid Administrative Code
Title 23: Division of Medicaid
Part 202: Hospital Services, Chapter 1: Inpatient Services

Newborns

a. Well newborn services provided in the hospital must be billed separately from the mother's hospital claim.
   i. **The hospital must notify the Division of Medicaid within five (5) calendar days of a newborn's birth via the Newborn Enrollment Form located on the Division of Medicaid's website.**
   ii. The Division of Medicaid will notify the provider within five (5) business days of the newborn's permanent Medicaid identification (ID) number.

MississippiCAN
Newborn Enrollment

Newborn Enrollment Form Menu option display when Conduent user logs into Web Portal:

Newborn Form

MISSISSIPPI DIVISION OF MEDICAID

Newborn Enrollment Form

Effective 12/01/2015

This form is to be used by birth hospitals to enroll all deemed eligible newborns in Medicaid. All information must be completed by the birth hospital to obtain a Medicaid Identification Number for the newborn. Please complete this on-line form and return by email to newborn@medicaid.ms.gov by selecting the submit button at the end of the form.

Do you want to submit: ☑ New ☐ Updated

MOTHER'S INFORMATION

MEDICAID ID NUMBER: _____

FIRST NAME: _____

LAST NAME: _____

MOTHER'S SOCIAL SECURITY NUMBER: _____

MOTHER'S DATE OF BIRTH : _____

MOTHER'S ADDRESS: _____

_____

NEWBORN INFORMATION

FIRST NAME: _____ MIDDLE NAME: _____

LAST NAME: _____

DATE OF BIRTH : _____ TIME OF BIRTH: _____

GENDER (M or F): _____ Birth order, if multiples: _____ Check if parental rights terminated: ☐

FATHER'S NAME: _____

TO BE COMPLETED BY DIVISION OF MEDICAID OFFICE OF ELIGIBILITY

Newborn Medicaid ID: _____

OTHER INFORMATION: _____

DOM CONTACT: _____ DATE: _____

CONTINUE ENTERING MOTHER/CHILD INFORMATION BELOW

HOSPITAL NAME: _____ MEDICAID PROVIDER ID: _____

CONTACT NAME: _____ EMAIL: _____

TELEPHONE: _____ EXT: _____ FAX: _____ DATE: _____

Toll-free 800-421-2408 | Phone 601-359-6050 | Fax 601-576-4164 | Office of Eligibility

MISSISSIPPI DIVISION OF MEDICAID

MississippiCAN
Newborn Enrollment

HPE Service Modifier

- A service modifier is in place in MMIS to restrict claims payments to the HPE period. **When a full Medicaid application that covers HPE months is approved, the service modifiers must be voided to allow full eligibility and payment of all allowable claims.** This is true when the full application is approved by HPE staff or the RO and when a reapplication that includes approved HPE months is subsequently filed with the regional office after a full Medicaid denial.

Division of Medicaid Administrative Code
Title 23: Division of Medicaid, Part 100: General Provisions
Chapter 8: Coverage of the Categorically Needy in Mississippi
Rule 8.11: Mandatory Presumptive Eligibility Determined by Qualified Hospitals

MississippiCAN
Newborn Enrollment

Title 23: Division of Medicaid
Part 200: General Provider Information, Chapter 3: Beneficiary Info
Rule 3.2: Newborn Child Eligibility

A. The Division of Medicaid covers an infant:

- 1. Whose mother was eligible for Medicaid in the child's birth month for the first year of life.
  a. Deemed newborn Medicaid eligibility begins with the birth month and continues through the month of the child's first (1st) birthday unless one (1) of the termination reasons in Miss Admin Code Part 101, Rule 11.2 is applicable.
  b. There is no requirement that the newborn live with the biological mother in order for the continuous eligibility to apply for the infant.
- 2. Born to immigrant mothers who qualify for Medicaid on the basis of emergency medical services for the first (1st) year of the infant's life.

MississippiCAN
Newborn Enrollment

When are Newborns enrolled?

- Newborns born to a Medicaid mom who is currently enrolled in a MississippiCAN Coordinated Care Organization and will automatically be placed in the same plan as the mother.

- The mother has to be on Medicaid to allow the newborn to be deemed eligible for the birth month.

- DOM is aware that not all beneficiaries are being placed in the same CCO as the mom.
  - **Not submitting newborn forms timely or appropriately**
  - **Non-Medicaid mothers**
  - **Retroactive Medicaid mothers, and Hospital Presumptive Eligibility (HPE)**
  - **Newborn Name Changes**

- Should you receive a call regarding this issue please forward these calls to the Office of Coordinated Care 601-359-3789 or email Charlotte McNair at Charlotte.McNair@medicaid.ms.gov.

