Mississippi Division Of Medicaid

Provider Workshops

2019

MISSISSIPPI DIVISION OF MEDICAID

Morning Agenda

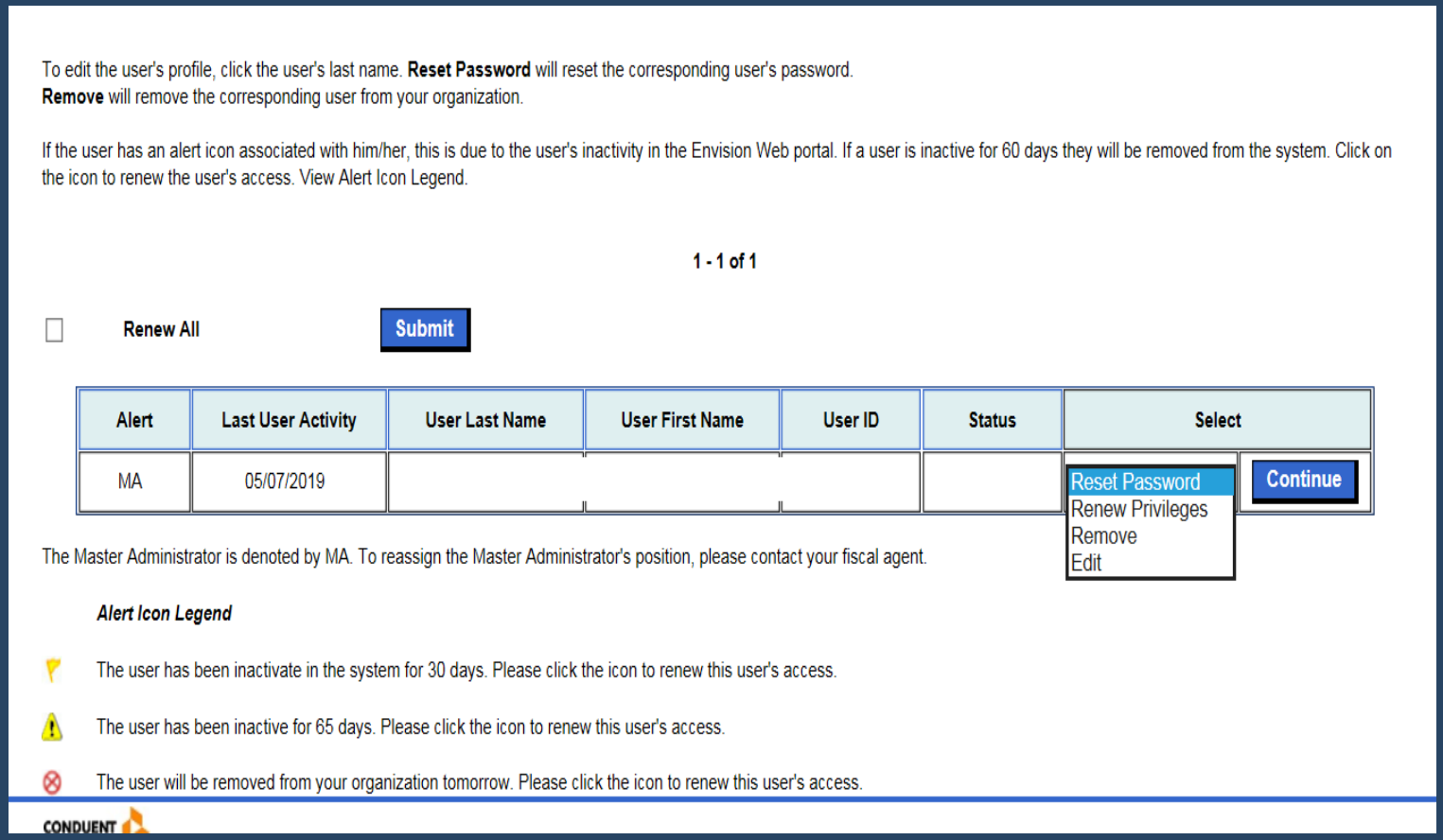
8:30 a.m.	9:00 a.m.	Registration
9:00 a.m.	9:15 a.m.	Welcome & Introductions
9:15 a.m.	11:00 a.m.	**General Medicaid Overview** **Timely Filing** **Managed Care Overview** **Rural Health Clinic** **Federally Qualified Health Centers**
11:00 a.m.	11:30 a.m.	Question & Answer Session
11:30 a.m.	12:30 p.m.	Help Desk
12:30 p.m.	1:30 p.m.	LUNCH ON YOUR OWN

General Claims Billing, Reviews, and Processing

Table of Contents

Top 10 Medicaid Issues

Web Portal Password Resets



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

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

1 - 1 of 1

Renew All Submit

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

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

Alert Icon Legend

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

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

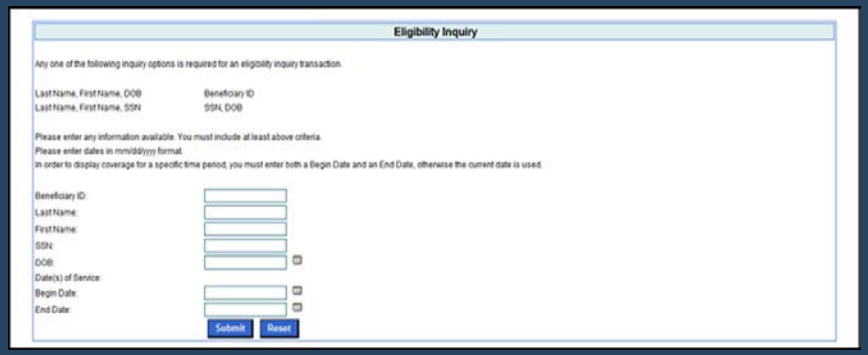
The user will be removed from your organization tomorrow. Please click the icon to renew this user's access.

CONDUENT

Verifying Eligibility

Providers may verify beneficiary eligibility using one of the following:

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

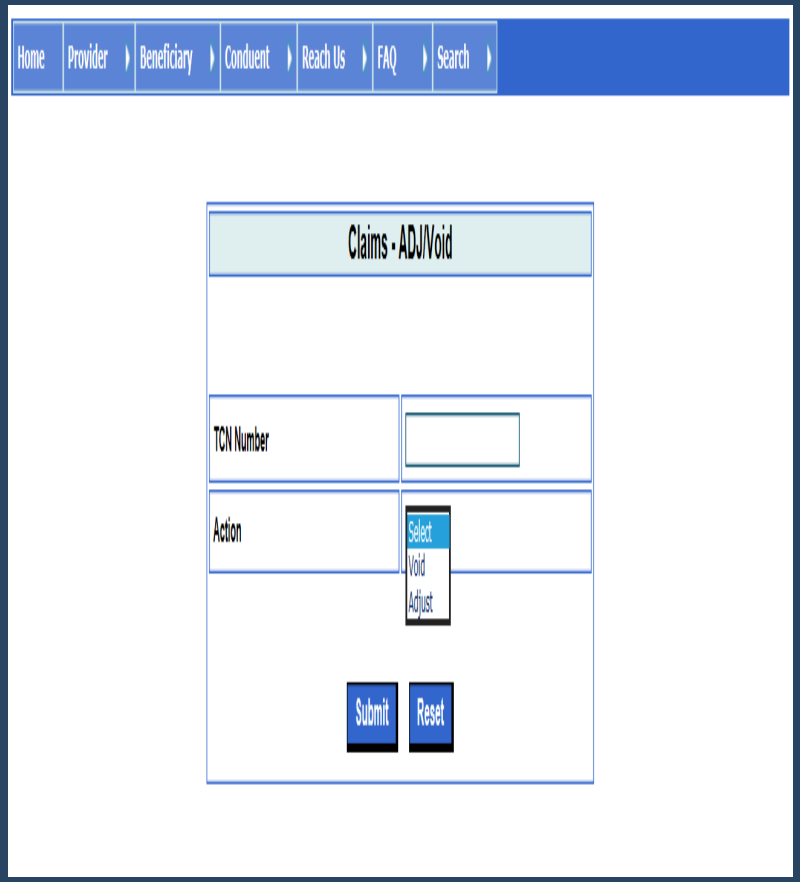


- You may check a Beneficiary's eligibility status by entering the following options:
  - Beneficiary ID or
  - SSN or
  - Beneficiary's name (*first name, last name*) and DOB

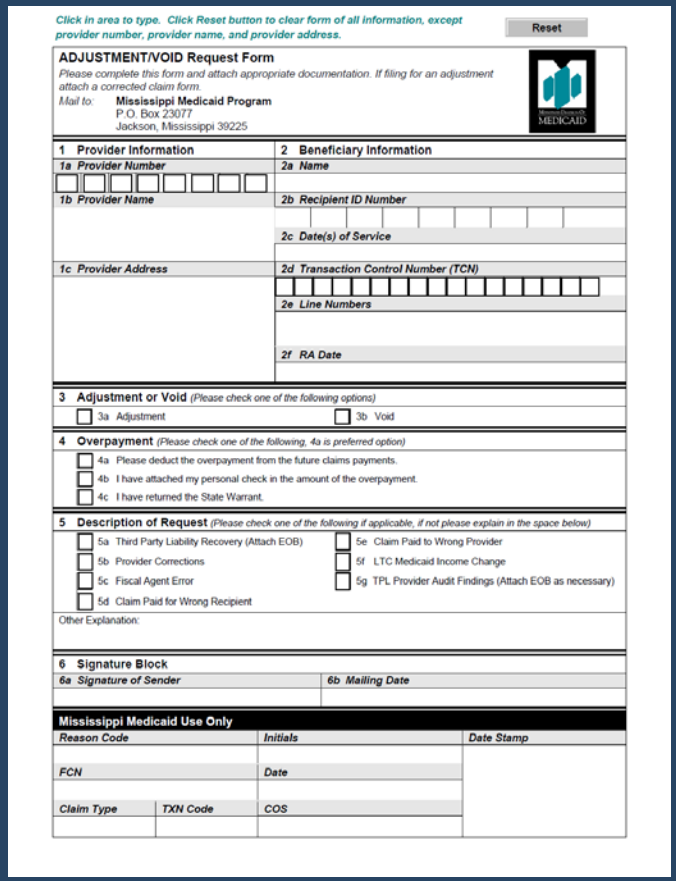
Adjusting and Voiding Claims

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

Web Portal Option



Paper Form Option



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

Reset

ADJUSTMENT/VOID Request Form

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

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

1 Provider Information

1a Provider Number

1b Provider Name

1c Provider Address

2 Beneficiary Information

2a Name

2b Recipient ID Number

2c Date(s) of Service

2d Transaction Control Number (TCN)

2e Line Numbers

2f RA Date

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

☐ 3a Adjustment ☐ 3b Void

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

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

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

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

Other Explanation:

6 Signature Block

6a Signature of Sender

6b Mailing Date

Mississippi Medicaid Use Only

Reason Code | Initials | Date Stamp

FCN | Date

Claim Type | TXN Code | COS

Importance of Updating Your Banking Information

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

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

Beneficiary File Updates

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

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

All 9's National Provider Identifier

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

National Correct Coding Initiative

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

NCCI Resources

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

Billing Vs. Coding

Your Provider Field Representative

can . . . .

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

Your Provider Field Representative

cannot . . .

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

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

Exception Code 0610

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

Request for Information (RFI) Submittal

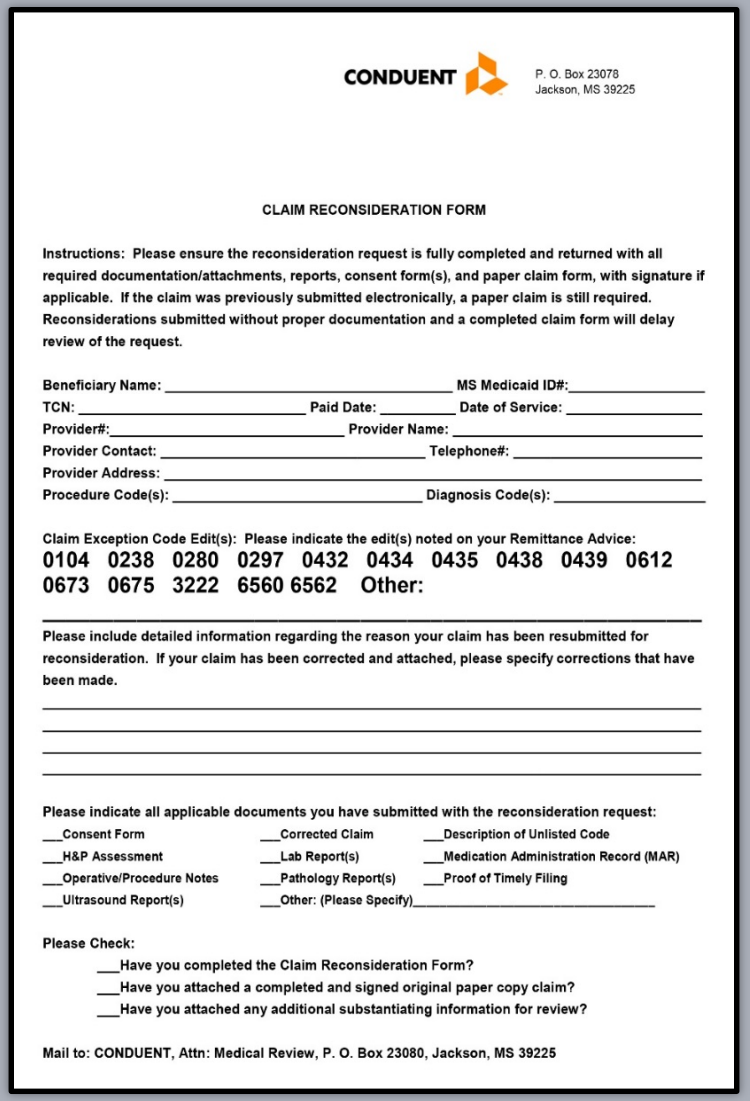
- Submit a RFI or request for public records in writing, by:
- You can submit a RFI or request for public records in writing by contact the Mississippi Division of Medicaid (DOM) multiple ways as listed below, including postal mail, fax and email. It is advised that you do not email forms or submit online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

Medicaid Fee-for-Service Claims Review

Claim Reconsideration

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

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



CONDUENT

P. O. Box 23078
Jackson, MS 39225

CLAIM RECONSIDERATION FORM

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

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

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

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

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

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

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

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

Completing a Claim Reconsideration Form

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

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

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

Claim Reconsideration Process

- Only claims that have gone through the system and denied, need to be sent in to Medical Review to be reviewed. Please make sure all proper documentation is included. *(The fully 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

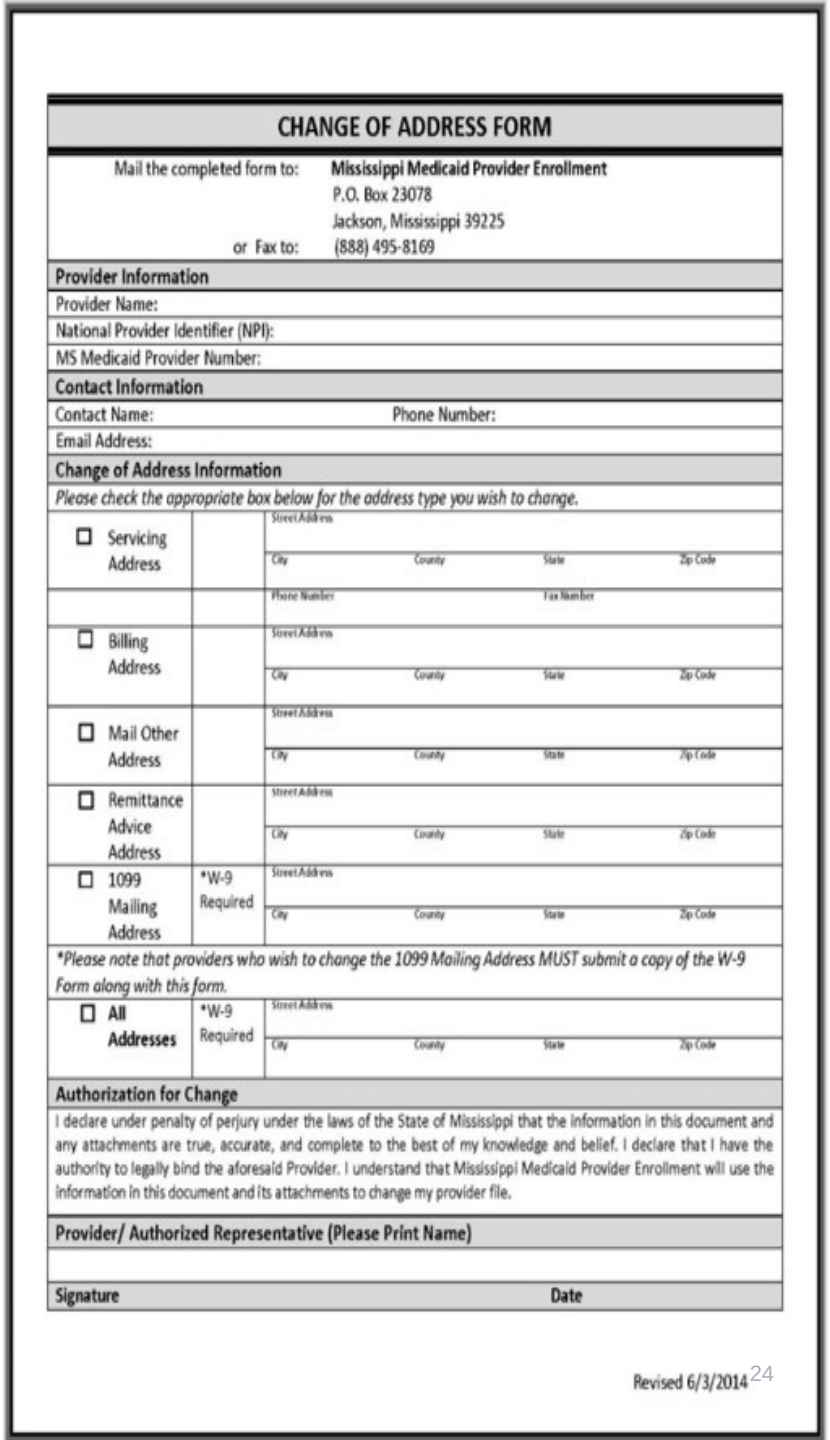
  Fax: 888-495-8169

- 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.

