Office of the Governor | Mississippi Division of Medicaid

Managed Care | MississippiCAN & CHIP

Provider Desk Reference

2020

MISSISSIPPI DIVISION OF
MEDICAID

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<td>Contact Information</td>
<td>Mississippi Division of Medicaid
550 High Street
Jackson, MS 39206
Toll-free: 800-421-2408
Website: www.medicaid.ms.gov

MississippiCAN Contacts
Conduent: For MississippiCAN enrollment
Toll-free: 800-884-3222
Website: www.ms-medicaid.com</td>
<td>Magnolia Health
111 E. Capitol St. STE 500
Jackson, MS 39201
Toll-free: 866-912-6285; Relay 711
Website: www.magnoliahealthplan.com

Secure Portal Email:
www.support.magnoliahealthplan.com</td>
<td>UnitedHealthcare Community Plan
Physical Address: 795 Woodlands Parkway, Suite 301, Ridgeland, MS 39157
Online: www.uhccommunityplan.com
Provider Services: 877-743-8734
UHC is moving away from fax communication.

Please refer to the sections below for contact information for specific services</td>
<td>Molina Healthcare of MS
188 E. Capitol Street, Suite 700
Jackson, MS 39201
Phone Number: 1-844-826-4335
Website:
https://www.molinahealthcare.com/providers/ms/medicaid/home.aspx

<table>
<tr><td>Main Fax</td><td>(844) 303-5188</td></tr>
<tr><td>Prior Auth – Inpatient Fax</td><td>(844) 207-1622</td></tr>
<tr><td>Prior Auth – All Non-Inpatient Fax</td><td>(844) 207- 1620</td></tr>
<tr><td>Behavioral Health – Inpatient Fax</td><td>(844) 20-1622</td></tr>
<tr><td>Behavioral Health – All Non-Inpatient Fax</td><td>(844) 206-4006</td></tr>
<tr><td>Pharmacy Authorizations Fax</td><td>(844) 312-6371</td></tr>
<tr><td>Radiology Authorizations Fax</td><td>(877) 731-7218</td></tr>
<tr><td>Transplant Authorizations Fax</td><td>(877) 813-1206</td></tr>
<tr><td>NICU Authorizations Fax</td><td>(844) 207-1622</td></tr>
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	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Provider Issues and General Inquiry	The General Inquiry Form may be faxed or mailed to DOM. **General Inquiry Form** https://medicaid.ms.gov/wp-content/uploads/2017/04/General-Inquiry-Form.pdf Managed Care **HELP US, HELP YOU** Please forward all issues and complaints to: MississippiCAN.Providers@medicaid.ms.gov *Please forward claims and examples of your provider issue.*	**Contact Us** Providers may submit general inquiries utilizing the Contact Us form on www.magnoliahealthplan.com/contact-us Provider Issue Inquiries can be submitted via the Secure Portal at **www.support.magnoliahealthplan.com** Or by contacting Provider Services at 866-912-6285; Relay 711 **Please see below regarding Claim issues:** **First Time –** 180 days from the date of service **Corrected Claims -** 90 days from the date of notification of payment or denial **Claim Reconsiderations -** 90 days from the date of notification of payment or denial **Claim Appeals** – 30 days from the date of receiving Magnolia's notice of Adverse Benefit Determination *As a reminder, **electronic** first time, corrected, and reconsideration claims can be submitted via our secure web portal at www.provider.magnoliahealthplan.com for your convenience *If choosing to submit **Paper** first time, corrected, and reconsiderations, they must be mailed to **P.O.Box 3090 Farmington, MO 63640** *Appeals cannot be filed via Magnolia Health's secure portal and must be mailed to **P.O. Box 3090 Farmington, MO 63640** along with supporting documentation	**Medical, Behavioral Health and Therapy Services** **For claims issues, please utilize LINK:** **Link portal at:** www.UHCprovider.com/Link *If LINK cannot fix your problem:* **Claims Issues:** southeastprteam@uhc.com **Network Issues:** networkhelp@uhc.com **UHC Policies:** www.uhcprovider.com/policies-protocols **Provider Services:** 877-743-8734 **Dental** **Provider Services:** 1-800-508-4862 **Online:** www.uhcproviders.com **Vision** **Provider Services:** 844-606-2724 **Online:** www.marchvisioncare.com	Providers may contact the Provider Services Call Center at: Phone Number: 1-844-826-4335 https://www.molinahealthcare.com/providers/ms/medicaid/contacts/contact_info.aspx Providers may also send inquiries to the Provider Services department mailbox (Provider Relations Department). MHMSProviderServices@Molinahealthcare.com

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	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Provider Representatives and Advocates*	**Conduent Provider Representatives** **Area 1 – North Central** Latasha Ford 601.572.3298 | Latasha.Ford@conduent.com **Area 2 – Northeast** Prentiss Butler 601.572.3298 | Prentiss.Butler@conduent.com **Area 3 – Delta** Claudia "Nicky" Odomes Claudia.Odomes@conduent.com | 601.572.3276 **Area 4 – Central** Justin Griffin Justin.Griffin@conduent.com | 601.206.2922 Randy Ponder Randy.Ponder@conduent.com | 601.206.3026 **Area 5 – Northeast** TBA – Interim Justin Griffin Justin.Griffin@conduent.com | 601.206.2922 Randy Ponder Randy.Ponder@conduent.com | 601.206.3026 **Area 6 – Southwest** Erica G. Cooper Erica.Cooper@conduent.com | 601.206.3019 **Area 7 – South** Porcha Fuller Porscha.Fuller@conduent.com | 601.206.2961 **Area 8 – Coastal** Connie Mooney Connie.Mooney@conduent.com | 601.572.3253	Provider Services is the first point of contact for any provider related issues such as claim denials, auth issues, etc.. Provider Services will provide a reference number for your call. After you have contacted Provider Services, been provided a reference number, and have allowed the appropriate timeframe for resolution, your next point of contact may be your Provider Network Specialist: Jasmine Shaw - 866-912-6285 Provider Services Customer Service Magnoliazone1@centene.com Desoto, Tunica, Tate, Marshall, Lafayette, Yalobusha, Leflore, Carroll, Montgomery, Webster, Choctaw, Oktibbeha, Attala, Winston Brittany Cole - 866-912-6285 Provider Services Customer Service Magnoliazone2@centene.com Benton, Tippah, Alcorn, Prentiss, Tishomingo, Union, Lee, Itawamba, Pontotoc, Calhoun, Chickasaw, Monroe, Clay | ***Out of State Providers*** Matthew Harris - 866-912-6285 Provider Services Customer Service Magnoliazone3@centene.com Sharkey, Humphreys, Issaquena, Holmes, Warren, Yazoo, Madison, Washington, Bolivar, Bolivar, Sunflower, Tallahatchie, Grenada, Coahoma, Quitman, Panola Jonathan Dixon - 866-912-6285 Provider Services Customer Service Magnoliazone4@centene.com Hinds, Claiborne Precious Griffith - 866-912-6285 Provider Services Customer Service Magnoliazone5@centene.com Rankin, Leake, Neshoba, Lauderdale, Kemper, Noxubee, Lowndes	**Medical Provider Advocates supporting professional and facility** Abe Barnes – Manager/DME Provider Representative/SW MS, East MS (interim) abraham_d_barnes@uhc.com / 763-283-2274 Jamille Bernard – Northern MS Jamille_Bernard@uhc.com / 763-361-0734 Tonya Daves – West Central MS Tonya_Daves@uhc.com / 952-202-4447 Tina Price – Southeast and Gulf Coast MS Tina_Price@uhc.com / 952-406-6057 Tanya Stephens – FQHC & RHC Provider Representative Tanya_M_Stevens@uhc.com / 763-361-0926 Stephanie Bullock – Statewide support for education and data attestation stephanie_bullock@uhc.com / 763-361-0974 Linda Fetch – Revenue Cycle Education Advocate for MS Facilities linda_fetsch@uhc.com / 314-839-7526 Matt Hilgers – Revenue Cycle Education Advocate for MS Physicians matt.hilgers@optum.com / 763-321-2223 **Behavioral Health Advocates** Dawn Teeter – Central to Southern MS Dawn.Teeter@optum.com / 952-687-4121 Rusty Palmer - Central to Northern MS James.Palmer@optum.com / 651-495-5298 **Dental Advocate** Teresa Morris Teresa_Morris@uhc.com / 952-202-2076 **Vision Advocate**	Provider Services Representatives Information is located on our website at the link below: https://www.molinahealthcare.com/providers/ms/medicaid/comm/Provider-Representatives-Map.aspx **Ricky Bailey -** 901-515-6703 Ricky.Bailey@molinahealthcare.com Desoto, Tunica, Tate, Panola, Marshall, Benton, Lafayette, Yalobusha, Calhoun, Chickasaw, Tippah, Union, Pontotoc, Lee, Alcorn, Tishomingo, Prentiss, Itawamba, Monroe | ***Includes Memphis*** **Jade McGowan -** 601-760-8779 Jade.McGowan@molinahealthcare.com Coahoma, Quitman, Tallahatchie, Grenada, Webster, Montgomery, Leflore, Carroll, Sunflower, Washington, Bolivar | ***Includes AR*** **Tuwanda Williams -** 601-760-8758 Tuwanda.Williams@molinahealthcare.com Sharkey, Humphreys, Issaquena, Holmes, Warren, Yazoo, Claiborne, Jefferson, Copiah, Lincoln, Adams, Franklin, Amite, Wilkinson, Simpson, Jefferson Davis, Lawrence, Pike, Walthall | ***Includes LA*** **Thomasina Robinson -** 601-317-8238 Thomasina.Robinson@molinahealthcare.com Hinds, Madison, Rankin, Smith, Covington, Choctaw, Attala, Winston, Noxubee, Kemper, Lauderdale, Leake, Neshoba, Scott, Newton, Jasper, Clarke, Wayne, Jones, Oktibbeha, Lowndes, Clay | ***Includes AL*** **Earl Robinson – *Manager, Provider Services (FQHCs only)* -** 601-760-2433 Earl.Robinson@molinahealthcare.com All Counties **LaKeida Ward *(Behavioral and Mental Health Providers Only)* -** 601-317-4313 LaKeida.Ward@molinahealthcare.com All Counties

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		Katharine St. Paul - 866-912-6285 Provider Services Customer Service Magnoliazone6@centene.com Jefferson, Adams, Wilkinson, Amite, Franklin, Copiah, Lincoln, Pike, Walthall, Lawrence, Simpson, Jefferson Davis Tracy Miller - 866-912-6285 Provider Services Customer Service Magnoliazone7@centene.com Scott, Newton, Smith, Jasper, Clarke, Covington, Jones, Wayne, Forrest, Perry, Greene Heather Samuel - 866-912-6285 Provider Services Customer Service Magnoliazone8@centene.com Marion, Lamar, Pearl River, Stone, Harrison, Hancock, George, Jackson Kiri Parson - 866-912-6285 Provider Services Customer Service MagnoliaFQ_CMHC@centene.com FQHC – State, CMHC – State, PMHC – State, RHC – Independent Only Diandra Lee, *Sr. Manager; Provider Relations* Raeshunn Williams, *Supervisor; Provider Relations* Provider Services Customer Service | 866-912-6285	Tyania Klingelhofer Tyania_m_klingelhofer@uhc.com / 443-896-0586	**Kwiinta Anderson -** 601-658-7408 Kwiinta.Anderson@MolinaHealthcare.com Marion, Lamar, Pearl River, Hancock, Forrest, Perry, Greene, George, Jackson, Stone, Harrison | ***Includes AL & LA*** **Chinwe Nichols - *Director, Provider Services*** - 601-863-3762 Chinwe.Nichols@molinahealthcare.com **Department Mailboxes** MHMSProviderServices@molinahealthcare.com *(Provider Services Mailbox)* MSBHProviderServices@molinahealthcare.com *(Behavioral Health Providers)*