Newborn Helpful Information

- **Providers must resubmit updated Newborn form for the following changes:**
  - Newborn name change
  - Correct Date of Birth
  - Correcting Gender (M or F)
  - Once the updated form has been resubmitted, please email Charlotte McNair at Charlotte.McNair@Medicaid.ms.gov. Charlotte will submit corrected forms to the appropriate CCO.

- **Non-Medicaid Mothers:**
  - If a Non-Medicaid mother delivers a baby, no newborn form is needed. The mother will need to go to her local regional Medicaid office and apply for Medicaid.

- **Retroactive Medicaid mothers:** These mothers may apply for Medicaid at the time of delivery; therefore the baby will be assigned to a CCO prior to the mother being enrolled with Medicaid.
  - This may cause the newborn and mother to be in different CCOs.

- **Hospital Presumptive Eligibility (HPE) for Newborn Enrollment:**
  - Please contact Lisa Smith at 601-576-4122.

- **When a baby is in the NICU and authorization is required, what Medicaid number is used when the baby does not have its own number?**

  Immediate need for medication of the Newborn, please contact DOM Pharmacy or CCO Pharmacy departments. https://medicaid.ms.gov/wp-content/uploads/2015/12/Mississippi-Medicaid-pharmacy-contact-and-billing-information.pdf

Newborn Enrollment

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

Newborn Enrollment

- Coverage is mandatory for infants born to Medicaid eligible mothers. The infant is deemed eligible with MSCAN for one year from date of birth.
- The hospital must notify DOM within five (5) calendar days of a newborn's birth via the Newborn Enrollment form located on the Divisions of Medicaid Envision web portal.
- Prior to assignment of the permanent Medicaid ID number, the Newborn Enrollment Form is forwarded to Molina Healthcare if the mother is already enrolled with Medicaid. Newborns of MississippiCAN mothers are automatically assigned to the same CCO as the mother by DOM.
- The Newborn Enrollment Form will help to create an authorization for claims payment for routine deliveries (3 day stay for vaginal deliveries, 5 day stay for C sections).
- Newborn notification is required within one (1) business day for all sick newborns requiring inpatient hospitalization.

Newborn Enrollment

- All approvals are subject to enrollment verification.
- If the mother of the baby (MOB) is primary with Molina at the time of the delivery, then the baby is covered under mom for 30 days:
  - The authorization is created under the mother's name initially.
- If the Mother of the baby (MOB) is secondary with Molina at the time of delivery, we need to first verify the policy holder of mom's primary coverage has maternity benefits.
- If the mother of the baby is not covered by Molina (or another MCO) at the time of the delivery, then the facility does know to whom to notify of the admission.
- When the babies in this situation get their own ID, they are then enrolled in a MCO (Managed Care Organization) and their enrollment is most commonly retro dated back to the baby's DOB. The facility then has 60 days from the date the baby's enrollment was processed to notify us of the IP stay and re must review the entire stay.

NICU Utilization Review Standards

- **Clinical information provided will be reviewed by the NICU CRC(nurse) for appropriate LOC;**

- **Review of Clinical Information will be done by the Medical Director and the following guidelines:**
  - Reviews should be completed with 24 hours of notification of admission
  - Infants that are < 34 weeks AGA, will be reviewed at minimum once every week
  - For infants that are > 34 weeks AGA or approaching discharge, we will review at minimum of twice a week.

NICU Utilization Review Standards

- **All NICU concurrent reviews will be completed by staff utilizing the current year version of nationally recognized criteria available to Molina staff.**
  - InterQual

- **All LOC reviews are subject to:**
  - Any state specific regulations and benefits;
  - As well as provider contracts.

- **The NICU CRC will notify the facility via fax or other accepted communication, of the LOC, dates approved, as well as when the next continued stay review is due.**

NICU Utilization Review Standards – Discharge Planning

- If the infant is approaching discharge, the CRC or the Health Plan designated person should ensure that all necessary authorizations and coordination of post discharge care is in place and approved as appropriate.

- If the infant is approaching discharge and we have not received updated clinical by the next review da

- These members usually have a lot of specialty follow up appointments, specialized equipment and other needs. Coordination of those items need to start as soon needs are identified and before discharge plans are made.