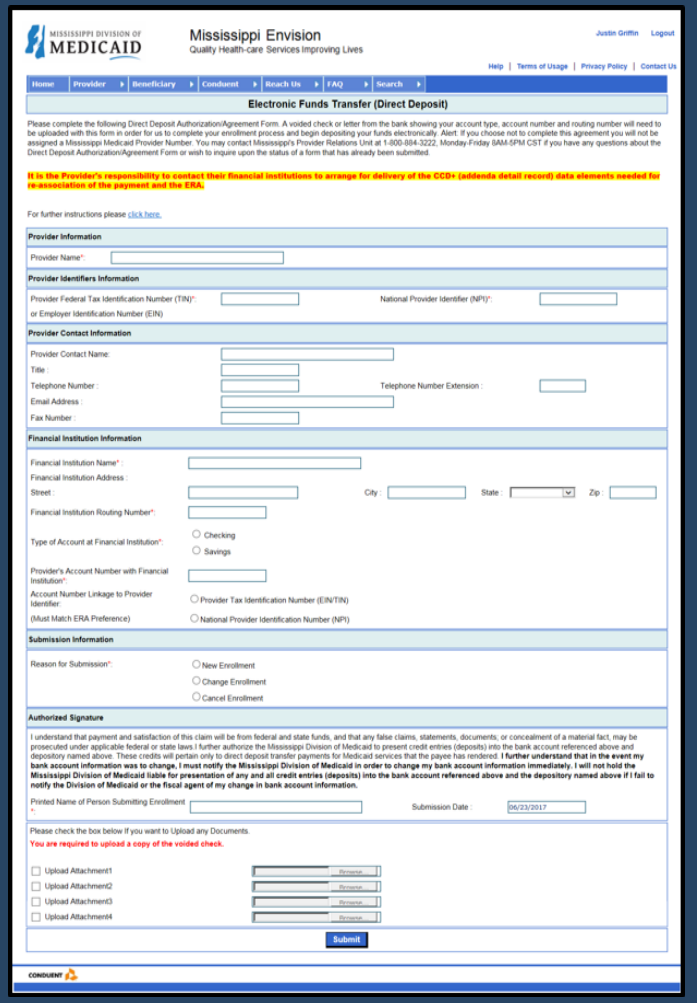
Banking (EFT) Form

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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Electronic Funds Transfer (Direct Deposit)

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

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

For further instructions please click here.

Provider Information

Provider Name*:

Provider Identifiers Information

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

National Provider Identifier (NPI)*:

Provider Contact Information

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

Telephone Number Extension :

Financial Institution Information

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

Submission Information

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

Authorized Signature

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

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

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

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

Submit

CONDUENT

Clarification

Attestation

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

Updating Licenses

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

Provider Revalidation

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

Common Edits not subject to Medical Review

Common Edits Not Subject to Medical Review

Edits

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

Edits

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

Medical Review Reminders

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

Revalidation

What is Provider Revalidation?

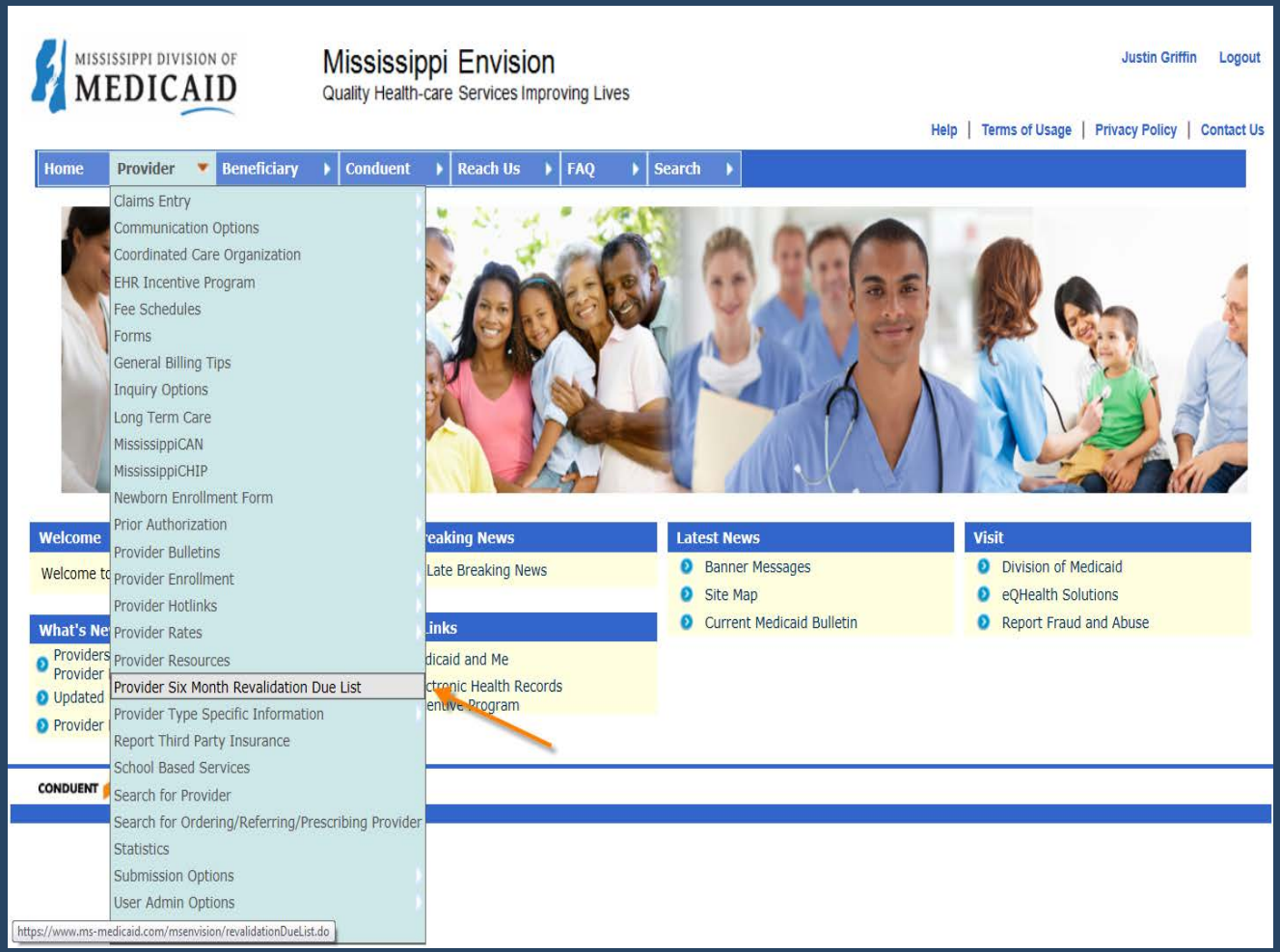
Provider Revalidation – a CMS requirement that mandates that providers who have been enrolled in Medicaid, regardless of provider type, must revalidate at least every five (5) years. Providers will need to verify that the information currently on his/her provider file is accurate and up-to-date in order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

What if I Fail to Revalidate

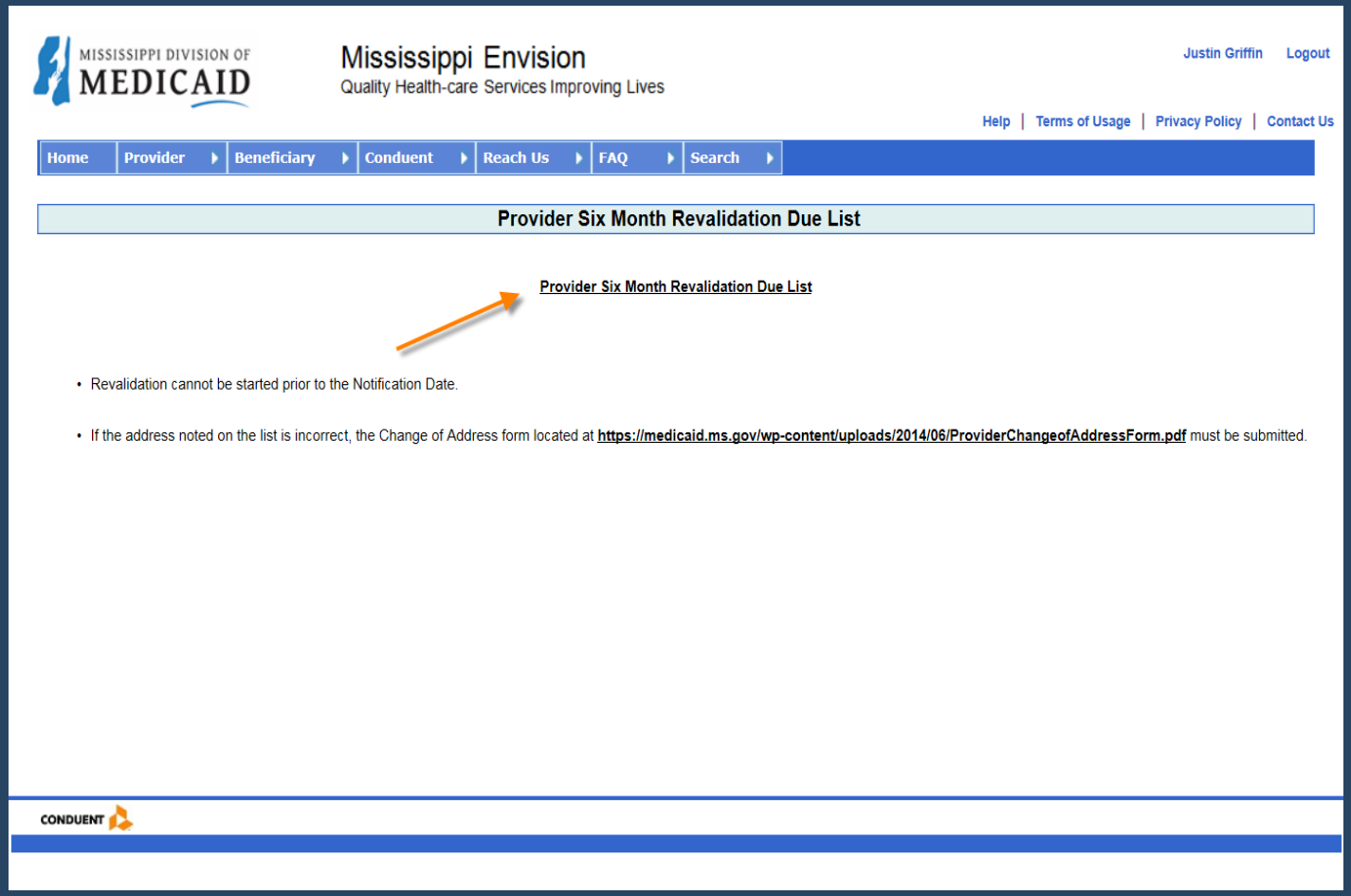
- Providers that fail to revalidate by the deadline will be terminated and required to re-enroll.
- If your Mississippi Medicaid Provider Number is termed due to failure to complete revalidation, your participation with the CCOs (Magnolia and United Healthcare and Molina Healthcare) will be termed as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

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

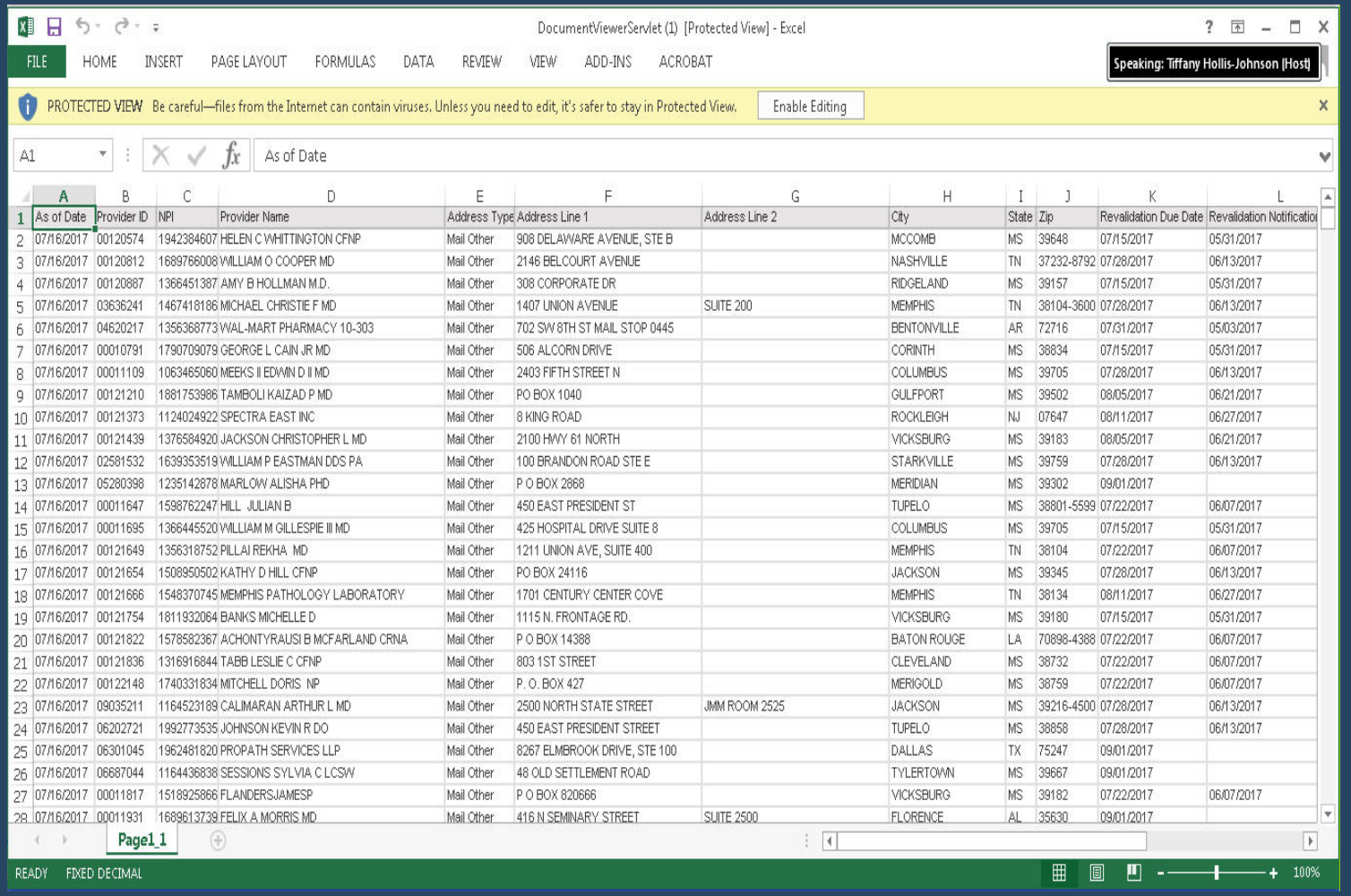
Six Month Provider Revalidation Due List



Six Month Provider Revalidation Due List



Six Month Provider Revalidation Due List



DocumentViewerServlet (1) [Protected View] - Excel

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

Speaking: Tiffany Hollis-Johnson [Host]

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

A1 | As of Date

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

Page1_1

READY FIXED DECIMAL 100%

Claims Timely filing

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

Effective July 1, 2019
for All Claims Not Paid by June 30, 2019

MISSISSIPPI DIVISION OF MEDICAID

Timely Filing
Fee-For-Service Claims

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

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

Timely Filing – Crossover Claims

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

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

Administrative Claim Review

Providers may request an Administrative Review of a claim when:

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

Administrative Claims Review

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

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

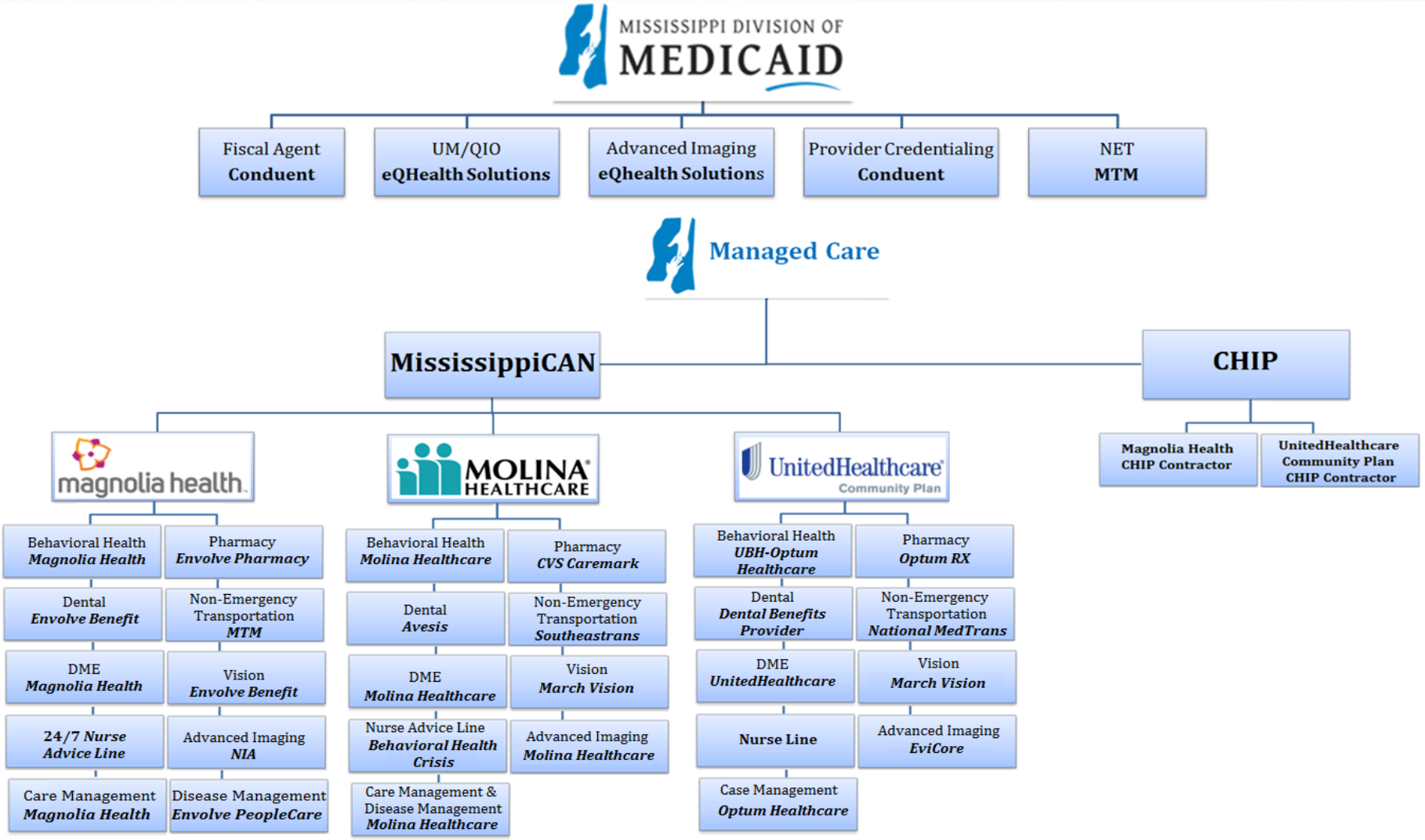
Division of Medicaid
Attention: Office of Appeals
550 High Street, Suite 1000
Jackson, MS 39201

Phone: **601-359-6050**

Fax: **601-359-9153**

Managed Care Overview

Medicaid Organizational Chart
Effective October 1, 2018



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

Managed Care Contact Information

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

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

Managed Care
Inquires and Complaints

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

Fax: 601-359-5252

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

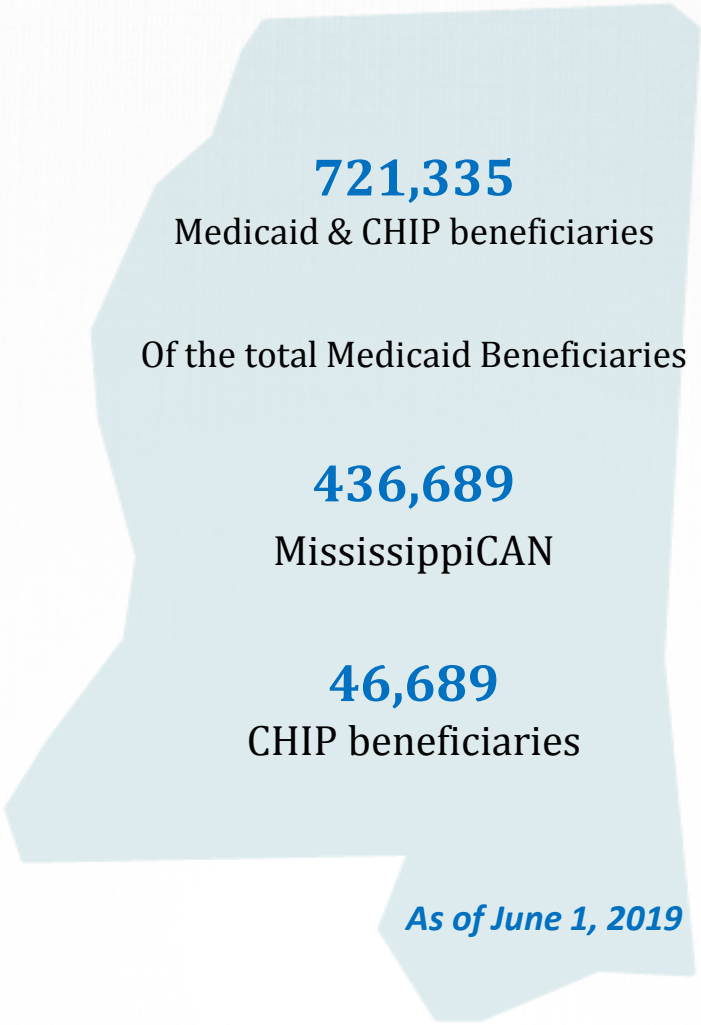
Managed Care Inquiries and Complaints	
Date	
Provider Name	
Provider ID Number	
Facility Name	
Contact Person	
Telephone Number	
Fax Number	
Beneficiary Name	
Beneficiary ID Number	
Telephone Number	
PLEASE PROVIDE DETAILED QUESTIONS AND/OR COMPLAINTS	

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.

OFFICE OF THE GOVERNOR | MISSISSIPPI DIVISION OF MEDICAID 52

Mississippi Managed Care Overview

Legislative Updates

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

Beneficiaries Not Eligible for MississippiCAN

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

Who is eligible for MississippiCAN?

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

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

MississippiCAN Enrollment

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

Mandatory Population:

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

MississippiCAN Enrollment

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

Optional Population:

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

Open Enrollment

MississippiCAN and CHIP

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

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

Eligibility Re-certifications and Updates

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

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

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

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

Eligibility Re-Certifications and Updates

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

Beneficiaries Rights

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

  Charges Not Beneficiary's Responsibility

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

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

Rural Health Clinic (RHC)

(Administrative Code: Title 23; Part 212; Chapter 1)

Rural Health Clinic

To participate as a Rural Health Clinic (RHC) in the Medicaid program, an organization must be approved by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) as an RHC.

Mississippi Administrative Code Part 212: Rural Health Clinics
https://medicaid.ms.gov/wp-content/uploads/2015/07/Admin-Code-Part-225.pdf

RHC Service Limits

The Division of Medicaid limits a RHC to no more than four (4) encounters per beneficiary per day, for each of the following provider types:

1. A physician, physician assistant, nurse practitioner, or nurse midwife,
2. A dentist,
3. An optometrist, or
4. A clinical psychologist or clinical social worker.

An exception is when the beneficiary suffers an injury or illness requiring additional diagnosis or treatment subsequent to the first encounter.

RHC Reimbursement

Up to four encounters may be reimbursed for the same date of service, limited to one encounter for each visit type:

- Medical
- Dental
- Vision/Eyeglass
- Mental Health

Additional medical encounters may be paid on the same date of service by submitting a paper claim with supporting documentation

RHC Reimbursement (cont.)

The Division of Medicaid uses the Prospective Payment System (PPS) method and an alternate payment methodology of reimbursement for Rural Health Centers (RHCs).

An RHC's encounter rate covers the beneficiary's visit to the RHC, which is inclusive of all services and supplies and drugs and biologicals which are not usually self-administered by the beneficiary, furnished as an incident to a professional service.

The RHC cannot refer the beneficiary to another provider that will bill the Division of Medicaid for the covered service, supply, drug or biological which is included in the RHC's encounter.

Drugs are included in the encounter rate, if purchased at a discounted price through a discount agreement.

RHC Laboratory Services

An RHC must provide the following six (6) laboratory services on site. These services are included in the encounter rate:

1. Chemical examinations of urine by stick or tablet method or both, including urine ketones,
2. Hemoglobin or hematocrit,
3. Blood glucose,
4. Examination of stool specimens for occult blood,
5. Pregnancy tests, and
6. Primary culturing for transmittal to a certified laboratory.

RHC Non-Covered Services

The Division of Medicaid does not cover:

- RHC services when performed in an inpatient or outpatient hospital setting.
- The cost of a sub-dermal implant as a separate service.

RHC Add-on Fees

The Division of Medicaid reimburses an additional fee for certain services provided outside the Division of Medicaid's regularly scheduled office hours.

- 99050
- 99051

The Division of Medicaid defines regularly scheduled office hours as the hours between 8:00 a.m. and 5:00 p.m., Monday through Friday, excluding Saturday, Sunday and federal and state holidays.

RHC Tele-Health

RHCs are allowed an additional fee per completed transmission, for telehealth services provided by the RHC acting as the originating site. The originating site facility fee procedure code = Q3014

- 1 unit equals 30 minutes
- 2 units are allowed per day

RHCs cannot bill for an encounter visit unless a separately identifiable service is performed.

RHC Co-mingling

The Division of Medicaid does not allow co-mingling which is defined as the simultaneous operation of an RHC and another physician practice where the two (2) practices share hours of operation, space, staff, equipment, supplies, and other resources.

Physicians and non-physician practitioners cannot operate a private Medicare or Medicaid practice during RHC hours of operation using the RHC's resources.

Federally Qualified Health Centers (FQHC)

(Administrative Code: Title 23; Chapter 1; Rule 1.1 – 1.7)

Federally Qualified Health Centers (FQHC)

To participate as a Federally Qualified Health Center (FQHC) or FQHC look-alike in the Medicaid program, an organization must be approved by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) as an FQHC or FQHC look-alike.

Mississippi Administrative Code Part 211: Federally Qualified Health Center

https://medicaid.ms.gov/wp-content/uploads/2013/12/Admin-Code-Part-211.pdf

FQHC Service Limits

The Division of Medicaid limits a FQHC and FQHC look-alike to no more than four (4) encounters per beneficiary per day, for each of the following provider types:

1. A physician, physician assistant, nurse practitioner, or nurse midwife,
2. A dentist,
3. An optometrist, or
4. A clinical psychologist or clinical social worker.

An exception is when the beneficiary suffers an injury or illness requiring additional diagnosis or treatment subsequent to the first encounter.

FQHC Reimbursement

Up to four encounters may be reimbursed for the same date of service, limited to one encounter for each visit type:

- Medical
- Dental
- Vision/Eyeglass
- Mental Health

Additional medical encounters may be paid on the same date of service by submitting a paper claim with supporting documentation.

The Division of Medicaid uses the Prospective Payment System (PPS) method and an alternate payment methodology of reimbursement for FQHCs and FQHC look-alikes.

FQHC Reimbursement

Encounter rates for an FQHC and FQHC look-alike covers the beneficiary's visit to the FQHC and FQHC look-alike , which is inclusive of all services and supplies and drugs and biologicals which are not usually self-administered by the beneficiary, furnished as an incident to a professional service.

The FQHCs and FQHC look-alikes cannot refer the beneficiary to another provider that will bill the Division of Medicaid for the covered service, supply, drug or biological which is included in the FQHC and FQHC look-alike encounter.

Drugs are included in the encounter rate, if purchased at a discounted price through a discount agreement.

FQHC Non-Covered Services

The Division of Medicaid does not cover:

- FQHC and FQHC look-alike services when performed in an inpatient or outpatient hospital setting.
- The cost of a sub-dermal implant as a separate service.

FQHC Add-on Fees

The Division of Medicaid does not cover:

- FQHC and FQHC look-alike services when performed in an inpatient or outpatient hospital setting.
- The cost of a sub-dermal implant as a separate service.

FQHC Tele-Health

FQHCs and FQHC look-alikes are allowed an additional fee per completed transmission, for telehealth services provided by the FQHC and FQHC look-alike acting as the originating site. The originating site facility fee procedure code = Q3014

- 1 unit equals 30 minutes
- 2 units are allowed per day

FQHCs and FQHC look-alikes cannot bill for an encounter visit unless a separately identifiable service is performed.

magnolia health™

Rural Health Clinic

8/7/2019

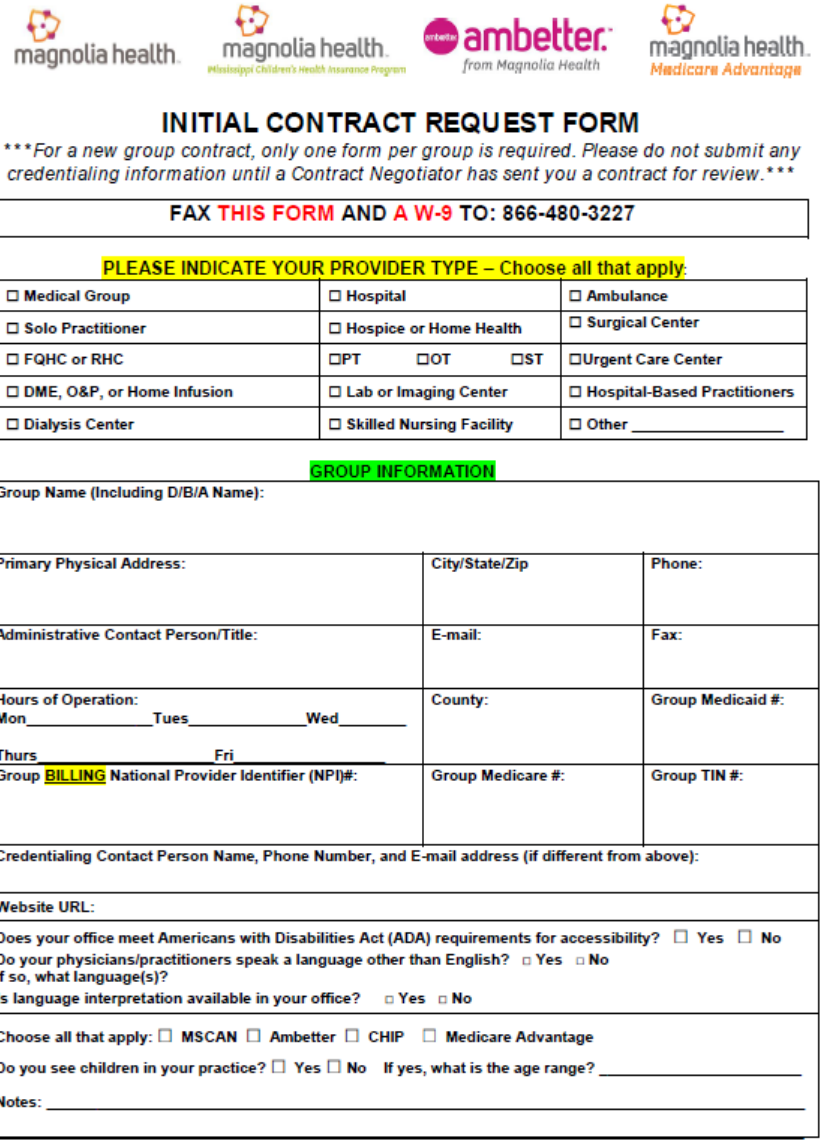
RHC Enrollment: New Group Contract Process

- To begin the contracting process, complete an Initial Contract Request Form in its entirety.
- Please send it back to the Contracting department along with a current W9 to fax number 1-866-480-3227.

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

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

**This form is not used by Behavioral Health Providers*



INITIAL CONTRACT REQUEST FORM

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

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

PLEASE INDICATE YOUR PROVIDER TYPE – Choose all that apply:

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

GROUP INFORMATION

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

New Group Contract Process

After the Contract Request Form is received:

- Our Contract Negotiator will build the Contract and/or Amendment and send a Contract Packet to the requestor which will include documents needed to credential all practitioners at your requested location(s).

Magnolia requires a contract be accompanied by:

- Completed CAQH / Provider Data Form or Mississippi Uniform Credentialing Application (MUCA) for each practitioner that you want added to your contract. Please ensure the required information below is updated in CAQH or attached with the MUCA:
  - Current Attestation (signed within the last 90 days)
  - Current Malpractice liability insurance face sheet
  - Current license copy
  - Current DEA certificate
  - Current CLIA certificate (if applicable).
  - W-9 form
  - Ownership and Disclosure Form
  - Collaborative Agreement (Nurse Practitioners and Physician Assistants)
- NOTE: Please follow the checklist that is in the instruction letter that is forwarded with your contract. The packet should be completed and returned to the e-mail address listed on the Contract Request Form.

Contracting Process

Magnolia requires a contract be accompanied by:

Completed CAQH / Provider Data Form or Mississippi Uniform Credentialing Application (MUCA) for each practitioner that you want added to your contract. Please ensure the required information below is updated in CAQH or attached with the MUCA:

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

NOTE: Please use the checklist provided in your packet to ensure all documents are completed.

Adding a New Practitioner

To link a new practitioner to your existing contract, please email the following documents to magnoliacredentailing@centene.com which are found on the magnolia website under the Become a Provider tab:

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

Before starting this process, please email magnoliacredentailing@centene.com to find out if the practitioner is already in network and linked to another provider.

Adding a Location

To link a new location to an existing contract, please email the following documents to magnoliacredentialing@centene.com which are found on the magnolia website under the Become a Provider tab:

- Provider Update Form For Contracted Providers
- Locations Page
- W-9

RHC Rates and Reimbursement

- RHCs can obtain their current “per visit rate” by reviewing www.ms-medicaid.com/msenvision/ProviderRates.
- Payment rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.
- In-network providers/schools will be reimbursed at 100% of their current encounter rate.
- All services provided in an inpatient hospital setting, outpatient hospital setting or a hospital’s emergency room will be reimbursed on a fee-for-service basis.

Reimbursement Continued…

- Service Limits
  - ❖ Reimbursement to an RHC is limited to no more than four (4) encounters, also referred to as a “visit”, per beneficiary per day, provided that each encounter represents a different provider type.