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Provider Enrollment/Credentialing*	**Medicaid Providers is conducted by Conduent, and providers must submit applications for enrollment.** All providers must: • Complete provider agreements and/or provider enrollment application packages. • Be licensed and/or certified by the appropriate federal and/or state authority. • Agree to furnish required documentation of the provider's business transactions per 42 CFR §455.105(b) within thirty-five (35) days of the date on the request. Agree to abide by the requirements of 42 CFR, PARTS 405, 424, 438, 447, 455, 457, 498, and 1007 of the Affordable Care Act (ACA) concerning the following: a) Provider Screening Procedures (42 CFR § 424.518) b) Provider Termination (42 CFR §455.416) c) Payment Suspensions (42 CFR §455.23) **MS Medicaid Administrative Code** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-200.pdf **Medicaid Provider Enrollment Package** https://www.msmedicaid.com/msenvision/downloadenrollPackage.do	**Contracting** In order to join Magnolia Health's network, please click on the link below to complete the contract request form: Medical - Join Our Network BH - Behavioral Health - Join our Network All applicants will be notified in writing by the Contracting Department within approximately 45 business days of receipt of your request. Once the contract request form has been reviewed, providers will be provided a credentialing application to complete and submit back to the Health Plan. **Providers must be enrolled as a Medicaid Provider and have an active Mississippi Medicaid ID #.** Providers must also be properly credentialed by Magnolia or other delegated authority. Visit https://www.magnoliahealthplan.com/providers/become-a-provider.html to view the list of documents needed to ensure your credentialing application is complete before mailing to: **Magnolia Health** **ATTN: Contracting Department** **111 E. Capitol St. STE 500** **Jackson, MS 39201** **Linking Practitioners to Existing Contracts** To link a new practitioner to your existing contract, please email the following documents to magnoliacredentailing@centene.com found on the magnolia website under the "Become a Provider" tab: • **Provider Data Form** • **Current licensure** • **Collaborative practice agreement (Nurse Practitioners and Physician Assistants)**	**Medical, Behavioral Health and Therapy Services** **Contact us!** First contact our Network team at networkhelp@uhc.com and have your TIN/SSN ready. Option: "Request for Participation" **Request to Join the Network:** www.uhcprovider.com/Join-Our-Network **Credentialing** Profile must be created/maintained by the provider at: **Online:** www.caqh.org >CAQH ProView **Toll Free:** 888-599-1771 Provider must meet all **criteria for MS Medicaid** and have a valid Medicaid ID (see Medicaid FFS requirements) (not required for CHIP) Federally required **"Disclosure of Ownership"** form found at: www.uhcprovider.com/forms Contracting and credentialing will occur simultaneously. Clean disclosures are required. **Sign and return contract** quickly because UHC does not routinely retro-actively assign an effective date. UHC will return executed contract "Credentialed" is NOT the same as "contracted." Credentialing must be completed before the contract is fully executed. Check Contract status by emailing: networkhelp@uhc.com **Dental** **Phone:** 1-800-508-4862 **Online:** www.uhcproviders.com **Vision** **Online:** www.marchvisioncare.com **Phone:** 844- 606-2724	Providers interested in joining Molina's MississippiCAN network must have an active Mississippi Medicaid ID number issued from the Mississippi Division of Medicaid. To join our network, please complete the Contract Request Form found on our website at https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx and follow the instructions given. A representative from our Provider Contracting Department will then reach out to you. Depending on the information submitted in the Contract Request Form, you may be directed to one of Molina's vendors to complete the credentialing and enrollment process. Otherwise, a Molina Provider Contracting representative will work with you directly. Documents that may be required for credentialing and enrollment include: • Provider Agreement • Provider Information Form • W-9 • Ownership and Control Disclosure Form • Practitioner Application Credentialing Form (if Provider does not have an updated and attested CAQH profile) • Health Delivery Organization Application • Provider Roster Once credentialing is complete, a letter will be generated to let you know the date of completion. Molina will countersign your Provider Agreement and provide you with a copy. Any related questions can be directed to Molina Provider Contracting at MHMSProviderContracting@molinahealthcare.com

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		• **W-9** • **Locations page** **Magnolia Credentialing Guidance Reminder** ✓ Practitioner's start date cannot precede the contract effective date. ✓ Practitioner's contracted payment eligibility cannot precede state Medicaid eligibility ✓ Practitioner's state date should be the date the provider group or practitioner notified the health plan that they have joined a contracted group via a roster submission or practitioner add process. Magnolia will not grant retro effective participation or credentialing request. **Important Note for Roster Submitters: Roster submission which include Medical and Behavioral Health Practitioners much include an indicator to ensure practitioner will be enrolled properly.**		Additional information on Molina's credentialing process can be found in Section 12 of Molina's MississippiCAN provider manual: https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Re-Credentialing/Revalidation*	**Medicaid Providers is conducted by Conduent, and providers must submit applications for enrollment.** All providers must: • Complete provider agreements and/or provider enrollment application packages. • Be licensed and/or certified by the appropriate federal and/or state authority. • Agree to furnish required documentation of the provider's business transactions per 42 CFR §455.105(b) within thirty-five (35) days of the date on the request. Agree to abide by the requirements of 42 CFR, PARTS 405, 424, 438, 447, 455, 457, 498, and 1007 of the Affordable Care Act (ACA) concerning the following: a) Provider Screening Procedures (42 CFR § 424.518) b) Provider Termination (42 CFR § 455.416) c) Payment Suspensions (42 CFR § 455.23) **MS Medicaid Administrative Code** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-200.pdf **Medicaid Provider Enrollment Package** https://www.msmedicaid.com/msenvision/downloadenrollPackage.do **Medicaid Provider Revalidation** Mississippi Envision (ms-medicaid.com) **Medicaid Provider PCP Attestation** Mississippi Envision (ms-medicaid.com) **Medicaid Ordering, Referring, and Prescribing Provider** Conduent Standards (ms-medicaid.com)	**In accordance with Federal, State and Contract requirements and Accreditation standards:** ✓ Credentialing formally re-credentials practitioners at least every thirty-six (36) months. ✓ The Re-credentialing due date is calculated from the date of the Initial credentialing decision. ✓ Practitioners who are terminated or voluntarily withdrawn from the network and subsequently seek to be reinstated must complete the initial credentialing process if the break in service is more than thirty (30) days or if more than thirty-six (36) months has elapsed since they were last credentialed. Once terminated, the following claim issues can occur: • Claim denials • Rejections • Being paid at an out-of-network rate **To prevent these issues:** • Providers should make sure that everything on CAQH is updated at all times and in a timely manner • The re-cred notification letters are mailed to provider's primary address that is listed in CAQH or Magnolia Health's system. • If your mailing address has changed, notify Magnolia Health immediately by submitting an address change request letter along with a W9 to magnoliacredentialing@centene.com **Re-cred questions and documents can be submitted to the following email addresses:** Facility re-cred email: facilitycred@centene.com Practitioner re-cred email: RECRED-CORPORATE@CENTENE.COM	Credentialing cycle is **every three-years** NCQA Standard) and providers should keep their CAQH profile current. UHC begins contacting providers via email (that is on file) and USPS 6 months before credentialing expires. **Online:** www.caqh.org > CAQH ProView **Toll Free:** 888-599-1771 **Disclosures Forms** are collected every 3 years from contract date or upon a notice of material change if within the 3-year cycle. www.uhcprovider.com/forms Medicaid Status must remain active (see Medicaid FFS) Contract is valid through the agreed upon date (see signed contract) **Dental** **Phone:** 1-800-508-4862 **Online:** www.uhcproviders.com **Vision** **Phone:** 844- 606-2724 **Online:** www.marchvisioncare.com	Molina recredentials every practitioner at least every thirty-six (36) months per NCQA standards. The recredentialing due date is calculated from the date of the initial credentialing decision or the last recredentialing cycle signoff date. Approximately six (6) months prior to the recredentialing due date, Molina will request the practitioner submit an application. Facilities are sent a recredentialing profile for completion and practitioners should utilize CAQH. The recredentialing team will send a minimum of three (3) written notices via email or fax to the provider for a current application with the third being a final notice to a confirmed credentialing contact. If no application is received after a final notice is sent to the provider, the file is closed out and the health plan is notified at least 60 days prior to the recredentialing due date. An intent to terminate notice will then be sent to the provider at least 30 days prior to their recredentialing due date. Providers who remain non-compliant will be terminated no later than the last day of the month recredentialing is due. Any related questions can be directed to Molina Provider Contracting at: MHMSProviderContracting@molinahealthcare.com

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		More information on the re-credentialing process can be found in our provider manual on P. 53 Provider Manual		

Provider Value Based Contracting	**Provider Value Based Incentives**
	Value-Based Incentives | Mississippi Division of Medicaid (ms.gov)
	
	QIPP – Quality Incentive Payment Program
	
	MAPS – Medicaid Access to Physician Services
	
	Managed Care Value-Based Withhold Program
		Provider Value Based Contracting is not currently utilized by all providers. If you would like to learn more about Value Based Contracting, please contact Provider Services at 866-912-6285 and ask to speak with a Contract representative.	The PATH program includes resources that assist the Providers with meeting their quality scores which will also increase their earning potential with the measures tied to the incentive program. This site (see link below) includes the following resources for Providers: PCOR (Patient Care Opportunity Report), coding resources & HEDIS® reference guides
			
			Online: www.uhcprovider.com/path-program
			Provider Services: 877-743-8734
				Value Based Reimbursement (VBR) opportunities for Molina Healthcare of MS (MHMS) will be available for network providers. Due to Molina being a growing health plan, the development of this program is on-going, and it is our intention to evolve a VBR methodology up to and including a shared savings approach.
				
				The proposed VBR program for MHMS will roll out as a program that assigns a flat incentive for agreed upon, measurable metrics with the participating provider(s). MHMS will institute a VBR program which would incentivize the provider(s) with a flat payment per episode in the following proposed areas:
				• Well Child
				  ○ EPSDT visits
				• Weight
				• Women's Annual Exams
				• Diabetes Screenings
				• Administrative Events
				  ○ Contract Compliance
				  ○ Credentialing and enrollment benchmarks and turnaround times
				  ○ Member satisfaction
				
				Important Note: *Not all of the above items will be applicable to all provider(s) and this is a non-exhaustive list as it is in further development. We anticipate having the first provider enrolled in a version of this VBR by the beginning of Q1, 2021.*

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
NPI and Medicaid ID Numbers*	**DOM Administrative Code** https://medicaid.ms.gov/providers/administrative-code/ The National Provider Identifier (NPI) is a unique identification number for covered health care providers. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). Healthcare providers must obtain their NPI through the National Plan and Provider Enumeration System (NPPES) **MS Medicaid Provider Billing Manual** https://medicaid.ms.gov/wp-content/uploads/2016/07/1.7-NPI-Provider-Enrollment.pdf • Providers must verify that the information submitted to all payers is consistent and accurate. • Providers must ensure that updates are consistent with NPPES. **NPPES** (hhs.gov) • The National Plan and Provider Enumeration System (NPPES) assigns NPIs, maintains and updates information about health care providers with NPIs, and disseminates the NPI Registry and NPPES Downloadable File. • The NPI Registry is an online query system that allows users to search for a health care provider's information.	Every practitioner enrolled with Magnolia Health Plan must have a NPI number. In addition, Billing or Group NPI numbers are used to link practitioners with their appropriate contracts and service locations. Every practitioner must have an active Medicaid ID# and NPI# matched on the Medicaid State File before contracting/credentialing can begin with Magnolia. If an active Medicaid ID # and NPI # aren't matched on the Medicaid State File, providers will encounter claim denials or rejections. Visit DOM website to learn more about how to apply for a Medicaid ID # Provider Manual, page 53 https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/CAID20110-MS2020PrvdrHndbk.pdf DOM website https://medicaid.ms.gov/wp-content/uploads/2016/07/1.7-NPI-Provider-Enrollment.pdf	All Medicaid/MSCAN providers are required to have an active Mississippi Medicaid ID number. NPI numbers submitted on a claim are used to validate that providers are actively enrolled as participating providers with the Mississippi Division of Medicaid. Use NPI numbers that are registered with the state of Mississippi. The following NPIs always require validation on the CMS 1500 claim form: • Rendering Provider • Billing Provider The following NPIs always require validation on the CMS 1450 claim (UB) form: • Billing Provider • Attending Provider • Operating Provider (if provided) If the NPI number is registered to more than one Medicaid ID number, the taxonomy code must also be submitted to enable a match to the Mississippi Medicaid provider registry. The billing NPI number is typically the NPI with multiple matches (rather than the rendering/attending/operating NPI). Claim-Filing Tips: • File Medicaid/MSCAN claims using NPI numbers that are registered with the Mississippi Division of Medicaid. • Include your provider taxonomy code as routine claim-filing practice. • When submitting a taxonomy code, please be sure to include the two-digit qualifier that identifies the number as a taxonomy code. It is a ZZ on the CMS 1500 (HCFA) form and B3 on the CMS 1500 (UB04) form. • Claims rejected for missing/invalid NPI or taxonomy information can be corrected and resubmitted for reconsideration within the appropriate time frames.	Providers interested in joining Molina's MississippiCAN network must have an active Mississippi Medicaid ID number issued from the Mississippi Division of Medicaid. In addition to possessing an active Medicaid ID number, all providers enrolled with Molina must have an NPI number. The NPI number submitted for credentialing and on claim submissions must match the NPI number registered with the Mississippi Division of Medicaid. Failure to submit claims correctly based on the above referenced information will result in the denial of the claim. Please visit our website to review this information: https://www.molinahealthcare.com/providers/ms/medicaid/home.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
			All state and federal identifiers and licenses are required to be current and without restrictions (NPI, DEA, Medicaid ID, etc.). Providers are assigned unique UHC Provider IDs which are usually the same for CAN, CHIP, Commercial, Medicare Supplement, DSNP, etc.) Sanctioned and restricted-practice providers are not permitted to participate with UHC unless provider successfully appeals.	