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/provider.**

NICU Prior Authorizations:
Phone: 1 (855) 714-2415
Inpatient Requests Fax: 1 (877) 731-7220

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

UnitedHealthcare®
Community Plan

Newborns

Inpatient Management (Newborn)

UnitedHealthcare Community Plan

- **Notification**
  - NICU admissions: Notification is required within one (1) business day for
  - Maternal admission: Notification is required within one (1) business day

- **Newborn Enrollment**
  - The state newborn notification form is used by DOM to determine eligibility and issue a Medicaid ID
  - Newborn notification form should be sent directly to DOM (Fax: 601-576-4164)
  - UHC does not use the newborn notification form for inpatient admission authorizations

- Concurrent reviews will be performed if the newborn remains inpatient at time of notification

- Retrospective review requests must be submitted by the hospital if the newborn has been discharged prior to receipt of a Medicaid ID

UnitedHealthcare®
Community Plan

Hospital Services and Newborns

Inpatient Management

UnitedHealthcare Community Plan

Verify Eligibility:

- Online
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  - Link Provider Portal: www.UHCProvider.com
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Notify UHC Inpatient Utilization Management

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- Fax: 888-310-6858

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- Performed until medical services are no longer needed

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- Begins on admission
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- Transitional Care Manager
- Multidisciplinary team
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Inpatient Management (Newborn)

UnitedHealthcare Community Plan

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- Retrospective review requests must be submitted by the hospital if the newborn has been discharged prior to receipt of a Medicaid ID