- Medically necessary services rendered by an RHC employee or contractual worker for an RHC beneficiary can be billed as an RHC encounter in multiple sites:
  - ❖ Rural Health Clinic
  - ❖ Skilled Nursing Facility
  - ❖ Nursing Facility
  - ❖ Residential Facility

Top Claim Denials

- Duplicate Claim
- State Medicaid ID Number
- Authorization Not on File
- COB/TPL
- Timely Filing
- Inappropriate Coding
- Delayed RHC Rate Updates

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

- A federally mandated service which provides preventive and comprehensive health services for children from birth up to age 21 who are eligible for Medicaid.
- Promotes preventive health care by providing early and regular medical, hearing, vision, and dental screenings
- Provides medically necessary health care to correct or prevent a defect, physical or mental illness, or a condition [health problem] identified through a screening.
- Promote the importance of vaccinations.

Where can EPSDT services be performed?

An EPSDT examination can be performed in an approved clinic listed below:

- Limited Local County Health Departments
- Limited School Systems
- Private and Public Provider Clinics
- Federally Qualified Health Clinics (FQHC)
- Rural Health Clinics (RHC)

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

magnolia health

Each of the following elements must be clearly documented to be considered an EPSDT Screening:

Screening for Sexually Transmitted Diseases	Hearing Screening and Follow up if needed	Tobacco, Alcohol, or Drug Use Assessment
Lead	Vision Screening and Referral if needed	Anticipatory Guidance
Nutritional Counseling	Psychosocial/ Behavioral Assessment	Dental Referral
Developmental Assessment	Depression Screening	Specialty Referral if needed
Hemoglobin and Hematocrit levels	Maternal Depression Screening	Return Appointment for next EPSDT visit
Height and Weight		Documentation of unclothed exam

EPSDT Billing Requirements

All EPSDT visit codes should be filed with an EP modifier. Covered codes for EPSDT services are found on the Envision website https://https://www.ms-medicaid.com/msenvision/index.do

Magnolia Follows the Bright Futures Periodicity Schedule for Screenings and Immunizations

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)

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.

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.

Peer to Peer Review

- If the treating practitioner does not agree with an adverse determination, the practitioner may discuss the decision with the Medical Director who rendered the decision.

- Contact information:

  1-866-912-6285

  Request to speak to the UM Department

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.

Prior Authorization 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

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.

Behavioral Health Contact Information

Provider Services: (866)-912-6285

Fax for submission of OTRs: (866) 694-3649

Appeals
Magnolia Health Plan
ATTN: Appeals Coordinator
12515-8 Research Blvd. Suite 400
Austin, TX 78759

Magnolia Website/Portal (BH):
https://www.magnoliahealthplan.com/providers/resources/behavioral-health.html

Contact Information

Important Numbers & Links

Provider Services:
(866)-912-6285

Fax for submission of OTRs:
(866) 694-3649

Provider Relations Fax Number:
855-669-0101

Magnolia Website:
www.magnoliahealthplan.com

Provider Relations

Jasmine Shaw
Provider Network Specialist
(Central and Southern MS)
Jasmine.L.Shaw@centene.com

Kiri Parson
Provider Network Specialist II
(North MS)
Kiri.L.Parson@centene.com

Things to Remember

- Referrals and authorization are not required for office visits.
- Magnolia partners with Rural Health Clinics to encourage members to establish medical homes.

magnolia health™

Federally Qualified Health Center

8/7/2019

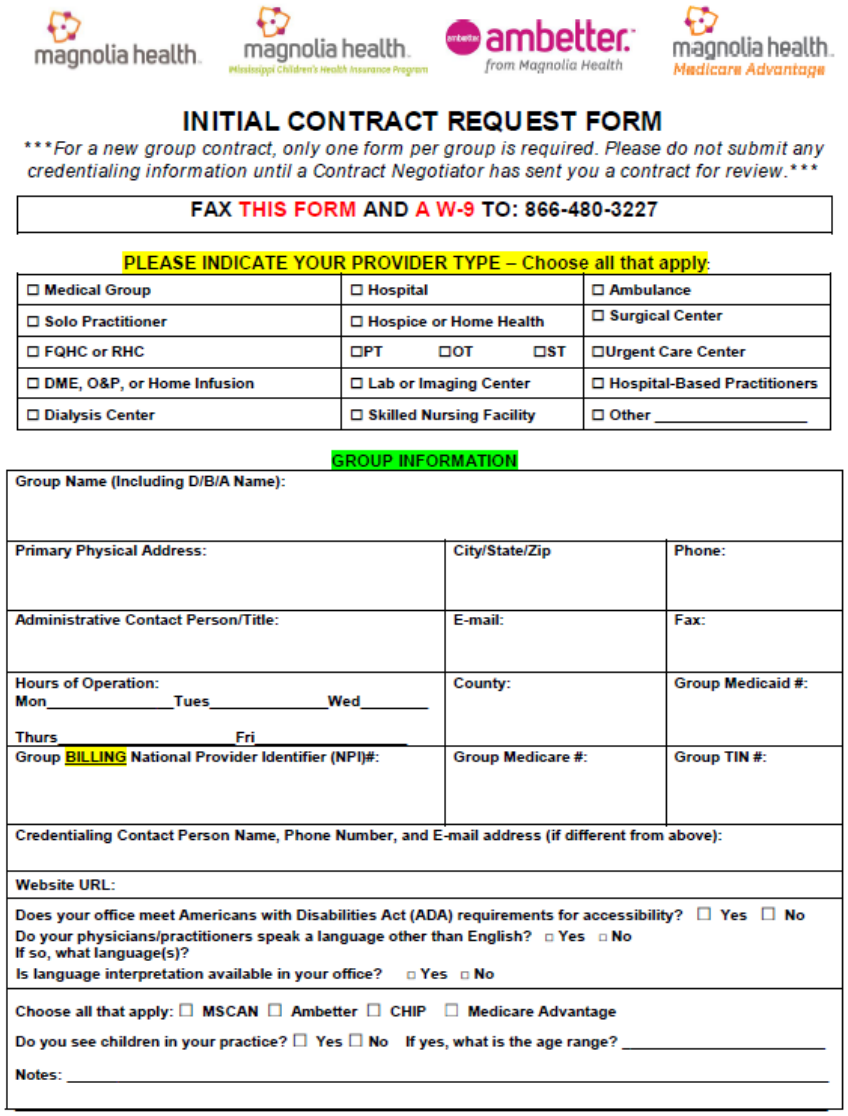
FQHC Enrollment:
New Group Contract Process

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

- Please send it back to the Contracting department along with a current W9 to fax number 1-866-480-3227.

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

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



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

INITIAL CONTRACT REQUEST FORM

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

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

PLEASE INDICATE YOUR PROVIDER TYPE – Choose all that apply:

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

GROUP INFORMATION

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

New Group Contract Process

After the Contract Request Form is received:

- Our Contract Negotiator will build the Contract and/or Amendment and send a Contract Packet to the requestor which will include documents needed to credential all practitioners at your requested location(s).

- The packet should be completed and returned to the e-mail address listed on the Contract Request Form.

New Group Contract Process

Magnolia requires a contract be accompanied by:

Completed CAQH / Provider Data Form or Mississippi Uniform Credentialing Application (MUCA) for each practitioner that you want added to your contract. Please ensure the required information below is updated in CAQH or attached with the MUCA:

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

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

Adding a New Practitioner

To link a new practitioner to your existing contract, please email the following documents to https://www.magnoliahealthplan.com/providers.html which are found on the magnolia website under the Become a Provider tab:

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

Before starting this process, please email https://www.magnoliahealthplan.com/providers.html **to find out if the practitioner is already in network and linked to another provider.**

Adding a Location

To link a new location to an existing contract, please email the following documents to magnoliacredentialing@centene.com which are found on the magnolia website under the Become a Provider tab:

- Provider Update Form For Contracted Providers
- Locations Page
- W-9

FQHC Rates and Reimbursement

- FQHCs can obtain their current “per visit rate” by reviewing www.ms-medicaid.com/msenvision/ProviderRates.
- Payment rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.
- In-network providers/schools will be reimbursed at 100% of their current encounter rate.
- All services provided in an inpatient hospital setting, outpatient hospital setting or a hospital’s emergency room will be reimbursed on a fee-for-service basis.

Top 5 Denials

- Duplicate Claim
- State Medicaid ID Number
- Authorization Not on File
- COB/TPL
- Timely Filing
- Inappropriate Coding

Early and **P**eriodic **S**creening, **D**iagnosis and **T**reatment

- A federally mandated service which provides preventive and comprehensive health services for children from birth up to age 21 who are eligible for Medicaid.
- Promotes preventive health care by providing early and regular medical, hearing, vision, and dental screenings
- Provides medically necessary health care to correct or prevent a defect, physical or mental illness, or a condition [health problem] identified through a screening.
- Promote the importance of vaccinations.

Documentation

Each of the following element must be clearly documented to be considered an EPSDT Screening:

- Growth Parameters
- Vital Signs
- Immunization Status
- Medical history
- Screening for Sexually Transmitted Diseases
- H&H
- Lead
- Nutritional Counseling
- Developmental Assessment

Continued…

- Height and Weight
- Hearing Screening and Follow up if needed
- Vision Screening and Referral if needed
- Psychosocial/ Behavioral Assessment
- Depression Screening
- Maternal Depression Screening
- Tobacco, Alcohol, or Drug Use Assessment
- Anticipatory Guidance
- Dental Referral
- Specialty Referral if needed
- Return Appointment for next EPSDT visit
- Documentation of unclothed exam

Where can EPSDT services be performed?

An EPSDT examination can be performed in an approved clinic listed below:

- Limited Local County Health Departments
- Limited School Systems
- Private and Public Provider Clinics
- Federally Qualified Health Clinics (FQHC)
- Rural Health Clinics (RHC)

Billing Requirements

All EPSDT visit codes should be filed with an EP modifier. Covered codes for EPSDT services are found on the Envision website https://https://www.ms-medicaid.com/msenvision/index.do

Magnolia Follows the Bright Futures Periodicity Schedule for Screenings and Immunizations

FQHC

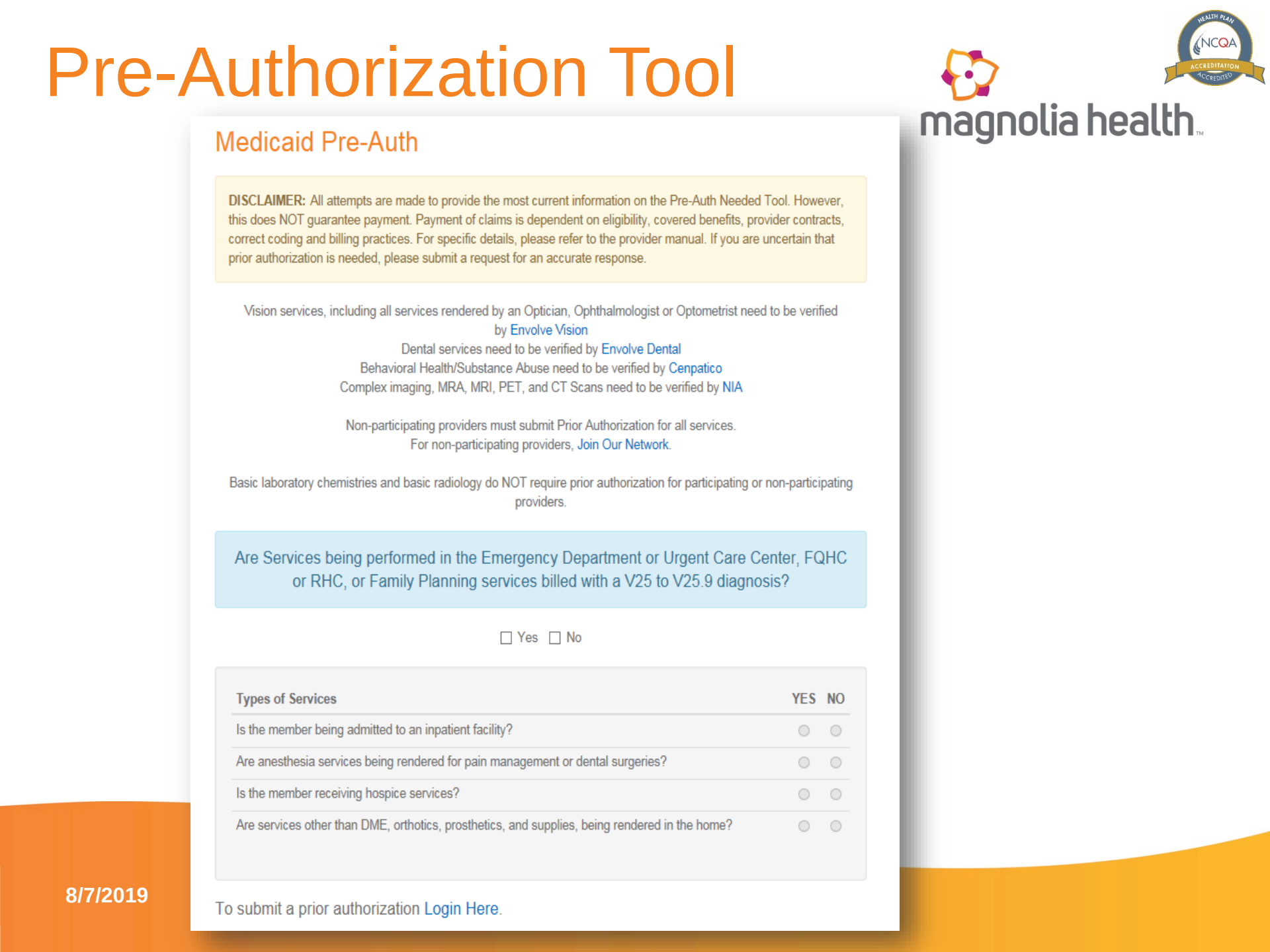
- Referrals and authorization are not required for office visits.
- Magnolia partners with the FQHC's to encourage members to establish medical homes.
- Magnolia has Care Managers embedded in two of the FQHC's.

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-Authorization Tool



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)

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.

Peer to Peer Review

- If the treating practitioner does not agree with an adverse determination, the practitioner may discuss the decision with the Medical Director who rendered the decision.

- Contact information:

  1-866-912-6285

  Request to speak to the UM Department

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

magnolia health

magnolia health

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

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

The Credentialing Process

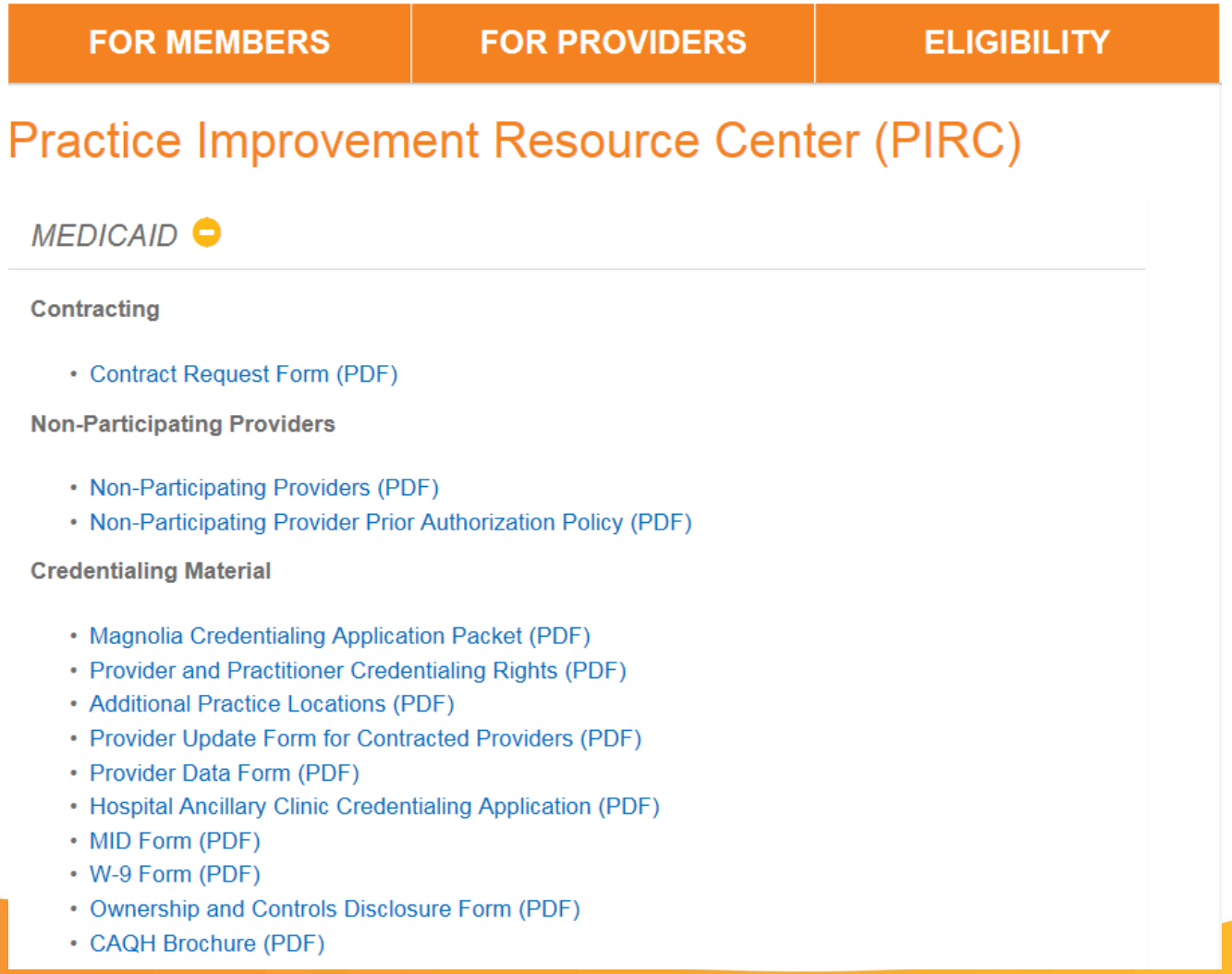
All providers who participate in the MississippiCAN program and choose to participate with Magnolia Health must also be a Medicaid provider in good standing with a **VALID MISSISSIPPI MEDICAID NUMBER**.