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Prior Authorizations**	Prior Authorization and Utilization Management is the review of appropriateness and medical necessity of care provided to patients. The UM/QIO vendor for Medicaid FFS is Alliant Health Solutions, and providers must submit clinical documentation for services requested to obtain UM approval. **DOM Administrative Code – Utilization Management** https://medicaid.ms.gov/providers/administrative-code/ **MS Medicaid Provider Billing Handbook** https://medicaid.ms.gov/wp-content/uploads/2020/07/Provider-Billing-Handbook-Entire-Document-7.27.20.pdf **MS Medicaid – Vendor - Utilization Management/Quality Improvement Organization (UM/QIO)** **Alliant Health Solutions** 775 Woodlands Parkway Suite #308 Ridgeland, MS 39157 https://ms.allianthealth.org/ **Inpatient Services** Phone: 888-243-1846 Fax: 888-503-1812 **Other Services** Phone: 888-224-3067 Fax: 888-506-2768	Some services require prior authorization from Magnolia Health in order for reimbursement to be issued to the provider. Click on the link to use our Prior Authorization Prescreen tool. Standard prior authorization requests should be submitted for medical necessity review at least five (5) business days before the scheduled service delivery date or as soon as the need for service is identified. Prior Authorization Form(s) can be located on our website at: http://www.magnoliahealthplan.com/for-providers/provider-resources/ Authorization requests should include all necessary clinical information. Urgent requests for prior authorization should be called in as soon as the need is identified. Authorizations can be submitted the following ways: Inpatient Fax: 1-877-291-8059 Outpatient Fax: 1-877-650-6943 Secure Web Portal: www.provider.magnoliahealthplan.com Phone: 1-866-912-6285 Email: magnoliaauths@centene.com **Post Service Review -** Requests for post service review will only be considered when prior authorization was not obtained due to extenuating circumstances such as retro active eligibility or natural disasters. Post service review decisions and notifications occur within 20 business days from the receipt of the request. **Concurrent Review** - Concurrent review decisions and notifications occur within 24 hours of the next	**Prior Authorization (PA):** Clinical review prior to elective or non-emergent services. Basic elements are same as Authorization. **Notification:** Process by which a hospital notifies UHC of an urgent/emergent hospital admission and provides clinical information to support inpatient days beyond the day of admission. **Notification is required for all urgent/emergent hospital admissions.** A notification is NOT a prior authorization. ****All Non-par providers must seek PA before rendering services to members** **Medical** **Phone:** 866-604-3267 **Fax:** 888-310-6858 **Online:** www.uhcprovider.com/prior-auth **PA Form:** www.uhcprovider.com/forms See "Inpatient Hospital Services" section for additional details. **To find information on Prior Authorization Requirements:** www.uhcprovider.com/prior-auth **Behavioral Health** **Phone:** 877-743-8734 **Online:** www.providerexpress.com/Behavioral Health PA **Dental** **Phone:** 1-800-508-4862 **Online:** www.uhcproviders.com **Therapy Services** **Phone:** 877-743-8734 **Online:** www.UHCprovider.com/Link> Prior Authorization and Notification **Pharmacy** **Online:** www.UHCprovider.com/Link >PreCheckMyScript **OR**	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 are included in our Provider Manual and are posted on our website at: https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx https://www.molinahealthcare.com/providers/ms/medicaid/resource/utilized_mgt.aspx **Authorizations can be submitted via the following methods:** **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: https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx Phone: (844) 826-4335 Inpatient Requests Fax: (844) 207-1622 All Non-Inpatient Fax: (844) 207-1620 Behavioral Health – Inpatient Fax: (844) 206-1622 Behavioral Health – All Non-Inpatient Fax: (844) 206-4006

<table>
<tr><th>Medicaid Fee-for-Service</th><th>Magnolia Health</th><th>UnitedHealthcare</th><th>Molina Healthcare</th></tr>
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<td>review date. The next review date is communicated via the notification of approval letter.

Coordination of Benefits - In the event a member is transferring to Magnolia from another payer, Magnolia shall be responsible for the costs of continuation of medically necessary services. Magnolia will honor authorizations from Medicaid and MSCAN CCO’s. Please submit a copy of the approval with the request for authorization to Magnolia.

To prevent auth denials - Submit all necessary clinical information with the authorization request and/or respond to the Health Plan’s outreach attempts for the necessary clinical information in order to make a determination on the authorization request.</td>
<td>https://www.covermymeds.com/main/prior-authorization-forms/optumrx/
Fax: 866-940-7328
Phone: 800-310-6826</td>
<td>
<table>
<tr><td>Pharmacy Authorizations Fax</td><td>(844) 312-6371</td></tr>
<tr><td>Radiology Authorizations Fax</td><td>(877) 731-7218</td></tr>
<tr><td>Transplant Authorizations Fax</td><td>(877) 813-1206</td></tr>
<tr><td>NICU Authorizations Fax</td><td>(844) 207-1622</td></tr>
</table>

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

Molina requires that all PA submissions to Molina include:
Member demographic information,
Facility information,
Date of admission or Date Span of Services
Clinical information sufficient to document the Medical Necessity of the admission or procedure.
Prior 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.
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</table>

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
				• 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. Failure to obtain authorizations timely may result in the denial of the claim.

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Prior Authorizations Reconsideration and Peer-to-Peer, and Appeals*	Providers may request reconsideration of prior authorization denials through Alliant Health Solutions. Providers must submit reconsideration requests within 30 calendar days and include all the clinical information and/or documentation needed to address the denial reason(s) listed in the decision notification. Reconsideration requests are referred to a new peer consultant for review. Following a reconsideration, any final adverse decision notification includes all applicable information for filing of appeals by beneficiaries or representatives according to DOM administrative code and rules. **MS Medicaid – Vendor - UM/QIO PA Quick Reference Guide** Alliant_UM-QIO_General PA_Quick.Reference.v2.pdf (allianthealth.org) **Prior Authorizations Obtained from Different Payers** • Verify the appropriate payer for member • Payers include Medicaid FFS, MississippiCAN CCOs (Magnolia, UHC, Molina) and CHIP CCOs (UHC and Molina) • Contact current payer Utilization Management Department via telephone and provide copy of authorization from prior payer • Obtain new authorization approval from current payer.	If the member does not agree with the authorization determination, the member or anyone they designate can request an appeal within 60 calendar days from the date on the notification of adverse benefit determination letter. Appeals for **pre-service** authorization determinations can be submitted by phone or in writing to: Magnolia Health Attention: Prior Auth Appeals Coordinator 111 East Capitol Street, Suite 500 Jackson, MS 39201 Phone: 1-866-912-6285/ Fax: 1-877-264-6519 ***Post service appeals (If services have already been rendered) should be submitted via the claims reconsideration process and mailed to P.O.Box 3090 Farmington, MO 63640** **Peer to Peer -** If the treating practitioner does not agree with the authorization determination, the practitioner may discuss the decision with the Medical Director who rendered the decision by contacting Provider Services. **Contact information:** **1-866-912-6285** **Request to speak to the UM Department to set up a Peer to Peer** **More information can be found beginning on page 33 of the provider manual** https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/CAID20110-MS2020PrvdrHndbk.pdf *Guidance above is for medical providers only*	**PA Reconsideration/Peer-to-Peer** reviews must be requested within 10 calendar days of the date of determination. **Medical, Behavioral Health, and Pharmacy** **Phone:** 877-743-8734 **Online:** www.UHCprovider.com/Link **Dental** **Phone:** 800-508-4862 **Mailing:** UnitedHealthcare P.O. Box 1391 Milwaukee, WI 53201 **Appeal** requests must be submitted in writing within 30 calendar days of the date of determination. **Medical, Behavioral Health, Pharmacy and Therapy Services** **Online:** www.UHCprovider.com/Link **Phone:** 877-743-8734 **Fax:** 801-994-1082 **Mailing:** UnitedHealthcare Community Plan Attn: Appeals P O Box 5032 Kingston, NY 12402-5032 **Dental** **Mailing:** UnitedHealthcare P.O. Box 1391 Milwaukee, WI 53201 **Vision** **Online:** www.forms.marchvisioncare.com **Mailing:** MARCH® Vision Care Attention: PDR Unit 6601 Center Drive West, Suite 200 Los Angeles, CA 90045	For providers seeking to appeal a denied Prior Authorization (PA) on behalf of a member only, fax Member Appeals at **(844) 808-2407.** MSCAN Pre-Service Appeals Form CHIP Pre-Service Appeals Form ▪ The Member Appeals process begins after the PA is denied and the Peer-to-Peer timeline has passed (5 days from the PA denial date). ▪ The Member (or Member Authorized Rep, or Provider on behalf of the Member with Written Member consent) has 60 days from the PA denial (ABD Letter) date to file the Member Appeal. ▪ 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. Requests can be made by contacting Molina at **1-(844) 826-4335.** ▪ Upon receipt of the Standard Appeal, the A&G team will send an Acknowledgement Letter within 10 days. ▪ The A&G team has 30 days from the receipt of the Standard Appeal to resolve the appeal. ▪ Upon receipt of an Expedited Appeal, the A&G team will send an Acknowledgement Letter with 1 day of receipt. ▪ The A&G team has 72 hours to resolve an Expedited Appeal. ▪ For both the Standard and Expedited Appeals, the process can be extended 14 days if additional information, research time or medical review time is needed. The Member will be advised orally and via an Extension Letter, that the Appeal has been extended and the reason why. For resolution of Standard and Expedited Appeals, the A&G team will contact the parties involved orally

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
				of the appeal decision and a Resolution Letter will be sent to the Member. https://www.molinahealthcare.com/providers/ms/medicaid/resource/utilized_mgt.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Member Care Management*	**Medicaid Quality Initiatives 2020** Medicaid Fee-for-Service (FFS) Care Management • HIV/AIDS • Hepatitis C • Hemophilia • Women and Infants 60 days postpartum • Disabled Child Living at Home (DCLH)	All Magnolia Health members have access to Care Management services. Referrals from Providers can be made in any of the following ways: Complete the Provider Referral Form for Care Management and Disease Management which is located under the Practice Improvement Resource Center (PIRC) section on www.magnoliahealthplan.com and fax the completed form to 866.901.5813 • Log in to the Secure Portal to complete the Provider Referral Form: www.provider.magnoliahealthplan.com • Telephone: 866.912.6285 Ext. 66415 to speak with the Care Management Department https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/Care-Management-Referrals-PDF.pdf	Our utilization management team is available Monday – Friday, 8 a.m. – 5 p.m. Central Time. Assistance is also available after hours. **Provider Services:** 888-980-8728 **Case Management:** 877-743-8731 **Disease Management:** 877-743-8731 **24-hour Nurse Line:** 877-370-4009	Molina Healthcare's Care Management Program involves collaborative processes aimed at meeting an individual's health needs, promoting quality of life, and obtaining cost-effective outcomes. Care Management employs a multi-disciplinary team approach in developing interventions to meet member needs. Members of this team are determined by the member and may include but not limited to: ▪ Member and their caregiver/representative ▪ Member's PCP and BH Provider ▪ Molina Medical Director ▪ Case Manager ▪ Inpatient Review Nurse ▪ Molina Pharmacist ▪ Molina BH Specialist ▪ Molina or External SW ▪ Any provider who can provide input on the member's care **Transitions of Care are when a member moves from one health care setting to another, usually during an acute health care episode.** *Examples:* Hospital → Outpatient Follow Up Hospital → PRTF The ToC program provides members with a ToC Coach who follows the member closely during the first 30 days post discharge and makes a minimum of 4 contacts over the 30-day period. Contacts usually occur as follows: 1st Contact - while in the hospital; and 2nd Contact - within 48 hours of discharge; and 3rd Contact - 7 days after the second contact; and 4th Contact - 14 days after the 3rd contact. Additional contacts are made based on member needs. ▪ Providers may request Care Management services by calling **(844) 794-8438**. Case Managers are available from 8 a.m. to 5 p.m. Central time, Monday – Friday. If you know the name of your members Care Manager,