magnolia health™

Newborns

8/7/2019

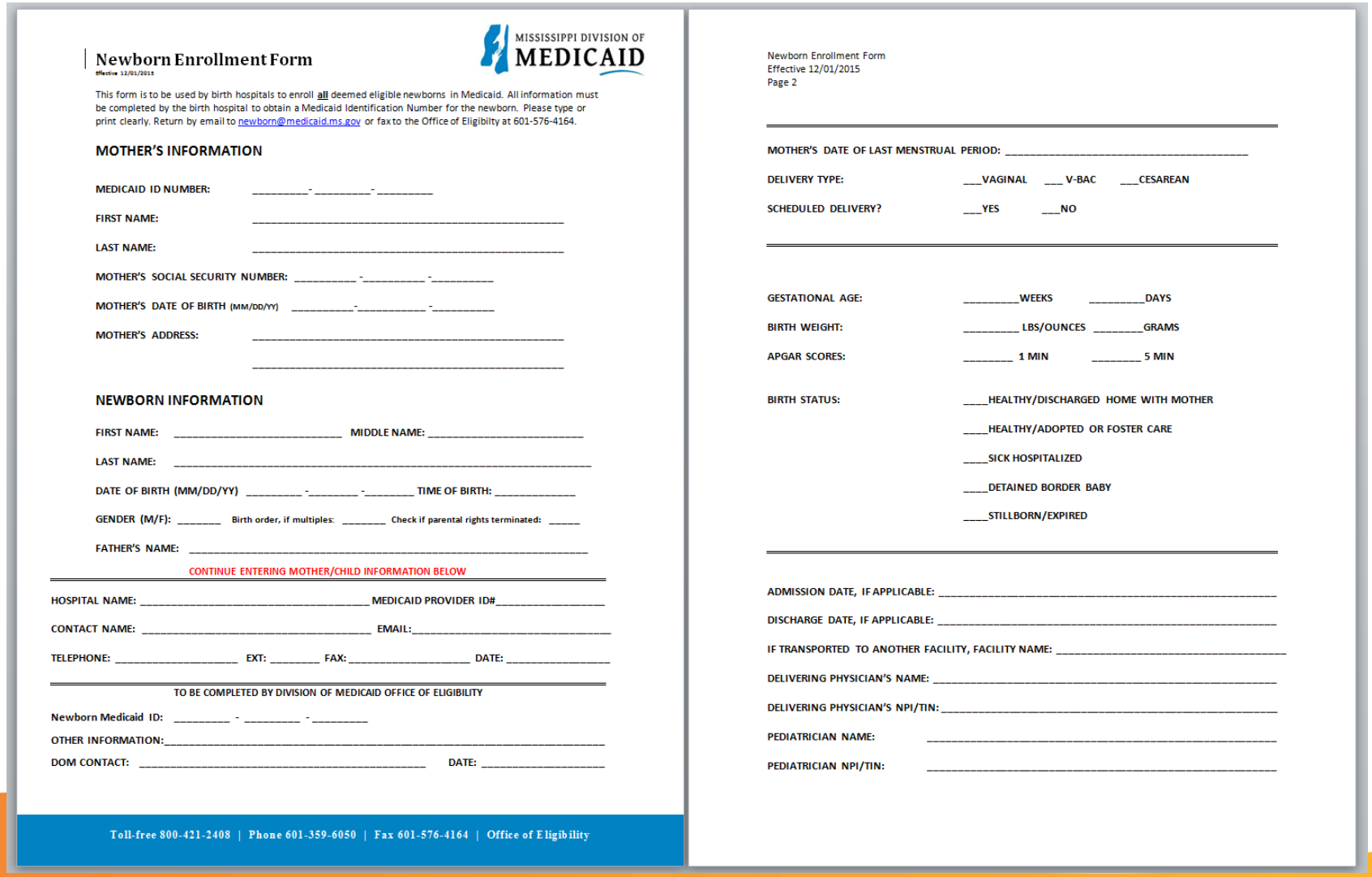
Newborn Enrollment Form Requirement

- Magnolia requires maternal information to acknowledge the maternity admission.
- The Division of Medicaid Newborn Enrollment Form includes all of the necessary information for routine deliveries and well-baby care (standard 3 day stay for vaginal deliveries, 5 day stay for C sections).

Timeframe of Submission

The NB Enrollment Form, located on the Mississippi Envision website, must be fully completed and submitted to the Division of Medicaid within 5 days of delivery.

Newborn Enrollment Form



Newborn Enrollment Form

Effective 12/01/2015

MISSISSIPPI DIVISION OF MEDICAID

This form is to be used by birth hospitals to enroll **all** deemed eligible newborns in Medicaid. All information must be completed by the birth hospital to obtain a Medicaid Identification Number for the newborn. Please type or print clearly. Return by email to newborn@medicaid.ms.gov or fax to the Office of Eligibilty at 601-576-4164.

MOTHER'S INFORMATION

MEDICAID ID NUMBER: _____-_____-_____

FIRST NAME: _____

LAST NAME: _____

MOTHER'S SOCIAL SECURITY NUMBER: _____-_____-_____

MOTHER'S DATE OF BIRTH (MM/DD/YY) _____-_____-_____

MOTHER'S ADDRESS: _____

_____

NEWBORN INFORMATION

FIRST NAME: _____ MIDDLE NAME: _____

LAST NAME: _____

DATE OF BIRTH (MM/DD/YY) _____-_____-_____ TIME OF BIRTH: _____

GENDER (M/F): _____ Birth order, if multiples: _____ Check if parental rights terminated: _____

FATHER'S NAME: _____

CONTINUE ENTERING MOTHER/CHILD INFORMATION BELOW

HOSPITAL NAME: _____ MEDICAID PROVIDER ID#_____

CONTACT NAME: _____ EMAIL:_____

TELEPHONE: _____ EXT: _____ FAX:_____ DATE: _____

TO BE COMPLETED BY DIVISION OF MEDICAID OFFICE OF ELIGIBILITY

Newborn Medicaid ID: _____ - _____ - _____

OTHER INFORMATION:_____

DOM CONTACT: _____ DATE: _____

Toll-free 800-421-2408 | Phone 601-359-6050 | Fax 601-576-4164 | Office of Eligibility

MOTHER'S DATE OF LAST MENSTRUAL PERIOD: _____

DELIVERY TYPE: ___VAGINAL ___ V-BAC ___CESAREAN

SCHEDULED DELIVERY? ___YES ___NO

GESTATIONAL AGE: _____WEEKS _____DAYS

BIRTH WEIGHT: _____ LBS/OUNCES _____GRAMS

APGAR SCORES: _____ 1 MIN _____ 5 MIN

BIRTH STATUS: ____HEALTHY/DISCHARGED HOME WITH MOTHER

____HEALTHY/ADOPTED OR FOSTER CARE

____SICK HOSPITALIZED

____DETAINED BORDER BABY

____STILLBORN/EXPIRED

ADMISSION DATE, IF APPLICABLE: _____

DISCHARGE DATE, IF APPLICABLE: _____

IF TRANSPORTED TO ANOTHER FACILITY, FACILITY NAME: _____

DELIVERING PHYSICIAN'S NAME: _____

DELIVERING PHYSICIAN'S NPI/TIN: _____

PEDIATRICIAN NAME: _____

PEDIATRICIAN NPI/TIN: _____

Inpatient and NICU Admissions

If complications develop with the mother or baby that necessitate additional hospital days or a non well-baby or NICU admission, an authorization request should be submitted along with clinical information to support the stay within two business days of the decision that the above is needed.

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)

Question & Answer Session