Credentialing cannot begin until the provider has a Valid Mississippi Medicaid Number. Please do not send in requests to credential a provider until this has been confirmed by Medicaid.

Credentialing Application

The Practitioner Credentialing Application is located at

www.magnoliahealthplan.com



Returning the Contract & Credentialing Documents

Ways you can submit your credentialing documentation:

- Email the documents with the signed contract to the Contract Negotiator who sent them to you.

- Fax to: 1-866-480-3227 to the attention of Contracting.

- Mail to:

Magnolia Health

Attn: Contracting

111 East Capital Street Suite 500

Jackson, MS 39201

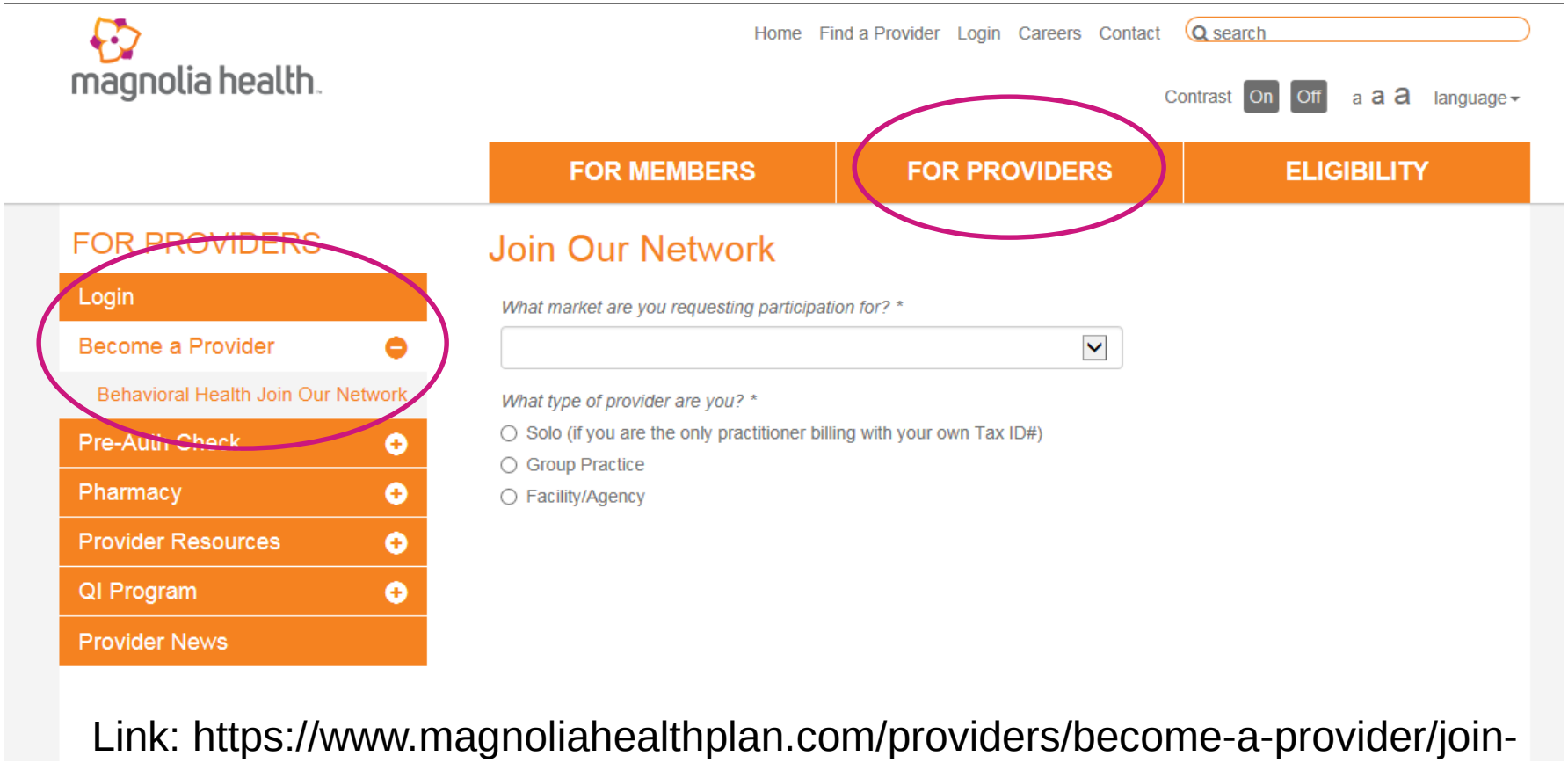
Recredentialing

- Recredentialing occurs every 36 months from the month of initial credentialing approval.
- Providers and Practitioners failing to comply with requests for recredentialing documentation are automatically administratively terminated at the end of their current credentialing cycle.
- Recredentialing is taking place now. Please verify with your practitioners if they have received any recredentialing request(s) from Magnolia's credentialing team.
- Recredentialing documents can be e-mailed to RECRED-CORPORATE@CENTENE.COM.
- Once all items are received and verified, credentialing may take up to 90 days. Please notify your local Provider Relations Specialist of any new practitioners that will be joining your facility prior to rendering services to Magnolia Health members.

*Magnolia uses VerifPoint, an NCQA-certified company, to assist with obtaining missing and expired documentation for credentialing purposes.

Credentialing and Contracting

Join Our Network



Link: https://www.magnoliahealthplan.com/providers/become-a-provider/join-our-network.html

Common Credentialing Barriers

- ✓ Credentialing application sent when Practitioner did not have a MS Medicaid ID.
- ✓ Release of Information (ROI) expired (signature date expires in less than 90 days)
- ✓ No response to requests for additional information from practitioner during the credentialing and re-credentialing process.
- ✓ CAQH information not updated by practitioner or permission not given to Magnolia to view CAQH data.
- ✓ Missing Collaborative Agreements – Needed for Nurse Practitioners
- ✓ Malpractice Insurance Certificate is expired.
- ✓ Missing or Incomplete Ownership and Disclosure Form

Federally Qualified Health Center (FQHC) & Rural Health Clinics (RHC)

2019 Mississippi Medicaid Provider Workshops

MOLINA HEALTHCARE

FQHC & RHC Services

The Division of Medicaid limits reimbursement to a FQHC (and FQHC look -alike) and RHC to no more than four (4) encounters per beneficiary per day, provided that each encounter represents a different provider type, as the Division of Medicaid only reimburses for one (1) medically necessary encounter per beneficiary per day for each of the following provider types:

1. A physician, physician assistant, nurse practitioner, or nurse midwife,
2. A dentist,
3. An optometrist, or
4. A clinical psychologist or clinical social worker.

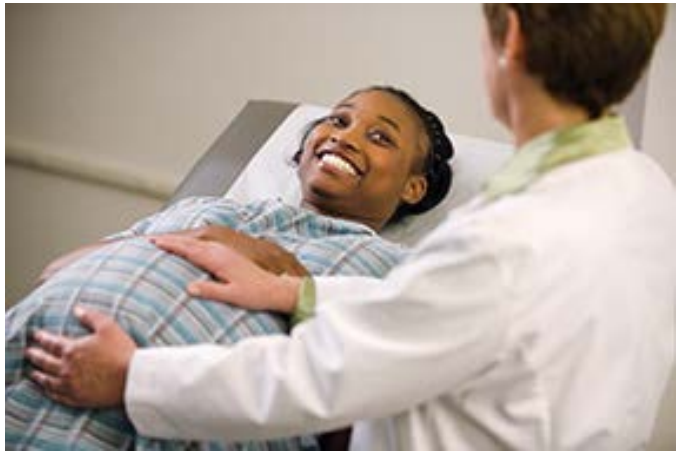
FQHC & RHC Enrollment

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

To join our network, please complete the Contract Request Form found on our website and follow the instructions given.

https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx

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



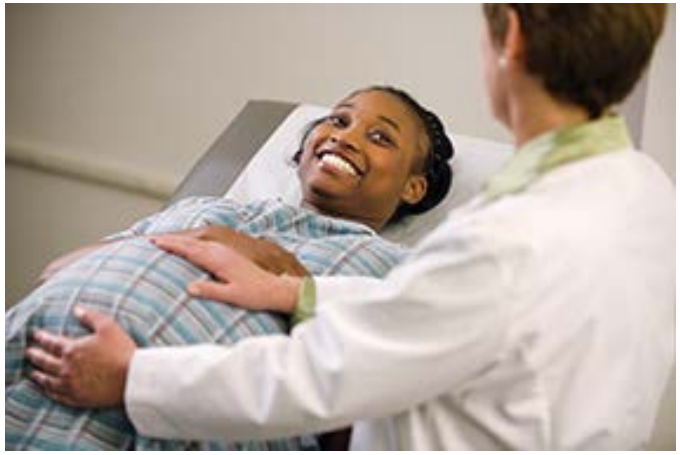
FQHC Enrollment & Credentialing

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

To join our network, please complete the Contract Request Form found on our website and follow the instructions given.

https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx

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



FQHC and RHC Rates

- Reimburse based on medical fee-schedule
- Division of Medicaid Fee Schedule
  - https://medicaid.ms.gov/providers/fee-schedules-and-rates/#

EPSDT Services

EPSDT stands for **Early Periodic Screening, Diagnosis and Treatment.** EPSDT is a program of checkups and health care services for children under the age of 21 to detect and treat health problems. EPSDT checkups are free for all children who is a Molina Healthcare member.

- **Early:** Identifying problems early, starting at birth.
- **Periodic:** Checking children's health at periodic, age-appropriate intervals.
- **Screening**: Doing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
- **Diagnosis:** Performing diagnostic tests to follow up when a risk is identified.
- **Treatment:** Treating the problems found.

Prior Authorizations Submissions

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

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

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

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

Prior Authorizations and Referrals

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

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

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

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

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

Request Submissions

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

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

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

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

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

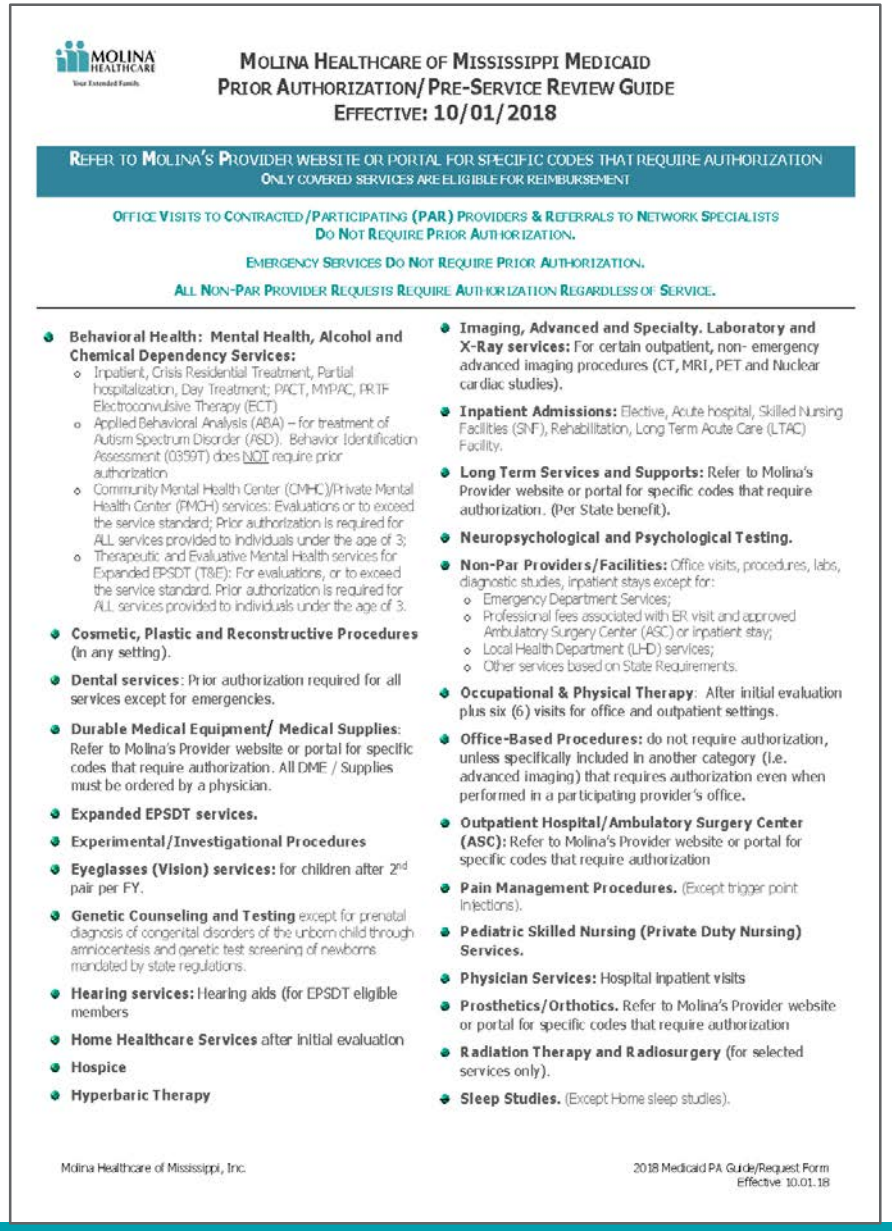
Behavioral Health Authorizations:
Phone: 1 (844) 826-4335
Inpatient Requests Fax: 1 (844) 207-1622
All Non-Inpatient Fax: 1 (844) 206-4006

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

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

Prior Authorization Review Guide

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



MOLINA HEALTHCARE

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

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

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

EMERGENCY SERVICES DO NOT REQUIRE PRIOR AUTHORIZATION.

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

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

Molina Healthcare of Mississippi, Inc.

2018 Medicaid PA Guide/Request Form
Effective 10.01.18

Pre-Service Review

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

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

Post-Service Review

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

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

Peer-to-Peer Review Process

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

Concurrent Review

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

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

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

Prior Authorization – Appeals

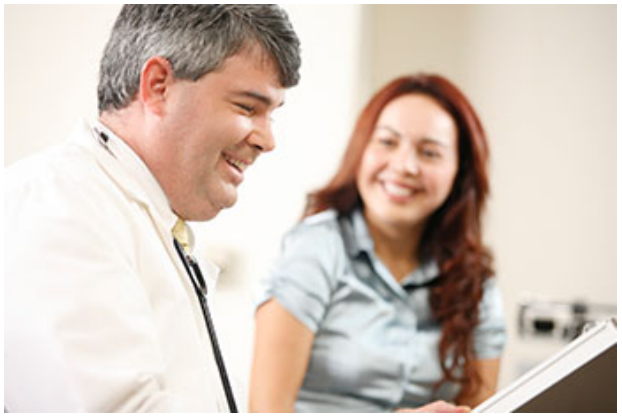
- Requests for authorization not meeting criteria must be reviewed by a designated Molina Medical Director or other appropriate clinical professional. Only a licensed physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate)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

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

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

Prior Authorization – Appeals

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



School Encounter Rates

School Based Administrative Claiming is an administrative function of DOM FFS. The CCOs are required to enroll and reimburse School-based providers, which are school districts with nurses providing EPSDT screenings.

School-based providers, which are school districts with nurses, providing EPSDT screenings.

These schools are contracted as FQHCs and are paid the encounter rate for services rendered.

Rates are determined by CMS and we are required to reimburse in accordance with those rates.

Effective Date Adjustment & Reimbursements

Effective dates and rates for FQHCs and RHCs are updated in our system when received from the Mississippi Division of Medicaid (DOM). Molina Healthcare reimburses the provider based on rates received from DOM.

- FQHCs must file Place of Service (POS) 50.
- RHCs must file POS 72.

How to correct the top issues

Error	Resolution
Insufficient information to meet medical necessity criteria following request for additional clinical	**Provider must submit the following with PA submissions:** • Current (up to 6 months), adequate patient history related to the requested services • Physical examination that addresses the problem • Lab or radiology results to support the request (Including previous MRI, CT, Lab or X-ray report/results) • PCP or Specialist progress notes or consultations • Any other information or data specific to the request
Untimely or no response to request for additional clinical	To ensure that authorizations are approved, submit requested information timely.
Provider non-participating	To ensure that authorizations and claims are approved, verify member eligibility and whether the provider is enrolled with the CCO, and if non-par, then submit a prior authorization for each service.
Provider billing incorrect Point of Sale (POS) code	FQHC claims are filed with POS 50, and RHC claims are filed with POS 72.
Incorrect use of modifiers or missing modifiers	To ensure that claims are as accurate as possible, cross-check with medical coding resources to ensure the correct modifier is being used
NPI submitted on claim different from NPI in provider file	To ensure accuracy, providers should update DOM and Molina provider enrollment files with updated NPI

FQHC Provider Representative

Earl Robinson
Sr. Rep, Provider Services


Earl.Robinson@molinahealthcare.com


(601) 760-2433

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 & STATE

FQHC
RHC

UnitedHealthcare®

Entering the Network

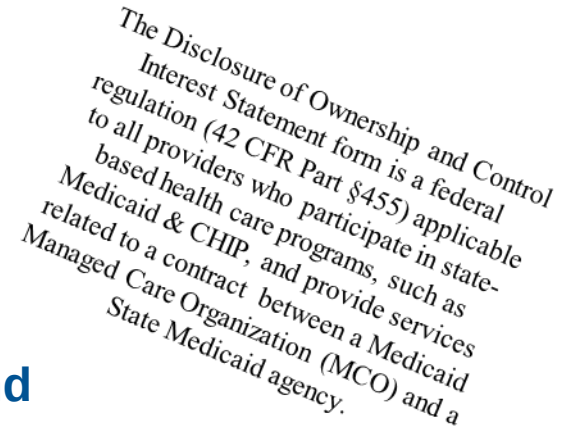
1. Apply for Provider Medicaid ID with MS Division of Medicaid
   - https://www.ms-medicaid.com/msenvision/downloadenrollPackage.do
   - Not required for CHIP participation

2. Complete credentialing application with CAQH
   - www.CAQH.org > CAQH ProView
   - 888-599-1771

Note that these initial steps do not directly involve UnitedHealthcare.