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
				you may contact them directly at **(844) 809-8438** with extension. ▪ Provider can fax Notifications of Pregnancy to Care Management at **(844) 206-0435** or email to **MHMS_CM_Referrals@MolinaHealthcare.com**. ▪ Weight Watchers Referral forms can be faxed to Care Management at **(844) 206-0435** or emailed to **MHMS_CM_Referrals@MolinaHealthcare.com**. Weight Watchers is available to Molina members actively enrolled in MSCAN: ➢ 18 years or older with a BMI equal to or greater than 27 ➢ Age 15-17 in 95th percentile in weight or above ➢ Member cannot be pregnant at the time of referral Member cannot have an active diagnosis of anorexia and/or bulimia Please visit our website to review this information: https://www.molinahealthcare.com/providers/ms/medicaid/resource/case_mgt.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Outpatient Hospital Services*	**Outpatient Hospital Services** Medicaid State Plan 2019 MS-SPA-19-0013-OPPS-approved-pages.pdf **Outpatient Hospital Services** Administrative Code Title 23: Medicaid Part 202 Hospital Services **Outpatient Prospective Payment System (OPPS) Medicaid** Fee Schedules and Rates | Mississippi Division of Medicaid (ms.gov) **Outpatient Hospital Payment Method for Mississippi Medicaid** Reimbursement | Mississippi Division of Medicaid (ms.gov)	**Outpatient** Prior to rendering services, check our Pre-Auth Tool at www.magnoliahealthplan.com to verify if prior-authorization is required for the service being performed. Please initiate the Authorization process at least five (5) calendar days in advance for non-emergent outpatient services. **Determination Timeframes** • Standard pre-service *outpatient* review decisions and notifications occur within 2 business days or 3 calendar days IF all necessary information is received with the request. • Urgent pre-service review decisions and notifications occur within 24 hours IF all necessary information is received with the request. • If additional information is needed to make a determination, the above timeframes may be extended. **Emergency Services** • Prior Authorization is NOT required for emergent services. • If these services result in an inpatient admission, Magnolia must be notified within one (1) business day and authorization must be requested within two (2) business days of admission as previously noted. **Discharge Planning** • Concurrent review staff will work closely with hospital staff to ensure a comprehensive discharge plan is developed and in place prior to discharge. • For members in Care Management, the Concurrent Review Nurse or designated staff will engage the member's Care	Prior Authorization may be required on specific Outpatient Hospital Services. **Online:** www.uhcprovider.com/prior-auth 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 Information on Link: www.uhcprovider.com/Link Information **Online:** www.UHCprovider.com/Link **Notifications/Prior Authorizations** **Online:** www.UHCprovider.com/Link **Phone:** 866-604-3267 **Fax:** 888-310-6858	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. Please visit our website to review this information: **Provider Manual** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		Manager to ensure appropriate discharge planning and follow-up. **Issue Resolution:** To prevent authorization denials, check pre-auth tool first to determine auth requirement. If auth is required submit all necessary clinical information with the authorization request and/or respond to the Health Plan's outreach attempts for the necessary clinical information in order to make a determination on the authorization request. Prior to rendering services, check our Pre-Auth Tool at www.magnoliahealthplan.com to verify if prior-authorization is required for the service being performed. Please initiate the Authorization process at least five (5) calendar days in advance for non-emergent outpatient services. Authorizations can be submitted: Outpatient Fax: 1-877-650-6943 Web: www.provider.magnoliahealthplan.com Phone: 1-866-912-6285 Email: magnoliaauths@centene.com		**Frequently Used Forms** https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx **Utilization Management** https://www.molinahealthcare.com/providers/ms/medicaid/resource/utilized_mgt.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Inpatient Hospital Services*	Inpatient Hospital services require prior authorization for services unless urgent/emergent care https://medicaid.ms.gov/inpatient-transition-information/ **Hospital Services, Part 202** **Chapter 1 Inpatient Hospital** https://medicaid.ms.gov/wp-content/uploads/2015/09/AdministrativeCode.pdf **Outpatient Hospital Payment Method for Mississippi Medicaid** Reimbursement | Mississippi Division of Medicaid (ms.gov) **MS Medicaid – Vendor - Utilization Management/Quality Improvement Organization (UM/QIO)** https://ms.allianthealth.org/	**Inpatient** All hospital inpatient stays require notification within one (1) business day following the admission. Facilities are required to submit a request for authorization within two (2) business days following the date of inpatient admissions that are not elective. Please initiate the authorization process at least five (5) calendar days in advance for elective inpatient services. **Determination Timeframes** • Standard pre-service *inpatient* review decisions and notifications occur within 24 hours or 1 business day IF all necessary information is received with the request. • Urgent pre-service review decisions and notifications occur within 24 hours IF all necessary information is received with the request. • If additional information is needed to make a determination, the above timeframes may be extended. **Emergency Services** • Prior Authorization is NOT required for emergent services. • If these services result in an inpatient admission, Magnolia must be notified within one (1) business day and authorization must be requested within two (2) business days of admission as previously noted. **Discharge Planning** • Concurrent review staff will work closely with hospital staff to ensure a comprehensive discharge plan is developed and in place prior to discharge. • For members in Care Management, the Concurrent Review Nurse or designated staff will engage the member's Care	All inpatient hospital admissions require notification within one (1) business day **Online:** www.UHCprovider.com/Link **Phone:** 866-604-3267 **Fax:** 888-310-6858 Concurrent reviews are performed for extended stays that exceed authorized and/or generally accepted LOS. The provider initiates concurrent review the same as notification **Online:** www.UHCprovider.com/Link	For emergent inpatient admissions, notification to Molina must occur once the patient has been stabilized in the emergency department. Notification of admission is required to: • Verify member eligibility; • Authorize care, including level of care; and • Initiate inpatient review and discharge planning. Molina requires that notification includes Member demographic information, facility information, date of admission and clinical information sufficient to document the Medical Necessity of the admission. Hospitals are required to notify Molina within 24 hours or the first business day of any inpatient admission, including deliveries. Prior authorization is required for inpatient and outpatient surgeries and for all elective inpatient admissions to any facility. Molina performs concurrent review in order to ensure: • Patient safety; • Medical Necessity of ongoing inpatient services; and • Adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from the provider. We will request updated clinical records from the inpatient facility at regular intervals during the member's inpatient admission and ask that updates are provided within 24 hours of the request to better serve you and our members. Molina's Utilization Management staff determines if the collected medical records and requested clinical information are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding and Medical Necessity requirements.

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		Manager to ensure appropriate discharge planning and follow-up. **Issue Resolution:** To prevent authorization denials, submit all necessary clinical information with the authorization request and/or respond to the Health Plan's outreach attempts for the necessary clinical information in order to make a determination on the authorization request. Prior to rendering services, check our Pre-Auth Tool at www.magnoliahealthplan.com to verify if prior-authorization is required for the service being performed. Please initiate the Authorization process at least five (5) calendar days in advance for non-emergent outpatient services. Authorizations can be submitted: Outpatient Fax: 1-877-650-6943 Web: www.provider.magnoliahealthplan.com Phone: 1-866-912-6285 Email: magnoliaauths@centene.com		Please visit our website to review this information: https://www.molinahealthcare.com/providers/ms/medicaid/resource/utilized_mgt.aspx https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx

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<tr><th></th><th>Medicaid
Fee-for-Service</th><th>Magnolia Health</th><th>UnitedHealthcare</th><th>Molina Healthcare</th></tr>
<tr><td>Retrospective Reviews</td><td>Retrospective review is a review that is conducted after services are provided to a Member.

MS Medicaid – Vendor - Utilization Management/Quality Improvement Organization (UM/QIO)

https://ms.allianthealth.org/</td><td>Retrospective review is an initial review of services provided to a member, for which authorization and/or timely notification to Magnolia was not obtained, due to extenuating circumstances related to the member (i.e., member was unconscious at presentation, member did not have their Magnolia ID card or indicate Magnolia coverage, services authorized by another payer who subsequently determined member was not eligible at the time of service, or natural disasters).

Retro authorizations should be requested if any of the qualifiers are met.

Requests can be submitted in the following ways:
• Inpatient Fax: 1-877-291-8059
• Outpatient Fax: 1-877-650-6943
• Secure Web Portal: www.provider.magnoliahealthplan.com
• Phone: 1-866-912-6285
• Email: magnoliaauths@centene.com

A decision will be made within twenty (20) business days following receipt of all necessary information for any qualifying service cases.
If you do not meet the qualifying reasons listed above, the claim dispute process should be followed. Claim reconsiderations should be mailed to:
Magnolia Health
Attn: Claim Reconsiderations
P.O.Box 3090
Farmington, MO 63640</td><td>Retrospective Review is a review for medical necessity after services are initiated or a member retroactively switches to UHC after services are initiated/rendered

Online: www.UHCprovider.com/Link
Phone: 866-604-3267
Fax: 888-310-6858</td><td>Retrospective 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;
• appropriateness of care guidelines defined by UM policies and criteria;
• regulation and guidance; and
• evidence based criteria sets.
Please visit our website to review this information: https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx

Provider may also contact:
Tammy Grant, RN, BSN, CPM
SIU Nurse Investigator
Office Phone: 601-863-3701</td></tr>
</table>

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Claims Filing*	**MS Medicaid Fiscal Agent - Conduent** https://www.ms-medicaid.com/msenvision/index.do **MS Medicaid Provider Billing Manual** https://medicaid.ms.gov/providers/billing-manual/ **MS Medicaid Administrative Code Part 200 General Provisions** Administrative Code (ms.gov) **Conduent Contact Information** https://www.ms-medicaid.com/Contact_Us.pdf **Provider and Beneficiary Services** (800) 884-3222 **Address** PO Box 23078 Jackson, MS 39225	Any retrospective review denials that fall outside of the guidelines as stated in the "Retrospective Review" section, claim denials that are in relation to prior authorization denials, as well as post service medical denials should follow the claim reconsiderations and appeals process. • First time claims should be submitted within 180 days from DOS • All requests for corrected claims and claim reconsiderations must be received within ninety (90) days of the last written notification of the denial or original submission date. • Claim appeals must be received within thirty (30) days of the denial or outcome of reconsideration request. First time, corrected, and reconsideration requests can be submitted in the following ways: Magnolia Health Web-Portal (preferred method) www.provider.magnoliahealthplan.com Electronic Claim Submission via one of our EDI trading partners on www.magnoliahealthplan.com Or Paper Claims Magnolia Health Attn: CLAIMS DEPARTMENT P.O. Box 3090 (MSCAN) Farmington, MO 63640 Claim appeals must be received within thirty (30) days of the denial or outcome of reconsideration request. Claim appeals cannot be submitted via the Secure Provider Portal and must be mailed to the address below along with supporting documentation and the required claim appeal form located on www.magnoliahealthplan.com:	**Clean Claim:** No defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made. Includes resubmitted claims with previously identified deficiencies corrected. Clean claim are further defined within state statute under §83-9-5. Use standard CMS-1500, CMS-1450/UB04 or respective electronic format Medicaid National Correct Coding Initiative (NCCI) edits are applied **Medical, Behavioral Health, Pharmacy and Therapy Services** Electronic claims submission at: www.UHCprovider.com/Link Education for Electronic Transactions or call 800-842-1109 **Mailing:** UnitedHealthcare P.O. Box 5032 Kingston, NY 12402-5032 Link Training On Line: www.uhcprovider.com/Link Training **Dental** **Online:** www.uhcproviders.com **Mailing:** Claims P.O. Box 481 Milwaukee, WI 53201 **Vision** **Online:** www.providers.eyesynergy.com **Mailing:** MARCH® Vision Care 6601 Center Drive West, Suite 200 Los Angeles, CA 90045	**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** Details regarding EDI submissions are located on our website at the following link: https://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/chinfo.aspx https://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/faq.aspx https://www.molinahealthcare.com/providers/common/medicaid/ediera/edi/guidanceinfo.aspx **Claims Mailing Address** Molina Healthcare of Mississippi, Inc. PO Box 22618 Long Beach, CA 90801 Claims Information is located on our website at the following link: https://www.molinahealthcare.com/providers/ms/medicaid/contacts/contact_info.aspx **MSCAN and CHIP Provider Manuals** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx **Claims mailed to our local office in Jackson, MS will be returned unprocessed.**

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		Paper Claims Magnolia Health Attn: CLAIMS DEPARTMENT P.O. Box 3090 (MSCAN) Farmington, MO 63640 Magnolia Health Provider Manual https://www.magnoliahealthplan.com/providers.html		

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<tr>
<td>Member Co-Payments and Service Limits*</td>
<td>Provider Billing Handbook
Billing Handbook | Mississippi Division of Medicaid (ms.gov)

1.8 Mississippi Division of Medicaid Benefits and Limitations

1.9 Co-payments and Exception Codes</td>
<td>Pharmacy Copays

Magnolia is committed to providing appropriate, high-quality and cost-effective drug therapy to all Magnolia members. Magnolia covers prescription medications. Magnolia also covers certain over-the-counter (OTC) drugs.

Magnolia follows the Medicaid Preferred Drug List (PDL) found here: https://medicaid.ms.gov/providers/pharmacy/preferred-drug-list/

Effective January 1, 2020, a $1.00 copay for prescription medications may apply for some Magnolia Health – MississippiCAN members.

This copay will apply to brand name drugs, over-the-counter drugs, narcotic drugs, and Benzodiazepine drugs.

There is a monthly out-of-pocket copay maximum of $11.00 per household. The copay maximum will reset on a monthly basis.

Members who meet the below criteria will be copay exempt:
Pregnant members
Members ages 18 and under
Members of the Indian race
Medications below are copay exempt :
Contraceptives
Antiretroviral drugs
Hepatitis C drugs
Vaccines

More information on Pharmacy Co-pays visit https://www.magnoliahealthplan.com/providers/pharmacy.html

Covered Services
With Magnolia, members are entitled to receive medical services and benefits listed in the covered</td>
<td>There are no member Co-Payments for MS-CAN. There are no limits on doctor visits.</td>
<td>MSCAN
There are no copays for MSCAN.

Services limits can be viewed at:
https://www.molinahealthcare.com/members/ms/en-us/mem/medicaid/overvw/coverd/benefits.aspx

CHIP
<table>
<tr><th>Coverage Plan</th><th>Provider Visit</th><th>ER Visit</th><th>Copay Max</th></tr>
<tr><td>MSCHP 01 (<150% FPL)</td><td>$0</td><td>$0</td><td>$0</td></tr>
<tr><td>MSCHP 02 (151%-175% FPL)</td><td>$5/visit</td><td>$15/visit</td><td>$800/ Coverage Period</td></tr>
<tr><td>MSCHP -3 (176%-209% FPL)</td><td>$5/visit</td><td>$15/visit</td><td>$950/ Coverage Period</td></tr>
</table>

Services limits can be viewed at:
https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/coverd/benefits.aspx</td>
</tr>
</table>

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		services section. Members are responsible for any non-covered services. Please Note: • Magnolia will not limit or deny services because of a condition members already have. • For services which are medically necessary and covered by Magnolia, members will not have any co-payments (co-pays), deductibles or other cost sharing. • If members receive healthcare services which are not medically necessary or if they receive care from providers who are out of the Magnolia network, they may be responsible for payment. • Members are notified of new changes in services, providers and locations via Magnolia's website, www.MagnoliaHealthPlan.com, addendums to the member handbook, and new member orientations and letters. More information on Covered Services can be found on pages 19-21 of the Member Handbook at: https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/CAID-19085-Magnolia%20MbrHbk.pdf If you have questions about medical necessity, contact Member Services at 1-866-912-6285.		

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Timely Filing of Claims	Claims for covered services must be filed within 12 months from the through/ending date of service. Providers are encouraged to submit their claims as soon as possible after the dates of service. Claims are processed and paid in the order of submission and not by the date of service. **MS Medicaid Provider Billing Manual** https://medicaid.ms.gov/providers/billing-manual/ **MS Medicaid Administrative Code Part 200 General Provisions Timely Filing and Administrative Reviews** Administrative Code (ms.gov)	**First time claims** – must submit claims within one hundred and eighty (180) calendar days of the date of service. **When Magnolia is the secondary payer** – must submit within three hundred and sixty five (365) calendar days of the final determination of the primary payer. **Corrected Claims and Reconsiderations** – must submit within ninety (90) calendar days from the issue date of notification of payment or denial. **Claim Appeals** – must submit within thirty days (30 days) of the notice of adverse benefit determination ***Claims received after the time frames provided will be denied as untimely***	To be considered for payment, a claim must be submitted within 180 calendar days of the date of service. UHC processes claims daily with most being processed within 10 calendar days of receipt.	Provider shall promptly submit to Molina Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Molina and should include all medical records pertaining to the Claim if requested by Molina or otherwise required by Molina's policies and procedures. Claims must be submitted by Provider to Molina within one-hundred eighty (180) calendar days after the discharge for inpatient services or the Date of Service for outpatient services. Claims filed within the appropriate time frame but denied can be corrected and submitted for reconsideration within ninety (90) days from the date of denial. If Molina is not the primary payer under coordination of benefits or third-party liability, Provider must submit Claims to Molina within one-hundred eighty (180) calendar days after final determination by the primary payer. Claims received outside of this timeframe will be denied for untimely submission. (see table below) **MSCAN and CHIP Provider Manuals** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx

Claims Submission	Timeframe
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

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Claims Reconsideration*	**Claims Reconsideration** The claims reconsideration process is designed to address claim inquiries for: • Service not covered by Medicaid • Authorization denied or service not authorized within specified Medicaid guidelines • Service denied as not being medically necessary • Repayment of identified overpayments **For claim reconsideration contact:** **Conduent** P. O. Box 23076 Jackson, MS 39225 1-800-884-3222 https://ms-medicaid.com https://www.medicaid.ms.gov/wp-content/uploads/2014/11/Provider-Billing-Handbook.pdf Contact DOM/Conduent Provider Field Representatives for claims assistance. https://medicaid.ms.gov/wp-content/uploads/2017/03/March2017-Provider-Bulletin.pdf	**A claim reconsideration is the first step of the claim dispute process.** All requests for corrected claims or claim reconsiderations must be received within **ninety (90) days** of the last written denial/adjudication notification, example: Date of EOP. The preferred submission method for a claim reconsideration is through Magnolia Health's secure portal at: www.provider.magnoliahealthplan.com. The secure portal will allow attachments and supporting documentation to accompany your request. Claim reconsiderations submitted in writing or mail are accepted, but not preferred. When submitting a mailed reconsideration please include the following: • Written communication (i.e. letter) outlining disagreement of claim determination • Indicate "Reconsideration of (original claim number)" Mailed or written reconsiderations can be sent to: **Magnolia Health Plan** **Attn: Reconsideration PO BOX 3090** **Farmington, MO 63640**	**Claims Reconsideration** reviews must be requested within 90 calendar days of the date of determination. **Medical, Behavioral Health, Pharmacy and Therapy Services** **Online:** www.UHCprovider.com/Link **Phone:** 877-743-8734 **Mailing:** UnitedHealthcare Community Plan Attn: Appeals P O Box 5032 Kingston, NY 12402-5032 **Dental** **Mailing:** Corrected Claims P.O. Box 481 Milwaukee, WI 53201 **Vision** **Online:** www.forms.marchvisioncare.com **Mailing:** MARCH® Vision Care Attention: PDR Unit 6601 Center Drive West, Suite 200 Los Angeles, CA 90045	Providers disputing a Claim previously adjudicated must request such action within 30 days of Molina's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all Claim disputes must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Provider website and the Provider Portal. The form must be filled out completely in order to be processed. Additionally, the item(s) being resubmitted should be clearly marked as reconsideration and must include the following documentation: • Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request. • The Claim number clearly marked on all supporting documents Forms may be submitted via fax, mail, or provider portal. Claims Disputes/Reconsideration requested via the CRRF may be sent to the following address: **Molina Healthcare of Mississippi, Inc.** **Attention: Claims Disputes/Adjustments** **188 E. Capitol St. Suite 700** **Jackson, MS 39201** MSCAN Post-Service Appeals Form CHIP Post-Service Appeals Form **Submitted via fax: (844) 808-2409** Reconsiderations for a denied claim are filed by the Provider with 60 days of the Remittance Advice. These requests are the first request and not regarding PA issues, retro review or medical necessity. The A&G team has 30 days to research and resolve the Reconsideration. A resolution letter will be sent to the requesting Provider on the Reconsideration determination.