Entering the Network (cont.)

3. **Contact UHC Credentialing to request participation in MSCAN and/or CHIP**
   - 877-842-3210
   - Enter Tax ID and select '*Other Professional Services*'
4. **Disclosure of Ownership forms**
   - www.uhccommunityplan.com > Provider Forms
   - Online submission or mail/fax/email
   - State requirement delegated to CCO
5. **Contract will be sent once credentialing and disclosures are completed/approved**
   - Questions can be directed to Network Management at 1-866-574-6088
   - Demographic forms/info can be sent to:
     - Fax: 855-773-3156
     - email HPDemo@uhc.com
6. **Sign and return contract**
7. **UHC will send final copy to provider once loaded**


The Disclosure of Ownership and Control Interest Statement form is a federal regulation (42 CFR Part §455) applicable to all providers who participate in state-based health care programs, such as Medicaid & CHIP, and provide services related to a contract between a Medicaid Managed Care Organization (MCO) and a State Medicaid agency.

Re-credentialing

- Re-credentialing is conducted every 3 years in compliance with NCQA standards and to ensure professional qualifications remain valid and current

- UHC begins outreach efforts several months in advance of re-cred date.
  - Needed action is specified in the letter.
  - If provider takes no action, additional letters will continue to be sent.
  - If re-cred date is reached and no provider action has taken plan, termination processes will begin.

FQHC and RHC Policies

FQHC and RHC

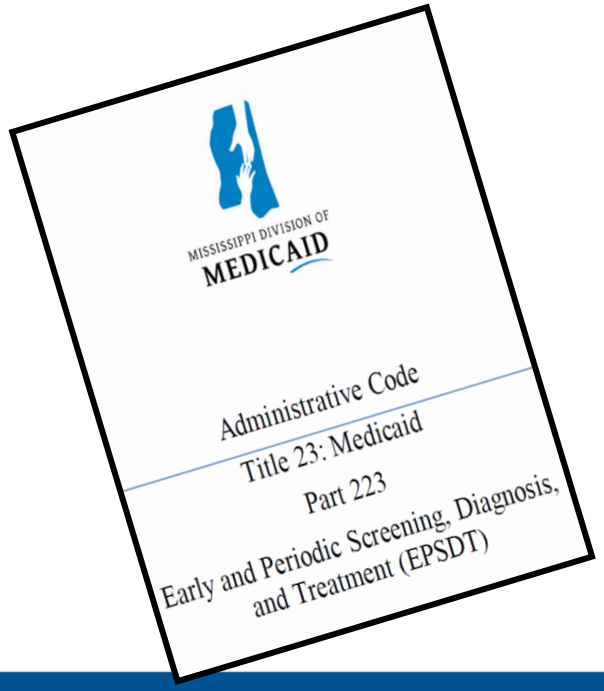
UnitedHealthcare COMMUNITY & STATE

- Encounters
  - Place of service 50 and 72
  - 4 distinct encounters per day *(acute exception)*
  - Designated provider types
    - Medical Doctor (MD)
    - Doctor of Osteopathic Medicine (DO)
    - Physician Assistant (PA)
    - Advance Practice Nurse (APN)
    - Doctor of Dental Medicine (DMD)
    - Doctor of Dental Science (DDS)
    - Doctor of Optometry (OD)
    - Licensed Clinical Social Worker (LCSW)
    - Psychologist

Early & Periodic Screening, Diagnosis and Treatment

UnitedHealthcare COMMUNITY & STATE

- Must be registered with DOM
- 15 point clinical requirements
- Periodicity adherence
- Bill correctly to indicate EPSDT svcs
- EPSDT Coordinator 601-718-6609



Check Eligibility and Assigned PCP

- **To check member eligibility**
  - Medicaid's Envision website: msmedicaid.acs-inc.com
  - UHCProvider.com > Link > Patient Eligibility & Benefits
  - Call UnitedHealthcare Community Plan Provider Services
    - MississippiCAN: 877-743-8734
    - Mississippi CHIP: 800-557-9933

- **To verify PCP affiliation, Check your Panel via Link**
  - PCP Assignment is a requirement for each member
  - A preferred PCP is identified for each member either through member self-selection or auto-assignment
  - PCPs are identified on member ID cards
  - Members can request a PCP change at any time and receive a new member ID card

Claims Filing

UnitedHealthcare COMMUNITY & STATE

Electronic vs. Paper

- Electronic claims can help reduce errors and shorten payment cycles.
- Learn more about electronic claims submission at UnitedHealthcareOnline.com > Tools & Resources > EDI Education for Electronic Transactions or call 800-842-1109.
- If a claim must be submitted on paper, please use the following address:

  UnitedHealthcare
  P.O. Box 5032
  Kingston, NY 12402-5032

Format

- All claims must be submitted using the standard CMS-1500, CMS-1450/UB04 or respective electronic format.
- Please include all appropriate secondary diagnosis codes for line items.

Timely Filing

- Claims must be filed within six months from the date of service (MSCAN & CHIP)

Inpatient Management

Admission & Birth Notifications* (non-emergent)

Verify Eligibility:

- Log on to the Medicaid Envision website at:
  www.ms-medicaid.com/msenvision
- Log on to the secure provider portal at:
  www.unitedhealthcareonline.com
- Contact UHC Provider Services: 877-743-8734

Notify a Care Manager:

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

Utilization Management/Case Management

- Call 877-743-8731 (Mon-Fri, 8am-5pm; or 24/7 for emergencies)
- Staff can assist with routine prior authorizations, admissions, discharges and coordination of members' care

**This does not replace any Medicaid requirement. Please continue to utilize the Newborn Enrollment Form for Member number.*

Disagree With a Decision?

UnitedHealthcare COMMUNITY & STATE

•Claims

- **Provider Services**
  1-877-743-8734
- **Website**
  UHCOnline.com
- **Reconsideration**
  Within 90 calendar days of determination
- **Appeal**
  Within 30 calendar days of determination
- **State Hearing**
  Within 30 calendar days of UHC appeal determination

Prior Auth/UM

- **Peer-to-peer**
  Within 14 calendar days of determination or 3 calendar days post-discharge
- **Concurrent Review**
  Within 14 calendar days of determination or 3 calendar days post-discharge
- **Appeal**
  Within 30 calendar days of determination
- **State Hearing**
  Within 30 calendar days of UHC appeal determination

Top Denials

Denials for No Authorizations due to out of network

- Loading providers to the group

Incorrect rates loaded

- Pending investigation and resolution

Invalid NPI with Incorrect Taxonomy

- Education has been provided and this is no longer an issue.

Question & Answer Session

Afternoon Agenda

1:30 p.m.	3:00 p.m.	**Behavioral Health Session**
3:00 p.m.	3:30 p.m.	Question & Answer Session
3:30 p.m.	4:30 p.m.	Help Desk

Behavioral Health

(Administrative Code: Title 23: Part 206; Chapters 1 and 2)

Behavioral Health Programs

The Office of Mental Health is comprised of three divisions:

Mental Health Programs:

- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Pre-Admission Screening and Resident Review (PASRR)

Special Mental Health Initiatives:

- Autism Spectrum Disorder (ASD) Services
- Mississippi Youth Programs Around the Clock (MYPAC)
- Substance Use Disorder (SUD) Services
- Community Support Program 1915(i)
- Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver

Mental Health Services:

- Acute Freestanding Psychiatric Facilities
- Community/Private Mental Health Centers (CMHC/PMHC)
- Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)
- Outpatient Mental Health Hospital Services
- Psychiatric Residential Treatment Facilities (PRTF)
- Psychiatric Units at General Hospitals
- Psychiatric Services by Physicians or Nurse Practitioners
- Therapeutic and Evaluative (T&E) Mental Health Services for Children

Mental Health Programs

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Provides, in a protected institutional setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability.

- Effective September 1, 2019, the MS Department of Health will no longer conduct the utilization review for ICF/IID admissions.
- Alliant, DOM's new utilization management/quality improvement organization, will begin issuing prior authorizations for ICF/IID admissions on September 1, 2019.

Pre-Admission Screening and Resident Review (PASRR) is a process that ensures that an individual is appropriate for nursing facility placement and aids in determining whether an individual with an indication of Mental Illness, Intellectual Disability and/or a related condition could benefit from specialized or rehabilitative services. The screenings and resident reviews are conducted by the DOM PASRR Contractor and/or the Department of Mental Health.

Mental Health Services Inpatient

- **Acute Freestanding Psychiatric Facilities** provide acute services for children under 21, with an average length of stay of 7-10 days. Prior authorization is required.

- **Psychiatric Units at General Hospitals** provide acute psychiatric services for both children and adults, with an average length of stay of 7-10 days. Prior authorization is required.

Mental Health Services PRTF

Psychiatric Residential Treatment Facilities (PRTF) provide residential services for children under 21, with an average length of stay of 6 months. Prior authorization is required.

- Revised Bill Types: 86X and 89X
- Applicable Revenue Codes for PRTF are as follows:
  - 1001- All Inclusive Rate – Room and Board
  - 0183-Leave of Absence-Therapeutic Leave

    (Limited to 18 days per SFY)
  - 0185-Leave of Absence-Hospital Leave

    (Limited to 15 Consecutive Days per each absence due to inpatient hospital stay.)

Mental Health Services PRTF

Positive Impact of PRTF Inclusion to Managed Care

- Case Management- Fee for Service Medicaid offers no individualized case management services or care managers.
- Care managers provide assistance with discharge planning, and appropriate transition of care, as well as, meeting expectations of discharge follow-up requirements.
- Discharge planning checklist- Case managers utilize a checklist, which helps enable a smooth transition.
- All individuals in an inpatient/PRTF setting should be enrolled in care management.

Mental Health Services
Community/Outpatient Services

- **Psychiatry Services by Physicians or Nurse Practitioners** are limited to sixteen (16) visits per fiscal year, which do not affect the sixteen (16) physician office visits for medical issues. Children under the age of 21 may receive more visits, if medically necessary, with prior authorization.

- **Therapeutic and Evaluative Mental Health Services** are a component of the Expanded Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program for beneficiaries under the age of 21. All services must be medically necessary and some services require prior authorization. Service standards do apply, yet may be exceeded with proper prior authorization.

Special Mental Health Initiatives

- **Autism Spectrum Disorder Services** are covered for Early, Periodic Screening, Diagnosis and Treatment (EPSDT)-eligible beneficiaries with an Autism Spectrum Disorder (ASD) diagnosis when medically necessary and prior authorized.

- **Mississippi Youth Programs Around the Clock (MYPAC)** is a home and community- based Medicaid program for children and youth with Serious Emotional Disturbance (SED), that follows the High Fidelity Wraparound process. Prior Authorization is required.

- **Substance Use Disorder (SUD) Services** includes inpatient detoxification and a range of outpatient treatments. Depending on the service, prior authorization may be required.

Special Mental Health Initiatives
Home and Community Based Services

- **Intellectual Disabilities/Developmental Disabilities (ID/DD) Waiver** provides services to individuals who, but for the provision of home and community-based services, would require placement in an Intermediate Care Facility for Individuals with Intellectual Disabilities.

- **Community Support Program (CSP)** provides 1915(i) state plan services to individuals with Intellectual Disabilities and/or Developmental Disabilities or Autism.
  - Services available are Day Services - Adult, Supported Employment, Prevocational Services, Supported Employment, and Supported Living.
  - Individuals may not be enrolled in a Home and Community Based Service Waiver program and must qualify for full benefit Medicaid.

Both the ID/DD Waiver and CSP Program are operated by the Mississippi Department of Mental Health, Bureau of Intellectual and Developmental Disabilities.

Same Day Services/NCCI

DOM allows for same day services provided the services are not restricted in the:

- DOM Administrative Code
- National Correct Coding Initiatives (NCCI)
  - The CMS NCCI promotes national correct coding methodologies and reduces improper coding which may result in inappropriate payments of Medicare Part B and Medicaid claims.
  - NCCI Edit files are updated quarterly.
  - Medicaid NCCI Edit files and reference documents can be found at ***https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html***
  - Appropriate modifiers may be required in order for same day services to be reimbursed.

How to get more information

For more information about Behavioral Health:

Office of Mental Health
Mississippi Division of Medicaid
Toll-free: 800-421-2408
Phone: 601-359-9454
Website: ***http://medicaid.ms.gov***

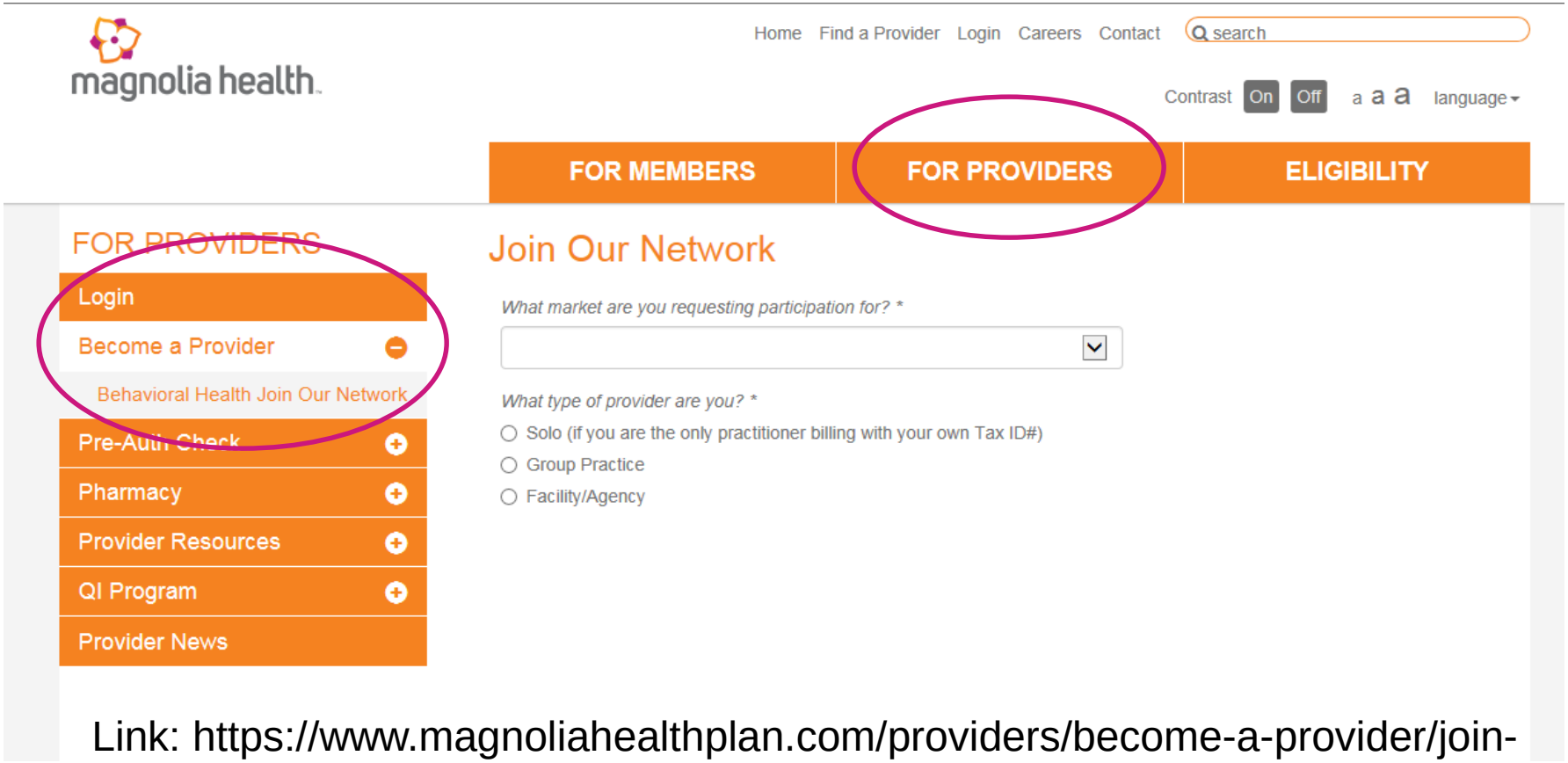
Administrative Code:
https://medicaid.ms.gov/providers/administrative-code/

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

Behavioral Health

Credentialing and Contracting

Join Our Network



Link: https://www.magnoliahealthplan.com/providers/become-a-provider/join-our-network.html

Common Credentialing Barriers

- ✓ Credentialing application sent when Practitioner did not have a MS Medicaid ID.
- ✓ Release of Information (ROI) expired (signature date expires in less than 90 days)
- ✓ No response to requests for additional information from practitioner during the credentialing and re-credentialing process.
- ✓ CAQH information not updated by practitioner or permission not given to Magnolia to view CAQH data.
- ✓ Missing Collaborative Agreements – Needed for Nurse Practitioners
- ✓ Malpractice Insurance Certificate is expired.
- ✓ Missing or Incomplete Ownership and Disclosure Form

Provider Updates

- In order to maintain a current profile, providers are required to notify Magnolia Health of any changes to their credentialing and demographic information when these changes occur.
- Demographic location information can be updated via the Magnolia Secure Web Portal for registered providers or by contacting Provider Services at 1-866-912-6285.
- If a practitioner at your facility will no longer be practicing under your contract please fax a termination letter on your company's letterhead to 1-866-480-3227.