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
				Please visit our website to review this information: https://www.molinahealthcare.com/providers/ms/medicaid/home.aspx
Claims Appeals	**Within thirty (30) calendar days after an agency (DOM) decision has been made, the provider may request a formal administrative hearing.** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-300.pdf **State Fair Hearing:** A hearing conducted by the Division of Medicaid or its Subcontractor in accordance with 42 C.F.R. § 431 Subpart E. Any adverse Action or Appeal that is not resolved wholly in favor of the Member by the Contractor may be Appealed by the Member or the Member's Authorized Representative to the Division for a State Fair Hearing conducted in accordance with 42 C.F.R. § 431 Subpart E. A Member or Authorized Representative may request a State Fair Hearing if he or she is dissatisfied with an Action that has been taken by the Contractor within thirty (30) calendar days of the final decision by the Contractor. The Member must exhaust all CCO level Grievance and Appeal procedures prior to requesting a State Fair Hearing with the Division of Medicaid. The Provider must exhaust all CCO level Grievance and Appeal procedures prior to requesting a State Administrative Hearing with the Division.	A Claim Appeal is the next step of the claim dispute process following the outcome of a claim reconsideration. Claim appeals must be received within **thirty (30) days** of the denial or outcome of a reconsideration request. Claim appeals **cannot** be submitted via the Secure Provider Portal and must be mailed to the address below along with supporting documentation and the required claim appeal form located on www.magnoliahealthplan.com. **Magnolia Health** **Attn: CLAIMS DEPARTMENT** **P.O. Box 3090 (MSCAN)** **Farmington, MO 63640** For more information regarding the claim dispute please visit Magnolia's Provider Manual found here: https://www.magnoliahealthplan.com/providers.html or contact Provider Services at 1.866.912.6285.	**Appeal** requests must be submitted in writing within 30 calendar days of the date of determination. **Medical, Behavioral Health, Pharmacy and Therapy Services** **Online:** www.UHCprovider.com/Link **Fax:** 801-994-1082 **Mailing:** UnitedHealthcare Community Plan Attn: Appeals P O Box 5032 Kingston, NY 12402-5032 **Dental** **Mailing:** UnitedHealthcare P.O. Box 1391 Milwaukee, WI 53201 **Vision** **Online:** www.forms.marchvisioncare.com **Phone:** (844) 606-2724 **Mailing:** MARCH® Vision Care Attention: PDR Unit 6601 Center Drive West, Suite 200 Los Angeles, CA 90045	• Appeals for a denied claim are filed by the Provider with 30 days of the upheld Reconsideration resolution letter. These requests are the second request and not regarding PA issues, retro review, or medical necessity. • Appeals for a denied claim are filed by the Provider with 30 days of the remittance advice. These requests are the first or second request and it IS regarding PA issues, retro review, or medical necessity (clinical appeals). • Upon receipt of the second level or clinical Provider Appeal, the A&G team will send out an Acknowledgment Letter within 10 days. • The A&G team has 30 days to research and resolve the Provider Appeal. • For the Provider Appeal, the process can be extended 14 days if additional information, research time or medical review time is needed. The Provider will be advised via an Extension Letter that the Appeal has been extended and the reason why. A resolution letter will be sent to the requesting Provider the Provider Appeal determination. Failure to follow the above referenced guidelines may result in delays processing your request, or a denial. Please visit our website to review this information: https://www.molinahealthcare.com/providers/ms/medicaid/home.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Grievances	A State Grievance system is inclusive of grievances and appeals. Each MCO must have a system in place for enrollees that include a grievance process, an appeal process, and access to the State's fair hearing system. *Grievance* means an expression of dissatisfaction about any matter other than an action, as ''action'' is defined in this section. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO or PIHP level and access to the State fair hearing process. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.) https://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title42/42cfr431_main_02.tpl	Providers have the right to file a Grievance with Magnolia Health. A Grievance is considered to be an expression of dissatisfaction which can be submitted either orally or in writing about any matter or aspect pertaining to Magnolia or its operation, other than an adverse Benefit Determination. Please note that Adverse Benefit Determinations disputes should follow the claims dispute process and are not considered a grievance. Grievances must be submitted within **thirty (30) calendar days** of the date of the event causing the dissatisfaction. Magnolia will confirm receipt of the Grievance within **five (5) calendar days** of receipt of the Grievance. Confirmation letter will be mailed. Grievances are resolved with thirty (30) calendar days of the date of receipt. Timeframe may be extended if additional information is required to reach closure of the grievance. Providers will be notified of the outcome a of their grievance by letter.	**Grievances** must be filed within 30 calendar days of the date of the dissatisfying event. A care provider may file verbally or in writing. **Medical, Behavioral Health, Pharmacy, Therapy Services, and Non-Emergent Transportation** **Online:** www.UHCprovider.com/Link **Phone:** 877-743-8734 **Fax:** 801-994-1082 **Mailing:** UnitedHealthcare Community Plan Attn: Appeals P O Box 5032 Kingston, NY 12402-5032 **Dental** **Phone:** 1-800-508-4862 **Mailing:** UnitedHealthcare P.O. Box 1391 Milwaukee, WI 53201 **Vision** **Online:** www.forms.marchvisioncare.com **Phone:** (844) 606-2724 **Mailing:** MARCH® Vision Care Attention: PDR Unit 6601 Center Drive West, Suite 200 Los Angeles, CA 90045	• For Member Grievances, the Member (or Member Authorized Rep or the Provider on behalf of the Member) can file a Grievance any time after the issue has been identified. • Upon receipt of the Member Grievance, the A&G team will send out an Acknowledgment Letter within 5 days. • The A&G team has 30 days from the receipt of the Member Grievance to resolve the issue. • For Member Grievances, the process can be extended 14 days if additional information, research time or medical review time is needed. The Member will be advised orally and via an Extension Letter that the Grievance has been extended and the reason why. • For Provider Grievances, the Provider can file a Grievance within 30 days that the issue has been identified. • Upon receipt of the Provider Grievance, the A&G team will send out an Acknowledgment Letter within 5 days. • The A&G team has 30 days from the receipt of the Provider Grievance to resolve the issue. • For Provider Grievances, the process can be extended 14 days if additional information, research time or medical review time is needed. The Member will be advised orally and via an Extension Letter that the Grievance has been extended and the reason why. Please visit our website to review this information: https://www.molinahealthcare.com/providers/ms/medicaid/home.aspx **MSCAN and CHIP Provider Manuals** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Balance Billings	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. https://www.ms-medicaid.com/PE_PDFs/ParticipationAgreement.pdf **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	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. 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. Providers should follow the claim reconsideration For more information, visit: https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/CAID20110-MS2020PrvdrHndbk.pdf	Per the MS CAN Provider Agreement/Amendment and Medicaid Administrative Code, the provider agrees to accept as payment in full the amount paid by UHC for Medicaid covered services Exclusions for CHIP are authorized co-payments. 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.	Providers may not balance bill Molina Members for any reason for covered services. Detailed information regarding the billing requirements for non-covered services are available in the MHMS Provider Manual. *Your Provider Agreement with MHMS requires that your office verify eligibility prior to rendering any service and obtain approval for those services that require prior authorization.* In the event of a denial of payment, providers shall look solely to MHMS for compensation for services rendered, with the exception of any applicable cost sharing/co-payments. ▪ The date of claim receipt is the date as indicated by its data stamp on the claim. ▪ The date of claim payment is the date of the check or other form of payment. **MSCAN and CHIP Provider Manuals** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Verifying Eligibility	Failure to verify eligibility on the date of service may result in non-payment of services because member is not eligible. Beneficiary Information. Rule 3.5 Verification of Eligibility https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-200.pdf **Access the Medicaid Envision web portal** https://www.ms-medicaid.com/msenvision/index.do	Failure to verify eligibility on the date of service may result in non-payment of services because member is not eligible. Eligibility can be checked in the following ways: The Secure Provider Portal at: Provider.MagnoliaHealthPlan.com Call Magnolia Health at 866-912-6285 OR Eligibility can also be accessed on: Medicaid Envision web portal https://www.msmedicaid.com/msenvision/index.do	**Online:** www.UHCprovider.com/Link **Phone:** 877-743-8734	Molina offers various tools to verify member eligibility. Providers may use our online self-service Web Portal, the integrated voice response (IVR) system, their eligibility rosters or speak with a Customer Service Representative at: **(844) 826-4335** Please Note – *At no time should a member be denied services because his/her name does not appear on the PCP's eligibility roster. If a member does not appear on the eligibility roster the provider should contact the Plan for further verification.* Web Portal: provider.molinahealthcare.com Customer Service/IVR Automated System: **(844) 826-4335** *Providers may also verify eligibility via the Medicaid Envision Web Portal.* Please visit our website to review this information: https://www.molinahealthcare.com/providers/ms/medicaid/home.aspx
Retroactive Eligibility	The Division of Medicaid determines when a Member is retroactively eligible for Medicaid. Beneficiary Information. Rule 3.3 Beneficiary Retroactive Eligibility https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-200.pdf SSI (Supplemental Security Income) disability program does not pay retroactive disability benefits. SSI disability beneficiaries can receive disability benefits for all months including the month of filing but no earlier than the date of filing. http://www.ssdrc.com/definitions8.html	The Division of Medicaid may assign retroactive eligibility to a member and assign the member to Magnolia Health. These dates are recognized and claims are paid accordingly. Medical reviews may be performed retrospectively to assure medical necessity of services. Claims should be filed with accurate dates of services For more information on Retro-Active Eligibility, please review The Division of Medicaid's Website by clicking on the link Retro-Active Eligibility	The Division of Medicaid may assign retro-active eligibility to a member and assign the member to UHC. These dates are recognized and claims are paid accordingly. Medical reviews may be performed retrospectively to assure medical necessity of services. Claims should be filed with accurate dates of services. **Provider Services:** 877-743-8734	The Division of Medicaid determines when a Member is retroactively eligible for Medicaid. Assignment to Molina will occur after. In cases of retroactive eligibility, we may perform a retrospective review to determine medical necessity. **MSCAN and CHIP Provider Manuals** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Newborn Enrollment	Coverage is mandatory for infants born to Medicaid eligible mothers. The infant is deemed eligible for one (1) year from the date of birth. **Deemed** infants are enrolled with Medicaid from the date of birth. The hospital must notify the Division of Medicaid within five (5) calendar days of a Newborn's birth via the Newborn Enrollment Form located on the Division of Medicaid's Envision secure web portal. https://www.ms-medicaid.com/msenvision/index.do The Division of Medicaid will notify the provider within five (5) business days of the newborn's permanent Medicaid identification (ID) number. https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-100.pdf **Non-Deemed** infants are those who mother was not enrolled in Medicaid or CHIP. Non-Deemed infants are enrolled with a Medicaid Application. These applications must be submitted to the Medicaid Regional Offices.	The Newborn Enrollment Form, located on the Mississippi Envision website, must be fully completed and submitted to the Division of Medicaid within 5 days of delivery. More information can be found in Magnolia Health's provider manual beginning on page 16 as well as the DOM MS Envision website. https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/CAID20110-MS2020PrvdrHndbk.pdf https://www.ms-medicaid.com/msenvision/index.do	Coverage is mandatory for infants born to Medicaid eligible mothers. The infant is deemed eligible for one (1) year from the date of birth. Deemed infants are enrolled with MississippiCAN from the date of birth. UHC accepts newborn member assignments from Medicaid. It should not be assumed that the baby will always follow the mother. See Medicaid FFS **Provider Services:** 877-743-8734 Newborn **Notification** is required within one (1) business day for NICU admissions, if mother is covered by UHC MSCAN **Online:** www.UHCprovider.com/Link **Phone:** 866-604-3267 **Fax:** 888-310-6858	• Coverage is mandatory for infants born to Medicaid eligible mothers. The infant is deemed eligible with MSCAN for one year from date of birth. • The hospital must notify DOM within five (5) calendar days of a newborn's birth via the Newborn Enrollment form located on the Divisions of Medicaid Envision web portal. • Prior to assignment of the permanent Medicaid ID number, the Newborn Enrollment Form is forwarded to Molina Healthcare if the mother is already enrolled with Medicaid. Newborns of MississippiCAN mothers are automatically assigned to the same CCO as the mother by DOM. • The Newborn Enrollment Form will help to create an authorization for claims payment for routine deliveries (3 day stay for vaginal deliveries; 5 day stay for C sections). • Newborn notification is required within one (1) business day for all sick newborns requiring inpatient hospitalization. **Provider Manual** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx **Frequently Used Forms** https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx **Utilization Management** https://www.molinahealthcare.com/providers/ms/medicaid/resource/utilized_mgt.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Newborn Prior Authorization*	The hospital must obtain a TAN for sick newborns requiring hospitalization whose length of stay is six (6) days or more. The baby's date of birth is the sick newborn's beginning date for certification. A sick newborn whose length of stay exceeds nineteen (19) days requires a concurrent review by the appropriate UM/QIO (eQHealth Solutions) http://ms.eqhs.org/Home.aspx The hospital can report the birth through eQSuite. When the provider reports the event in eQSuite, they should receive an instant TAN and see the information for the FFS beneficiary. The hospital must obtain authorization for newborns delivered outside the hospital and newborns admitted to accommodations other than well baby. **Hospital Services, Part 202, Rule 1.3 Prior Authorization of Hospital Services** https://medicaid.ms.gov/wp-content/uploads/2015/09/AdministrativeCode.pdf	To better serve our members and ease provider administrative burden, effective 10/1/2020 Magnolia will no longer enter authorizations for claim payment of routine deliveries. Claims submitted for routine deliveries that are not complicated and do not exceed the routine timeframes (three days for vaginal or five days for C-section) will not require an authorization to be on file for the claim to pay starting on 10/1/2020. Magnolia will continue to require authorizations to determine medical necessity for: • scheduled deliveries before 39 weeks gestation • delivery stays that are non-routine or complicated • delivery stays that exceed routine time frames Providers should wait to file a claim for the above stays until receiving a determination letter. The Division of Medicaid (DOM) will continue to require providers to submit newborn enrollment forms. Magnolia will continue to review newborn enrollment forms for deliveries that require an authorization, as noted above. If additional information is needed to complete the medical necessity review, we will make outreach. Magnolia considers a routine delivery a claim billed with a Level 1 DRG. Anything above a Level 1 DRG will require an authorization. Below are the DRGs that will not require an authorization. 540-1: Cesarean Delivery 541-1: Vag Del W Ster &/or D&C 542-1 Vag Del W Proc Esc Ster &/or D&C 560-1 Vaginal Del Please note, Magnolia requires authorizations for scheduled deliveries (inductions of labor or C-sections) prior to 39 weeks gestation in alignment with the Mississippi Division of Medicaid	Authorization is required for all **deliveries.** The processes for notification and authorization should be followed. Emergent deliveries should follow the notification process as PA is NOT required. All deliveries (vaginal & caesarean) follow guidelines set forth by the Medicaid Admin code for Maternity Services found at: https://medicaid.ms.gov/Admin-Code-Part-222.pdf Newborn **Notification** is required within one (1) business day for NICU admissions, if mother is covered by UHC MSCAN **Online:** UHCprovider.com/link. **Phone:** 866-604-3267 **Fax:** 888-310-6858 The Medicaid birth notification form, along with any additional information can be used if there is insufficient member information to submit all elements.	• All approvals are subject to enrollment verification. • If the mother of the baby (MOB) is primary with Molina at the time of the delivery, then the baby is covered under mom for 30 days: ○ The authorization is created under the mother's name initially. • If the Mother of the baby (MOB) is secondary with Molina at the time of delivery, we need to first verify the policy holder of mom's primary coverage has maternity benefits. • If the mother of the baby is not covered by Molina (or another MCO) at the time of the delivery, then the facility does know to whom to notify of the admission. • When the babies in this situation get their own ID, they are then enrolled in a MCO (Managed Care Organization) and their enrollment is most commonly retro dated back to the baby's DOB. The facility then has 60 days from the date the baby's enrollment was processed to notify us of the IP stay and re must review the entire stay. Failure to follow the above referenced guidelines may result in delays processing your request, or a denial. **Provider Manual** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx **Frequently Used Forms** https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx **Utilization Management** https://www.molinahealthcare.com/providers/ms/medicaid/resource/utilized_mgt.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		Administrative Code Title 23: Medicaid Part 222 Maternity Services, Chapter 1, Rule 1.1. Providers can contact the authorization department by contacting Provider Services at 1-866-912-6285		

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare

Non-Emergency Transportation*	Medical Transportation Management (MTM) is the state of Mississippi's non-emergency transportation (NET) manager. MTM arranges rides free of charge for eligible Fee for Service (FFS) Medicaid beneficiaries throughout the state.
	
	To schedule transportation:
	Call MTM toll-free at 1-866-331-6004 at least three (3) business days in advance, unless your trip is urgent. If you call less than three (3) business days prior to your appointment and the trip is not urgent, you may need to set up your visit for a different date.
	
	To file a complaint:
	Call MTM's toll-free WeCare line at 1-866-436-0457 if you have a complaint about the service you received. You may also use our convenient online form. If you are a transportation provider who would like to file a complaint, please call 1-844-399-9465. MTM will follow up on all complaints.
	
	Online Comment/Complaint Form
	
	If your ride is late:
	Call MTM's toll-free Where's My Ride line at 1-866-334-3794 if you have waited more than 15 minutes after your scheduled pick-up time OR if you called your driver after your appointment and have waited more than one hour to be picked up.
		Medical Transportation Management (MTM) is the non-emergency transportation provider for Magnolia Health. MTM provides transportation services statewide for Magnolia Health members. Members must call MTM to schedule transportation to healthcare providers for covered medical services, if no other means of transportation is available.
		
		Call MTM toll-free at 1-866-331-6004 at least three (3) business days in advance unless the trip is urgent.
		http://www.mtm-inc.net/mississipp
		
		How to Request Non-Emergency Transportation
		• Monday to Friday from 7 a.m. to 8 p.m.
		• Reservation line: 1-866-331-6004
		• You must call at least 3 business days prior to the appointment
		• Full name, address, phone number, date of birth
		• Medicaid ID number
		• Confirm pick up address
		• Date of the healthcare visit
		• Name, address and phone number of the place member is going
		• Medical reason for the visit
		
		Modes of Transportation
		• Public transit (bus)
		• Sedan
		• Public Motor Vehicle
		• Multi-passenger Van
		• Volunteer Driver
		• Wheelchair Van
		• Stretcher/Ambulance
		• Air
		• Gas mileage reimbursement (GMR)
		
		Trip Reservations *(3 business days prior)*:
		1-866-331-6004
			Medical Transportation Management (MTM), UHC's non-emergency transportation vendor, provides rides free of charge for UHC CAN members. This can include transportation within the state and across state lines as necessary. All appointments must be for a Medicaid covered service in order to be eligible for transportation services. Members, their representatives, and/or case managers should call MTM directly to schedule transportation. Gas mileage reimbursement is also available for members.
			
			Phone: 1- 844-525-3085
			
			Please call at least three (3) business days in advance of an appointment for driver transportation and at least one (1) business day in advance for gas mileage reimbursement.
			
			Grievances
			Phone: 877-743-8734
			Fax: 801-994-1082
			Mailing: UnitedHealthcare Community Plan
			Attn: Appeals
			PO Box 5032
			Kingston, NY 12402-5032
			
			Appeals
			Fax: 801-994-1082
			Mailing: UnitedHealthcare Community Plan
			Attn: Appeals
			PO Box 5032
			Kingston, NY 12402-5032
				MTM
				https://www.mtm-inc.net/providers/training/
				
				https://www.molinahealthcare.com/providers/ms/medicaid/contacts/contact_info.aspx
				
				How to Request Transportation
				• Monday to Friday from 7 a.m. to 8 p.m. (CST)
				• Member Reservation Line: 1-888-597-1206
				• Facility Line: 1-888-597-1203.
				  ○ Facility Line is dedicated for use by Health Plan Case Managers, Health Plan Representatives and Medical Facilities only.
				  ○ If Health Plan calls in trip request, no additional Prior Authorization is needed.
				• You must call at least 3 business days prior to the appointment
				• Full name, address, phone number, date of birth
				• Medicaid ID number
				• Confirm pick up address
				• Date of the healthcare visit
				• Name, address and phone number of the place member is going
				• Medical reason for the visit
				
				Modes of Transportation
				• Public transit (bus)
				• Sedan
				• Public Motor Vehicle
				• Multi-passenger Van
				• Volunteer Driver
				• Wheelchair Van
				• Stretcher/Ambulance
				• Gas mileage reimbursement (GMR)
				
				Things to Remember
				• Monday to Friday from 7 a.m. to 8 p.m.
				• Member Reservation Line 1-888-597-1206

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		Transportation to the following out of state counties is approved: • Tennessee: Shelby, McNairy, Hardin, Davidson, Madison • Louisiana: Madison, St. Tammany, Orleans, Concordia, Jefferson, East Baton Rouge, West Feliciana • Alabama: Mobile, Jefferson, Tuscaloosa • Arkansas: Phillips, Pulaski Where's My Ride: • 1-866-334-3794 Hours of Operation: • M-F 7:00am-8:00pm Routine Appointments • 24/7/365 Urgent Appointment Transportation to an out of state county not listed above requires an approved Distance Verification Form from referring/rendering healthcare provider Community Outreach • CO-MS@mtm-inc.net Support Team: • CM-Mississippi@mtm-inc.net Compliance/Quality Team: • QM@mtm-inc.net Complaints: • 1-866-912-3285 www.mtm-inc.net/mississippi		• You must call at least 3 business days prior to the appointment • Full name, address, phone number, date of birth • Medicaid ID number • Confirm pick up address • Date of the healthcare visit • Name, address and phone number of the place member is going • Medical reason for the visit

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Emergency Transportation	Emergency transportation includes ambulance, air transportation, and other. **Transportation, Part 201, Chapter 1, Ambulance** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-201.pdf **Ambulance Fee Schedule** https://medicaid.ms.gov/providers/fee-schedules-and-rates/#	Emergency transportation via ambulance and helicopter do not require authorization. Airplane/Fixed wing ambulance transportation requires prior authorization. Members should use an ambulance for emergency services. Members can ONLY be transported to a hospital ER for services. https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/CAID20110-MS2020PrvdrHndbk.pdf	Emergency and facility-to-facility transportation is handled by ambulance (air and ground) in accordance with Mississippi Medicaid (see Medicaid FFS). All generally accepted billing and modifiers apply to claims. Reimbursement is based on Medicaid rates and methodology. **Facility-to-Facility transportation requires a prior authorization AND a medical authorization for the receiving facility. The transportation auth will be denied if the transfer facility auth is not on file.** **Online:** www.UHCprovider.com/Link **Phone:** 877-743-8734 **Grievances** **Phone:** 877-743-8734 **Fax:** 801-994-1082 **Mailing:** UnitedHealthcare Community Plan Attn: Appeals PO Box 5032 Kingston, NY 12402-5032 **Appeals** **Fax:** 801-994-1082 **Mailing:** UnitedHealthcare Community Plan Attn: Appeals PO Box 5032 Kingston, NY 12402-5032	• Emergency services encompass covered inpatient and outpatient services, inclusive of dialysis services, that are furnished by a Medicaid qualified provider and needed to evaluate or stabilize an Emergency Medical Condition. • Emergency services do not require a prior authorization and will be reimbursed no less than the amount Medicaid reimburses Fee-For Service Providers, regardless of the provider's network participation. • Molina's goal is to ensure our members are accessing care in the appropriate setting. Our Care Management team will be actively involved with our members to assist them with how and where to seek treatment that best meets their needs. **MSCAN and CHIP Provider Manuals** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Dental Services***	**Dental Services, Part 204** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-204.pdf **Dental Services State Plan Amendment 2019** MS-SPA-19-0010-Dental-and-Orthodontic-Reimbursement-approved-pages.pdf **Dental Fee Schedule** https://medicaid.ms.gov/providers/fee-schedules-and-rates/# The Division of Medicaid requires prior authorization, except for emergencies, for certain medically necessary dental services by the Division of Medicaid's Utilization Review/Quality Improvement Organization (UM/QIO) or a contracted CCO's UM/QIO for non-EPSDT beneficiaries. The Division of Medicaid covers medically necessary dental services for EPSDT-eligible beneficiaries including: a) Diagnostic, b) Preventive, c) Therapeutic, d) Emergency, and e) Orthodontic. $2500 Annual Dental Benefit Limit $4,200/Beneficiary Per Lifetime Orthodontic Limit	All members have $2500 annual benefit limit Orthodontia Benefits are available to members age 20 and under, $4200 maximum per lifetime Credentialing Credentialing may take up to 90 days After credentialing is confirmed, you may register for the Provider Web Portal by contacting Provider Services at 844-464-5636 Claims: Claims timely filing is 180 days Payments for clean claims are made within 25 days and 35 days for paper claims Members with dual insurance coverage, submit claims to member's primary insurance first and then submit claim to Envolve with copy of the primary EOB For clearinghouse submissions with Envolve Dental, use payor ID – 46278 Option to enroll in Electronic Funds Transfer for quick payments Standard authorization requests: Submit complete documentation requirements to Envolve Dental at least fourteen (14) calendar days but no later than five (5) calendar days before a scheduled procedure that requires prior authorization. Determination is provided within 3 calendar days or 2 business days after receiving required documentation Emergency requests are determined within 24hrs Pre-payment review: In situations that involve severe pain, swelling, infection, hemorrhage, or trauma. Dental providers are encouraged to treat the member, call Envolve Dental within two business days to record the incident in the member's Envolve Dental record,	**General Information** **Online:** www.uhcproviders.com/ **Provider Services:** 1-800-508-4862 **Prior Authorization and COC** **Phone:** 1-800-508-4862 **Claim Submission** **Online:** www.uhcproviders.com/ **Mailing:** **Claims** P.O. Box 1391 Milwaukee, WI 53201 **Grievances** **Phone:** 1-800-508-4862 **Mailing:** UnitedHealthcare P.O. Box 1391 Milwaukee, WI 53201 **Appeals** **Mailing:** UnitedHealthcare P.O. Box 1391 Milwaukee, WI 53201	**General Network information** – Available on www.avesis.com How to become an Avēsis provider Visit www.avesis.com for provider contracting /credentialing information and all documentation is available along with the link to obtain assistance. General Covered Benefits: • Dental Program: Standard MississippiCAN and CHIP dental benefits for members over/under 21, exams, cleaning, etc., orthodontics (prior authorization required) • Hearing Program: Hearing Tests and Hearing Aids are limited to members under 21 Contact information for provider services - • 833-282-2419 Monday through Friday, 7:00 a.m. to 8:00 p.m. EST • Provider Relations - Kari Lewis - 410-413-9206 or Klewis@avesis.com • Provider Relations Internal - Jarhonda Brown - 410-413-9113 or jlbrown@avesis.com • Provider Relations Supervisor - Dana Flood - 410-413-9230 or dflood@avesis.com **CLAIMS** ▪ Clean claims are processed and adjudicated within 15 business days. State guidelines are within 30 days. ▪ A clean claim must include correct member information, provider, rendering service location , and billing information along with services provided. **Please note that the 5 leading zeros must be included as part of the member ID that is printed on the member's card.* ▪ Checks are run weekly.

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		and then submit the claim with all required documents on a 2012 ADA claim form marked "Retrospective Review" or "Pre-payment Review." BLEs: Prior to rendering services to members, please submit the BLE form and documentation to Envolve Dental by email to mail: BLE@EnvolveHealth.com **Envolve Dental** **Authorizations/BLE** **P.O. Box 25255** **Tampa, FL 33622-5255** A checklist and BLE form are included in our Provider Web Portal. Prior to rendering services to members, please submit the BLE form and documentation to Envolve Dental for review. - Note: Please do not submit the BLE form via the Provider Web Portal. Please see provider manual for additional information regarding BLE process For more information and to review benefit information, Envolve Dental can be contacted in the following ways: Web Portal: https://pwp.envolvedental.com Email: providerrelations@envolvehealth.com Provider Services: 844-464-5636 Fax: 844-815-4448 Contracting/Credentialing: 844-847-9807		▪ Electronic Funds Transfer (EFT) payments are deposited weekly. *Claim filing information* Avēsis Provider Portal – to gain access contact your provider relations representative Clearinghouse Submission – Avēsis Payor ID -86098 On a claim form to: Avēsis Dental Claims P.O. Box 38300 Phoenix, AZ 85069-8300 Online resources – Available at www.avesis.com To obtain a copy of the Orthodontic Continuation of Care form visit the Avesis provider portal at www.Avesis.com located under the knowledge center and forms. **Prior Authorization of Dental Treatment in an Out-patient department or Ambulatory Surgery Center setting must be submitted as follows:** • Providers should submit request using ADA code D9999 with the required Molina Mississippi Hospital Worksheet and all services that are requested to be performed on the ADA Claim form. • If **approved**, Avesis is to submit the request to Molina including the Avesis dental authorization to review and determine the approval of the Out- Patient department or ASC facility. • The final determination with both Avesis Dental and Molina Out- Patient facility Prior Authorization numbers will be emailed or faxed to the provider. The member can then be scheduled for treatment requested. • A copy of the determination will also be received via mail.