Behavioral Health
Top Claim Denials

8/7/2019

Top Claim Denials

- EX18- Duplicate Claim
- EX35- Benefit Maximum has reached
- EXA1- Authorization Not on File
- EX29- The Time Limit for Filing has Expired
- EXys- Reimbursement included in another code per CMS/AMA/Medical Guidelines

Clinical Guidelines

Inpatient and Outpatient

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

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

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

Please see Behavioral health provider manual here:

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

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
  - Revised Bill Types: 086X and 089X

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

- Fax number is 1-866-535-6974

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.

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.

Clinical Appeals & Quality Review

Appeals / Retro Overview

Communication about Appeals are received by the coordinators:

- ❑ Via mail
- ❑ Via email
- ❑ Via telephone

Appeal Coordinators Process Standard *(Pre and Post Service)*

- ❑ *Pre-service* appeal
- ❑ *Post-service* appeal
- ❑ Expedited
- ❑ Claim Appeal
- ❑ Retroactive Authorization
- ❑ Peer to Peer request

What is Care Management?

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

Key Focus

Integrated Care Management

- Proactive outreach to members with multiple conditions
- Holistic Approach

Discharge Planning

magnolia health

Post Discharge Assessment

- A post discharge assessment is completed following the hospital stay for all members enrolled in care management and members who score 50 or higher on the readmission risk score.
- This assessment asks members about reason member went to the hospital, and whether they have a primary care provider. It asks details about their medications, and follow up care.
- Outreach is initiated within 72 hours of member discharge from the hospital.
- We have different types of mail out material, such as
  - Disease-specific education,
  - Neonatal Intensive Care Unit (NICU) kits for our NICU babies
  - Sickle Cell kits to help manage our Sickle Cell members,
  - A Scale program for our Congestive Heart Failure (CHF) members,
  - Inhalers/spacers for our Asthma members.

The Golden 4

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

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

With improved discharge planning, hospitals readmissions have decreased.

Outpatient Behavioral Health Prior Authorizations

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

Behavioral Health Contact Information

Provider Services: (866)-912-6285

Fax for submission of OTRs: (866) 694-3649

Appeals
Magnolia Health Plan
ATTN: Appeals Coordinator
12515-8 Research Blvd. Suite 400
Austin, TX 78759

Magnolia Website/Portal (BH):
https://www.magnoliahealthplan.com/providers/resources/behavioral-health.html

Contact Information

Important Numbers & Links

Provider Services:
(866)-912-6285

Fax for submission of OTRs:
(866) 694-3649

Provider Relations Fax Number:
855-669-0101

Magnolia Website:
www.magnoliahealthplan.com

Provider Relations

Jasmine Shaw
Provider Network Specialist
(Central and Southern MS)
Jasmine.L.Shaw@centene.com

Kiri Parson
Provider Network Specialist II
(North MS)
Kiri.L.Parson@centene.com

Behavioral Health

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

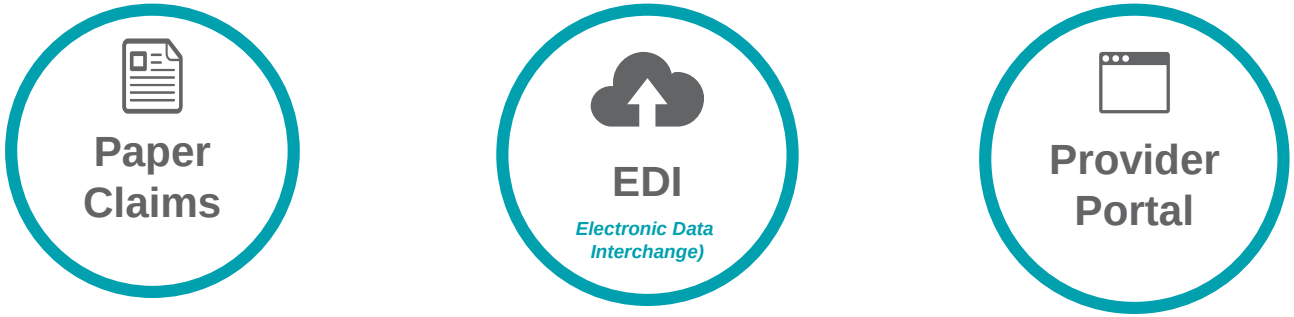
Claims Mailing Address:

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

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:



Claims Reimbursement

- **Reimburse based on the Division of Medicaid fee-schedule**
  - Community/Private Mental Health Centers (CMHC/PMHC)
  - Mississippi Youth Programs Around the Clock (MYPAC)
  - Psychiatry and Psychiatric Nurse Practitioners for Mental Health/Psychiatry Services
  - Psychiatric Residential Treatment Facilities (PRTF)

- **Division of Medicaid Fee Schedule**
  - https://medicaid.ms.gov/providers/fee-schedules-and-rates/#

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**

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**.

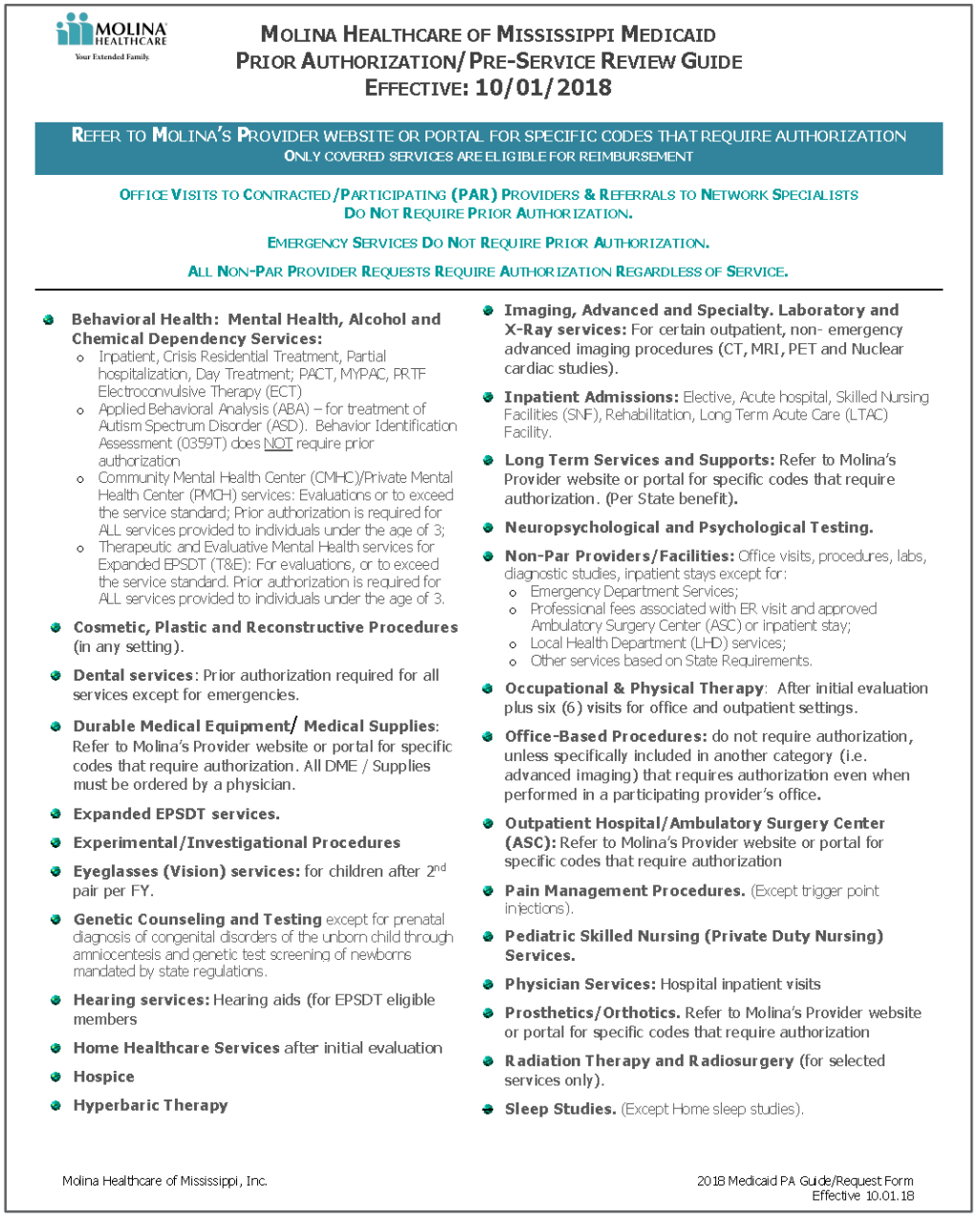
Behavioral Health Authorizations:
Phone: 1 (844) 826-4335
Inpatient Requests Fax: 1 (844) 207-1622
All Non-Inpatient Fax: 1 (844) 206-4006

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.

Care Management: Case Manager

- Case Managers (CM) are nurses and social workers who conduct health risk assessments either by phone or face-to-face to identify member needs and develop specific interventions to help meet those needs.

- Molina Case Managers use information from the assessment process to develop and implement individual care plans with the member based on member's own identification of primary health concern and an analysis of available data on the member's medical condition and history.

- All MississippiCAN Members are eligible for Case Management services; different levels of interventions are based on the individual needs and conditions of each individual:

  - **Health Management** - Health Management is focused on disease prevention and health promotion. It is provided for members whose lower acuity chronic conditions put them at risk for future health problems.
  - **Case Management** - Case Management is provided for members who are at high risk for re-hospitalization post ToC intervention with case management needs that warrant triage. These services are designed to improve the member's health status and reduce the burden of disease through education and assistance with the coordination of care including LTSS.
  - **Complex Case Management** - Complex Case Management is provided for members who have experienced a critical event or diagnosis requiring the extensive use of resources and need additional support navigating the health care system. The primary goal of Complex Case Management is to help members improve functional capacity and regain optimum health in an efficient and cost-effective manner.
  - **Intensive Needs Case Management** - Level 4 focuses on members having an end-stage diagnosis that would otherwise meet criteria for palliative care or hospice services. This level includes members at high risk for re-hospitalization post ToC intervention with continued need for stabilization, comfort care or other high intensity, highly specialized services.

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.

How to correct the top issues

Error	Resolution
Requests for psychological testing that lack clinical information to meet medical necessity	**Provider must submit the following information with request:** • Diagnosis (suspected or demonstrated) including rule-out diagnoses • Lack of presenting symptoms and/or functional impairment noted on request • Request that do not include the test(s) to be administered during psychological testing • Request that do not indicate the question(s) psychological testing will answer and impact on treatment plan
Prior authorization denial because member requires a higher level of behavioral health care	Provider must validate that a licensed psychiatric MD oversight and/or and advanced practice provider with a collaborating psychiatric MD for higher level of care for CSU. Verify through collaborating agreement through credentialing or during peer-to-peer review.
CPT 99201 (new patient office or other outpatient services) CPT 99201 (established patient service) CPT 96372 (Therapeutic prophylactic, or diagnostic injection) HCPCS T1002 (15 minutes of RN services)	CPT 99201 (new patient office or other outpatient services) CPT 99201 (established patient service) Possibly paid by another payer? CPT 96372 – May be reported with any hydration therapy, IV drug administration, or chemotherapy administration T1002 – These activities include pre-op and post-op visits, administration of fluids, monitoring

Behavioral Health Provider Representative

LaKeida Ward Sr. Rep,
Provider Services (Behavioral Health)

LaKeida.Ward@molinahealthcare.com

MSBHProviderServices@MolinaHealthCare.Com

(601) 317-4313

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 & STATE

Behavioral Health

UnitedHealthcare

UnitedHealthcare
COMMUNITY & STATE

Credentialing

UnitedHealthcare

Provider and Member Resources

UnitedHealthcare COMMUNITY & STATE

UnitedHealthcare Community Plan

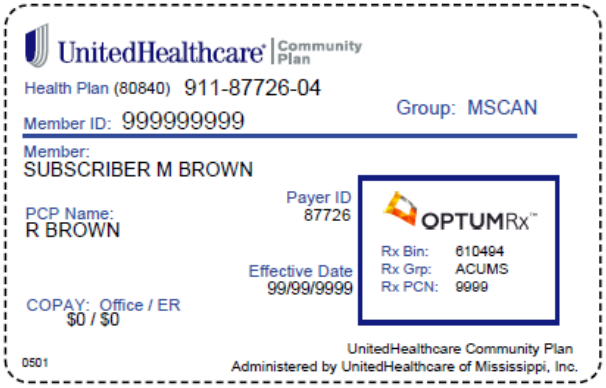
is aware of the important role of the member's support team. Family, guardians or representatives can be a big help in getting the right services, and can use this information to assist in supporting the member
in coordination with Optum Specialty Networks coordinates and manages the physical, mental health/substance use and pharmacy benefits for members

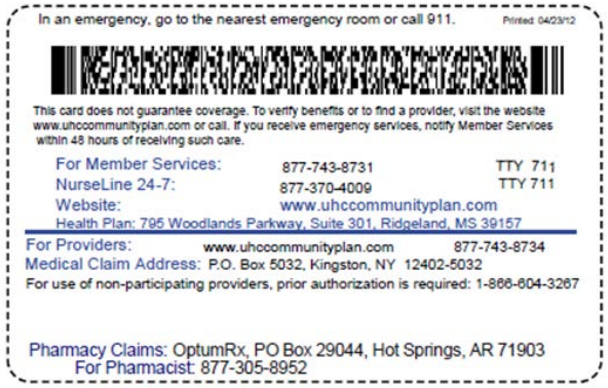
Member Services and Care Coordination health plan phone numbers:

Members – **1-877-743-8731**, Providers – **1-877-743-8734**

Member ID Cards

Sent directly to the member
Member's ID number will be their Medicaid number
All relevant contact information will be on the back of the card for both medical and behavioral customer service





Provider Relations

Please contact us with any questions so that together we can make the health care system work better for everyone.

Rusty Palmer, LPC-S
Network Manager (MS)-North
Optum/United Behavioral Health
james.palmer@optum.com
Phone: 1-651-495-5298
Fax: 1-855-291-7422

Dawn Teeter
Network Manager (MS)-South
Optum/United Behavioral Health
dawn.teeter@optum.com
Phone: 1-952-687-4121
Fax: 1-844-328-5129

Join Our Network –
Start Credentialing Application

UnitedHealthcare COMMUNITY & STATE

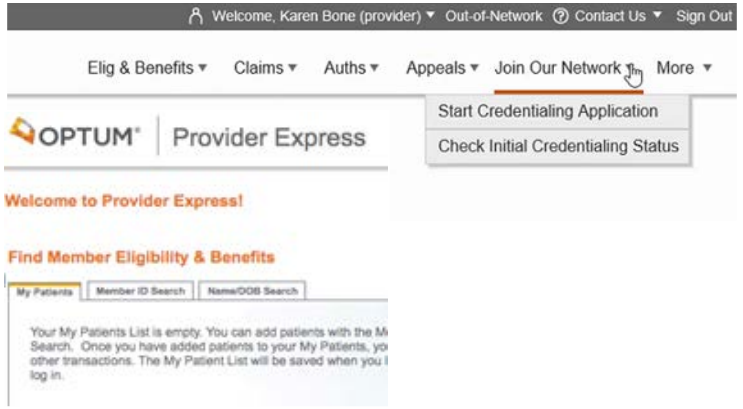
Apply for provider Medicaid ID with MS Division of Medicaid:
ms-medicaid.com/msenvision/downloadenrollPackage.do

Not currently required for CHIP participation

Two options will display when the user clicks 'Join our Network':

'Start Credentialing Application' will transfer the user to the NPRF

'Check Initial Credentialing Status' will transfer the user to the status bar



Integration with CAQH

The user clicks the 'Start Credentialing Application' link, Provider Force connects to OHBS Facets and found a CAQH ID loaded on the OON record for this provider. Using the CAQH ID, Provider Force retrieves the provider's data from the CAQH application

Pre-populated NPRF

If the CAQH application is complete, active on Optum roster, and the provider has given Optum authorization to access the application data, we will pre-populate as many of the NPRF fields as possible. Note the updated messaging at the top of the form; any changes to data that came from CAQH must be updated on the CAQH website

UnitedHealthcare
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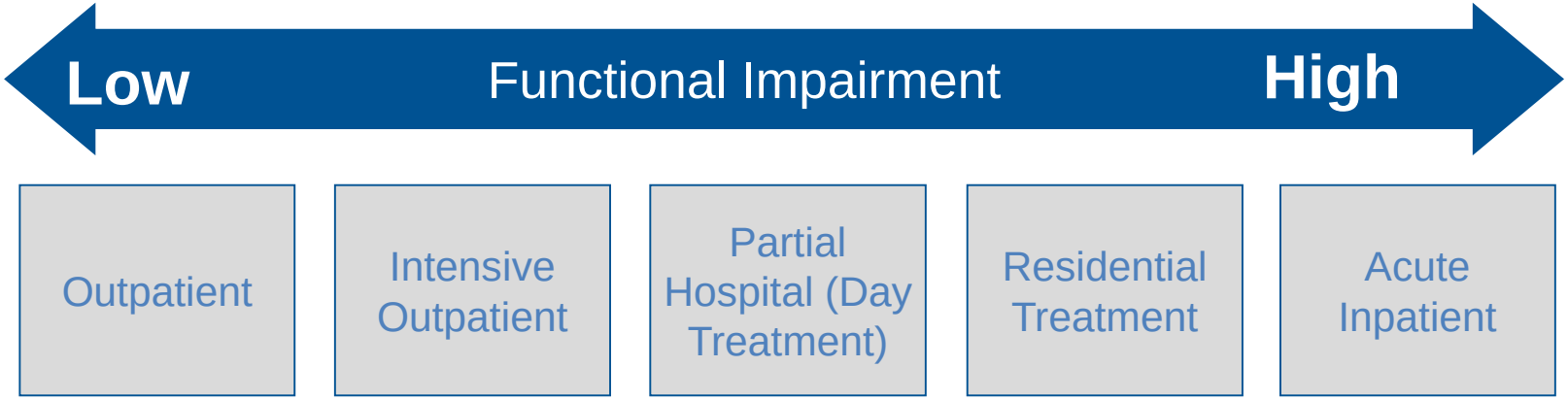
Behavioral Health and SUD

UnitedHealthcare

Behavioral Health Care

UnitedHealthcare COMMUNITY & STATE

The right care. At the right time.



Care Advocacy Teams

Assessment and Triage (A&T)

- Incoming provider calls
- Incoming member calls (including crisis)
- Non-routine outpatient requests
- Initial facility requests

Facility-Based Care (FBC)

- Concurrent reviews
- Intensive care management
- Discharge planning
- Care Coordination referrals when needed

Behavioral Health and SUD Benefits

UnitedHealthcare COMMUNITY & STATE

Service Description/Level of Care	Prior auth required?
Acute Inpatient	Yes
Intensive Outpatient/Partial Hospitalization	Yes
Routine Outpatient Services	No
Non-Routine Outpatient Services (Psychosocial Rehab H2030, Community Psychiatric Supportive Treatment H0036, BH Day Treatment H2012)	No
Residential Treatment – Psychiatric Residential Treatment Facility, Crisis Residential T2038)	Yes

Assessment/Treatment Plan Requirements

UnitedHealthcare COMMUNITY & STATE

Prior authorization IS required for specific services (MYPAC)

Treatment Plan Authorization Requests can be submitted by calling **1-877-743-8734**

Services must Meet Medical Necessity – this applies to initial and concurrent reviews

Prior Auth is required for:

- PRTF/MYPAC
- Inpatient BH

List of services requiring prior authorization:

UHCProvider.com > Health Plans by State > Mississippi > Prior Authorization

Request prior authorization online, or by phone or fax:

Online: Use the Prior Authorization and Notification app on Link

Phone: **1-866-604-3267** (Mon-Fri, 8 a.m. – 5 p.m.; or 24/7 for emergencies)

Fax: **1-888-310-6858**; fax form is available at UHCProvider.com > Health Plans by State > Mississippi > Prior Authorization > PA Paper Fax Forms

Prior authorization is not required for emergency or urgent care

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

For more information, please see the Treatment Plan Guidelines at:
providerexpress.com/content/ope-provexpr/us/en/our-network/welcomeNtwk/wMS.html

Discharge Planning

UnitedHealthcare COMMUNITY & STATE

Must include the following components in every plan

- Anticipated date of discharge
- Objective, measurable goals that would need to be met for the member to be discharged
- Identify next level of care for the member, (e.g., school-based services only, outpatient therapy)---Include contact info if appropriate
- Member and/or parent/guardian agreement with plan
- How to resume services if needed
- Resources in the community for the parent/guardian and member
- How discharge is coordinated with the school and other providers

Algorithms for Effective Reporting and Treatment (ALERT)

UnitedHealthcare COMMUNITY & STATE

As an alternative to requiring precertification for routine and community-based outpatient services, the Algorithms for Effective Reporting will review cases retrospectively to ensure members are receiving care which meets coverage standards

Member Identification

- Claims data
- Service combinations
- Frequency and/or duration that is higher than the norm: 90th Percentile

Clinical Review

- Licensed Care Advocate and Peer Reviewers
- Review diagnosis, member's unique needs, treatment plan and progress
- Ensure care meets coverage guidelines:
- Provider Express

Outcomes

- Approved Care
- Treatment Plan Modification:
  - Reduction in Services
  - Inclusion of different service
  - Intervention approach recommendations

Practice Management Program

UnitedHealthcare COMMUNITY & STATE

Additionally, we will provide oversight of service provision through our practice management program.

Program Components

- Regular and comprehensive analysis of claims data by provider/provider group:
  - Service/diagnostic/age distribution
  - Proper application of eligibility criteria
  - Appropriate frequency of service/duration of service
- Outreach to provider group when appropriate to discuss any potential questions arising from the claims analysis
- Potential outcomes from discussion:
  - No additional action necessary
  - Program audit including record review
  - Performance Improvement Plan (PIP)
  - Targeted precertification as part of PIP

Resource Information

For more information,

https://www.uhcprovider.com/en/resource-library/behavioral-health-resources.html

Optum l United Behavioral Health
www.optum.com

24/7 at www.providerexpress.com

•Online Transactions for Claims, Authorizations, Eligibility, Practice Information and More….

- Commercial Health Plan: 800-557-5745
- Medicare or Medicaid accounts: 866-673-6315

Want more referrals? Become an Express Access Provider today!

Express Access FAQ

Express Access FAQ Video

Top Denials

UnitedHealthcare Community Plan

1. **Duplicate billing of services that have already been submitted and paid**: We have a team of claims analysts who conduct trend analysis and identify providers that are submitting large volumes of duplicate claims. This team will outreach to provider relations and identify the duplicate billing activity. Our Provider Relations team will outreach to the provider and discuss rationale for duplicate billing, educate, and offer any claims type training as needed.

2. **Lack of clinical documentation to support the services rendered**: Our practice management team frequently reviews provider claims and will outreach to specific identified providers requesting medical records for review to support the claims submitted. Practice Management will identify lack of documentation for the services that justify the level of care and educate the provider.

3. **Lack of Medical Necessity to support continued services at a specific level of care**: Our ALERT team, based on ALERT algorithms, identifies utilization patterns that are not consistent with best practices. Optum is more effectively communicating the outcome of these reviews with secure fax as well as email communication requesting clinical information needed. In addition, provider training has been undertaken to educate providers around the ALERT process and how important it is to communicate to Optum when a member's clinical presentation has changed to warrant a higher level of care or continued services.

Claims Submission

UnitedHealthcare COMMUNITY & STATE

Required Claim Forms

Form 1500 (CMS-1500 form)
UB-04 form (Inpatient/PRTF)

Claims/Customer Service # :

Phone: **1-866-556-8166**
Fax: **1-855-312-1470**

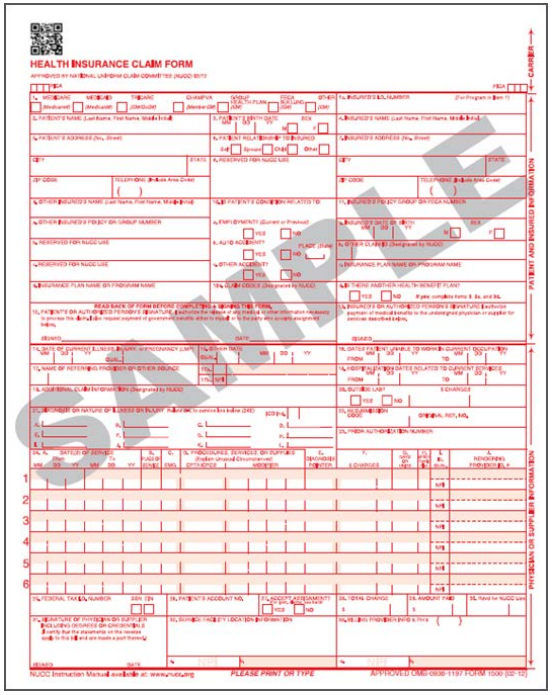
Electronic Claims Payer ID:

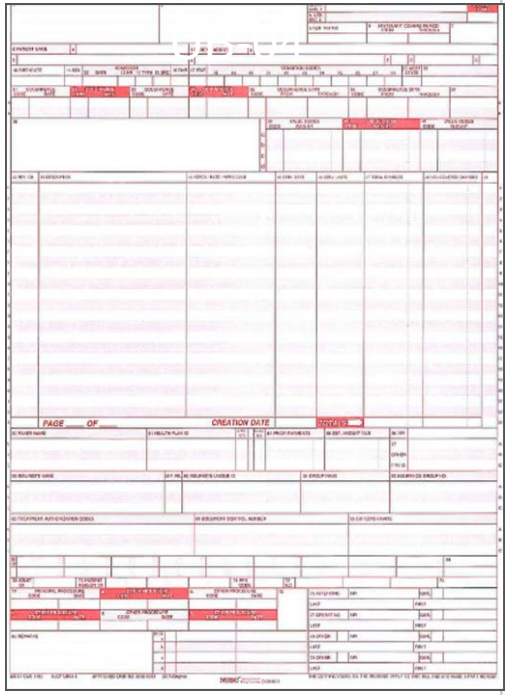
87726

Paper Claims:

When submitting behavioral Claims by paper, please mail claims to:

United Healthcare
P.O. Box 5032
Kingston, NY 12402-5032





Timely Submission:

UnitedHealthcare Community Plan requires that you initially submit your claim within 180 days of the date of service

Submission Requirement:

Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at cms.gov

Claims Submission Option 1-
Online

Log on to uhcprovider.com:

Secure HIPAA-compliant transaction features streamline the claim submission process

- Performs well on all connection speeds

- Submitting claims closely mirrors the process of manually completing a Form-1500 claim form

Allows claims to be paid quickly and accurately

You must have a registered user ID and password to gain access to the online claim submission function:

To obtain a user ID, call toll-free **1-866-842-3278**

Claims Submission Option 2 -
EDI/Electronically

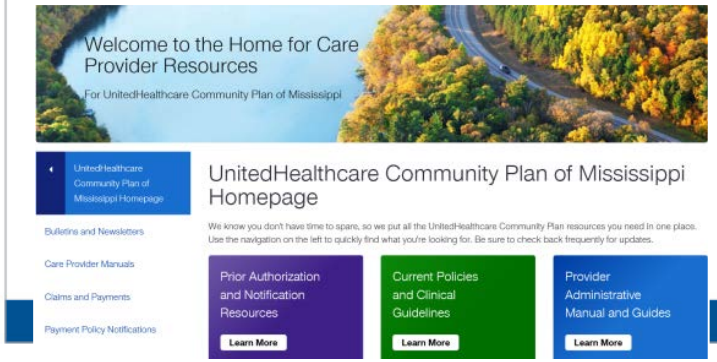
UnitedHealthcare® COMMUNITY & STATE

Electronic Data Interchange (EDI) is an exchange of information

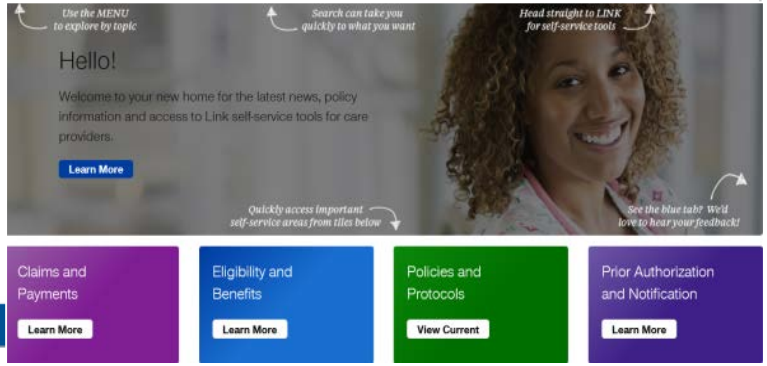
Performing claim submission electronically offers distinct benefits:

- **Fast** - eliminates mail and paper processing delays
- **Convenient** - easy set-up and intuitive process, even for those new to computers
- **Secure** - data security is higher than with paper-based claims
- **Efficient** - electronic processing helps catch and reduce pre- submission errors, so more claims auto-adjudicate
- **Notification** - you get feedback that your claim was received by the payer; provides claim error reports for claims that fail submission
- **Cost-efficient** - you eliminate mailing costs, the solutions are free or low-cost
- You may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims is 87726

Additional information regarding EDI is available on:
uhcprovider.com/en/health-plans-by-state/mississippi-health-plans/ms-comm-plan-home.html



and
uhcprovider.com



Submitting Corrected Claims

UnitedHealthcare COMMUNITY & STATE

Corrected claims can be submitted up to 90 calendar days from the denial.

1. **To resolve a claim issue where the claim was submitted with incorrect/inaccurate information, the following options are available:**

   In-network clinicians and groups can log in and file a Corrected or Void claim via the ***Claim Entry*** transaction, by choosing "Corrected" or "Void" as the Claim Frequency Code option, and entering the claim number of the original claim (claims must be in a finalized status in order to correct or void them). For additional information, view the Guided Tour documentation, page 24.

   Fill out a Form 1500 claim and write “CORRECTED CLAIM” (or "VOID CLAIM") across the top of the form, and complete the form with the corrected information. Include a copy of the original statement, and mail to the address listed on that statement.

2. **To resolve a claim issue where the claim was processed incorrectly, the following options are available:**

   In-network clinicians and groups can log in, look up the claim via the ***Claim Inquiry*** transaction, and file a **Claim Adjustment Request**. For additional information, view the Guided Tour video of the Claim Inquiry and Claim Adjustment Request transactions.

   Access the Claim Inquiry/Adjustment Request Form and mail it to the address listed on the EOB/PRA form.

   Contact a claims representative via Provider Express's Live Chat (for registered users) by logging in and going to Claim Inquiry (or My Submitted Claims, if the claim was submitted online):

   - Locate the claim and towards the upper right on either "detail" page (above the member's ID #), click the link "Have questions about claim status?" to access Claims Live Chat.
   - If you cannot locate the claim, then click the "Can't find claim status online?" link on the main Claim Inquiry page

Electronic Payment & Statements (EPS)

UnitedHealthcare COMMUNITY & STATE

With EPS, **you receive electronic funds transfer (EFT) for claim payments,** plus your EOBs are delivered online:

- Lessens administrative costs and simplifies bookkeeping
- Reduces reimbursement turnaround time
- Funds are available as soon as they are posted to your account

To receive **direct deposit and electronic statements through EPS** you need to enroll at myservices.optumhealthpaymentservices.com**.** Here is what you will need:

- Bank account information for direct deposit
- Either a voided check or a bank letter to verify bank account information
- A copy of your practice's W-9 form

If you're already signed up for EPS with UnitedHealthcare Commercial or UnitedHealthcare Medicare Solutions, you will automatically receive direct deposit and electronic statements through EPS for UnitedHealthcare Community Plan when the program is deployed.

Note: For more information, please call **1-866-842-3278**, option 5, or go to *UnitedHealthcareOnline.com* > Quick Links > Electronic Payments and Statements

Complaints and Grievances

UnitedHealthcare and Optum strive for excellence in building a better experience for our providers and members. If you are experiencing issues we want to know.

- Complaints must be submitted within thirty (30) calendar days of the date of the dissatisfaction. We resolve complaints within one (1) calendar day. You can submit your complaint by calling our Provider Services line at **877-743-8734**.
- Grievances must be submitted within thirty (30) calendar days of the date of the dissatisfaction. We resolve grievances within thirty (30) calendar days. You can submit your grievance by phone, fax, or mail to:

Phone: **877-743-8734**
Fax: **877-384-1179**
Mail: **Optum**
Attention MSCAN/CHIP Grievance Team
P.O. Box 30768
Salt Lake City, UT 84130-0768

Appeals and Expedited Appeals

- All appeals must be received within thirty (30) calendar days of the date of the notice of Adverse Benefit Determination.
- Appeals are resolved within thirty (30) calendar days of receipt. We may extend that resolution timeframe by fourteen (14) calendar days if you request an extension or if we determine that there is need for additional information and the delay is in your best interest.
- Expedited appeal determinations are made as expeditiously as the member's health requires but no later than seventy-two (72) hours of receipt.
- Appeals can be submitted by fax and mail to:

Fax: **801-994-1082** (standard)
801-994-1349 (urgent)

Mail: **Appeals and Grievances**
P.O. Box 5032
Kingston, NY 12402-5032

State Administrative Hearings

- After you have exhausted your appeal rights with UnitedHealthcare, then State Administrative Hearings are available to MSCAN providers
- Hearing requests must be submitted within thirty (30) calendar days of the date of your appeal determination.
- Your request should be sent to the Division of Medicaid at:

Mail: **MS Division of Medicaid**
Office of Appeals
550 High Street. Suite 1000
Jackson, MS 39201

Behavioral Health Case Management

UnitedHealthcare COMMUNITY & STATE

Optum is the services arm of UnitedHealth Group, serving UnitedHealthcare members by:

- Identifying high-cost, complex, at-risk individuals with BH diagnosis and enrolling in Case Management program
- Comprehensive assessment to identify gaps in care and barriers to health
- Engaging by telephone and field visit as needed
- Creating important linkages between member and providers
- Experts about local community resources
- Providing education about complex medical or healthcare information in easy-to-understand language

Optum is seeking to improve patient health, access to care and safe transitions by partnering with In-Network UnitedHealthcare providers and facilities, and lending the support of our clinicians wherever we can be of service:

- Licensed, professional medical and/or behavioral clinicians (RNs, LPC's, LCSW, etc.)
- Help with post-discharge appointments, often able to link member to providers, transportation, and Peer Support Services where Peers can accompany to appointments
- Are available to assist in discharge planning with internal access to local UHC providers
- May attend and contribute at facility rounds meetings as needed

Post Discharge Support

- Field-Based Clinicians (BHA or RN) and Community Health Workers
- Comprehensive review of post-discharge instructions
- Member may receive a post-discharge visit at home if needed
- Linked with resources to help with providers, medication reconciliation, community resources, housing services
- Member may remain in Case Management until stable in the community, with varying levels of care utilized as needed
- Focus on 7-day, 30-day and 90-day follow-up appointments
- Prevent unnecessary “rapid readmission” that may result from lack of care or education

Question & Answer Session