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
				• If **denied**, the provider and member have options listed for the appeals process on the notification received. ***Please note that all provider fax, and email information must be kept up to date***

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare

Vision Services**	Vision service is an optional benefit under the state's Medicaid program and financial assistance is provided as follows:
	
	A. Eyeglasses for all Medicaid beneficiaries who have had surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses are medically indicated within six (6) months of the surgery and is in accordance with rules established by Medicaid, or
	B. One (1) pair of eyeglasses every five (5) years and in accordance with rules established by Medicaid. In either instance, the eyeglasses must be prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the beneficiary selects.
	C. Eye exams for all eligible beneficiaries are covered
	
	Administrative Code Title 23: Medicaid Part 217 Vision Services
	https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-217.pdf
	
	Vision Fee Schedule
	Vision-Fee-Schedule-Print-Date-11032020-clf-final.pdf (ms.gov)
		Routine Exam Services - Eligible diagnosis for preventive vision exams can be found on our website at envolvevision.com/forms. Navigate to the Eligible ICD Coding Information section and select the Eligible ICD Codes for all other States (PDF).
		
		Medically necessary eyewear covered:
		Medically necessary eye care services covered for all members. Medical/Surgical services are subject to Evolve Vision Utilization Management policies and procedures. Policies and procedures can be found by logging into Eye Health Manager at envolvevision.com/logon.
		
		Providers should comply with Magnolia Health Plan's drug formulary or preferred drug list when prescribing medications for a members. This information can be found at www.magnoliahealthplan.com/for-members/pharmacy/.
		
		Dispensing Requirements (male/female, adult/child):
		Providers must have a selection of at least 30 standard-size frames available at no cost to the member. Frames must meet the following requirements:
		• Only standard frames are covered. Deluxe frames are not covered. Providers may not dispense a more expensive frame than is covered under the Medicaid Program and bill the member for the difference.
		• Eyeglass frames should be durable and constructed to be normally resistant to damage or breakage to minimize the need for replacement.
		
		Lenses must meet the following requirements:
		• Plastic or glass lenses are covered for members age 21 and over. Polycarbonate, plastic, or glass lenses are covered for members under age 21.
			MARCH® Vision Care
			6601 Center Drive West, Suite 200
			Los Angeles, CA 90045
			Website: www.marchvisioncare.com
			Provider Website: www.providers.eyesynergy.com
			• Click on the Contact Us link to email us or
			• Call the Mississippi State toll free number (844) 60-MARCH or (844) 606-2724 between the hours of 7:30AM – 5:30PM CT
			
			Our ***new*** Contact Us page on www.marchvisioncare.com allows providers to enter their specific contact information, choose a subject that will help get your question or issue to the appropriate teams for faster resolution. It has a description free form text box where providers can detail their questions and/or issues which will allow MARCH® team members to research prior to contacting the provider to help drive provider satisfaction. The new page also offers two contact options in which the provider prefers to be contacted either via email or phone. Turn around time metrics are in place to assure questions and/or issues are resolved timely.
			
			What can you find on www.marchvisioncare.com?
			• Provider Reference Guide includes Mississippi specific details about plan administration, Contact Information, Benefits and Eligibility verification and confirmation numbers, electronic payment information, Claims submission options – eyesynergy®, EDI, Paper Claims and Corrected Claim submission instructions, Standards of Care outline and Credentialing requirements
			• Mississippi specific benefits for Medicaid and CHIP members
			• Frame Kit catalogs
			• Demographic and Application Forms
				Routine vision, which includes a comprehensive eye exam and eyewear, is provided through our third-party vendor, MARCH® Vision Care.
				Who is MARCH® Vision Care?
				• MARCH® specializes in the administration of vision care benefits for health care organizations, specifically for government sponsored programs such as Medicaid, Medicare, and Medicare-Medicaid plans.
				• MARCH® partners with dedicated eye care professionals throughout the United States and currently supports over 6 million Medicaid and Medicare members nationwide.
				CREDENTIALING
				All providers are required to complete an electronic Provider Credentialing Application or submit their CAQH number for credentialing.
				
				How to Become a MARCH® Vision Care Provider
				To become a MARCH® Vision Care provider, visit www.marchvisioncare.com > Join the Network and complete the online MARCH® Provider Application.
				MARCH® Contact Information
				Providers may contact MARCH® Vision Care by:
				• Website: www.marchvisioncare.com
				  ○ Choose your specific state toll free number
				  ○ Contact Us link
				• Email: providers@marchvisioncare.com
				• Address: 6601 Center Drive West, Suite 200
				• Los Angeles, CA 90045
				
				To access online provider resources go to marchvisioncare.com > Provider Resources to view:
				➢ State specific telephone numbers
				➢ Contact Us via email
				➢ Provider Reference Guide
				➢ State specific benefits
				➢ Frame Kit catalogs
				➢ Demographic and Disclosure Forms
				MARCH® administers:

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		• All lenses must meet FDA impact resistant regulations. A member may purchase non-covered lens features such as scratch resistant or anti-reflective coating. If a member chooses to purchase non-covered services, the member must be properly advised in advance and documentation must be maintained in the member's medical records of such election. Additionally a provider may collect these charges directly from the member. Medically Indicated EyeWear – Prior authorization is not required for medically necessary eyewear, however is subject to retrospective review. Prosthetic eyes are a covered service for members under 21. Prior authorization is not required, however, providers are instructed to attach the invoice when submitting a claim for prosthetics. **Prior authorization is required for the following:** J2778 (Lucentis), J0178 (Eylea), J0179 (Beovu), J2503 (Macugen), J3396 (Visudyne) and J3398 (Luxturna), Unlised procedure codes and experimental or investigational procedures. Note : J9035 (Avastin) does not require prior authorization for participating providers. Prior authorization requests should be submitted to envolvevision.com/logon or via fax at (877) 865-1077 Requests for prior authorizations for the ocular injectables listed above must be sent using Prior Authorization Request for Anti-VEGF Injectables (PDF) located on the Envolve website at envolvevision.com/forms All procedures must be performed at a participating facility. Non-emergency services performed without prior authorization will be denied and the member	• Training and Education Brain Sharks and guides 1. Dedicated Mississippi Provider Relations Advocate. 24/7 access to eyesynergy® (sSubmit claims and materials orders, check patient eligibility, generate confirmation numbers and view claim payments). 2. Quarterly newsletters containing new or changes in existing processes emailed and/or faxed to all providers	➢ Routine eye exams and materials that include polycarbonate and/or anti-reflective coating at no charge to the member ➢ Frame and lens replacements after cataract surgery benefits for Molina Healthcare of Mississippi – MississippiCAN members. **PROVIDER PORTAL** eyeSynergy® is MARCH® Vision Care's web portal that gives you 24/7 access to eligibility, benefits, claims and lab order information. • To register and access eyeSynergy®, visit providers.eyesynergy.com. • We encourage you to enroll to receive payments electronically for faster claims payments • MARCH® Vision Care partners with PaySpan® Health for Electronic Funds Transfers (EFTs) and Electronic Remittance Advices • (ERAs). • This service is FREE to MARCH® Vision Care providers. • PaySpan® Health enables online presentment of remittance/vouchers and straight-forward reconciliation of payments to empower our providers to reduce costs, speed secondary billings, improve cash flow, and to help the environment by reducing paper usage. **Where to Find Participating Network Providers** MARCH® Vision Care offers a diverse panel of providers who can be found in the online provider directory. To access the directory, visit the "Locate a Provider" page on MARCH®'s website www.marchvisioncare.com. You can search for providers by using specific criteria (i.e. plan state, benefit plan, zip code, provider name, etc.).

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		will be held harmless for payment of benefits normally covered under their benefit plan. **Eligibility should be verified prior to rendering services.** Providers may contact Envolve Vision by phone at 888- 241-0663 or online at The Eye Health Manager (www.envolvevision.com/logon) to learn more about the benefit limitations.		

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Therapy Services (Speech, Physical, Occupational)	**Therapy Services, Part 213** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-213.pdf **Envision Fee Schedule and Rates** https://medicaid.ms.gov/providers/fee-schedules-and-rates/ https://msmedicaid.acs-inc.com/msenvision/questionanswer.do?CATEGORY_TYPE=Therapy	Prior Authorization for Initial Evaluation for Physical Therapy, Occupational Therapy, and Speech Therapy services is not required. Prior Authorization is required for Physical Therapy, Occupational Therapy, and Speech Therapy services for members age 13 and older after completion of the Initial Evaluation and for continuation of therapy. Prior Authorization Form(s) can be located on our website at: http://www.magnoliahealthplan.com/for-providers/provider-resources/ Authorizations can be submitted: Fax: 1-877-650-6943 Web: www.provider.magnoliahealthplan.com Phone: 1-866-912-6285 Email: magnoliaauths@centene.com	**General Information** **Online:** www.myoptumhealthphysicalhealth.com **Provider Services:** 877-743-8734 Therapy agreements are initiated by OptumPhysical Health. Existing UHC medical agreements can be amended to include any therapy services through UHC. **Prior Authorization** **Online:** www.UHCprovider.com/Link > Prior Authorization and Notification **Phone:** 877-743-8734 **Claim Submission** **Online:** www.UHCprovider.com/Link **Mailing:** UnitedHealthcare P.O. Box 5032 Kingston, NY 12402-5032 Link Training On Line: www.uhcprovider.com/Link Training Education for Electronic Transactions **phone:** 800-842-1109 **Grievances** **Online:** www.UHCprovider.com/Link **Phone:** 877-743-8734 **Fax:** 801-994-1082 **Appeals** **Online:** www.UHCprovider.com/Link **Fax:** 801-994-1082 **Mailing:** UnitedHealthcare Community Plan Attn: Appeals P O Box 5032 Kingston, NY 12402-5032	Please review our PA requirements for Therapy Services here: https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx Therapy Services includes: ▪ Active POC ▪ Therapy within 30 days of the treatment plan ▪ Certificate of Med necessity by prescribing provider ▪ Measurable goals Therapy Services not included: ▪ Services that does not meet medical necessity ▪ Services duplicate therapy ▪ Services provided by Physical therapy aids ▪ Services in a group Please file the appropriate modifiers for therapy services.: ▪ GN ▪ GO ▪ GP Failure to follow the above referenced guidelines may result in delays processing your request, or a denial. **Provider Manual** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx **Frequently Used Forms** https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx **Utilization Management** https://www.molinahealthcare.com/providers/ms/medicaid/resource/utilized_mgt.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare

Medical Services Reconsideration	Providers may submit requests for reconsideration of closed or open procedure codes, maximum units allowed, and other medical service reconsiderations.
	
	The Fee-for-Services information is located on DOM website:
	
	Reconsideration Process
	Fee-for-Service Forms link:
	https://medicaid.ms.gov/resources/forms/
	
	Reconsideration form link:
	https://medicaid.ms.gov/wp-content/uploads/2014/04/ClaimCheck_Reconsideration_Form.pdf
	
	Appeals Process
	Administrative Code Part 300 link (Provider Appeals): https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-300.pdf
		Magnolia Health works in conjunction with Medicaid to consider services that are otherwise not covered or restricted by the Mississippi Medicaid fee schedule.
		
		A request for reconsideration is a communication from the provider about a disagreement with the manner in which a claim was processed. Generally medical records are not required for a request for reconsideration; however, if the request for reconsideration is related to a code audit, code edit, or authorization denial, medical records must accompany the request for reconsideration.
		
		If the medical records are not received, the original denial will be upheld.
		
		Reconsiderations may be submitted in the following ways:
		• Magnolia Health's Secure Portal at www.provider.magnoliahealthplan.com
		• Providers may send a written letter that includes a detailed description of the reason for the request. In order to ensure timely processing, the letter must include sufficient, identifying information, which includes, at a minimum, the following:
		  o language stating it is a request for reconsideration
		  o Member's ID number and Name
		  o Date of Service
		  o Total Charges
		  o Provider Name
		  o Original EOP
		  o and/or Original Claim Number
		Written requests for reconsideration and any applicable attachments must be mailed to:
		Magnolia Health
		Attn: Claim Reconsiderations
		P.O.Box 3090
		Farmington, MO 63640
		Denied claims should be addressed in accordance with the timely filing guidelines.
			UHC works in conjunction with Medicaid to consider services that are otherwise not covered or restricted by the Mississippi Medicaid fee schedule.
			
			A review for medical necessity should be obtained. For denied claims or authorizations, please contact **Provider Services:** 877-743-8734
			
			Denied claims should be addressed in accordance with timely filing.
				The denial or limited authorization of a requested service, including determinations on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized services; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the Division of Medicaid.
				
				Reconsiderations may be filed via the following methods:
				Preferred Method – online via Molina's Provider Portal:
				https://provider.MolinaHealthcare.com/provider/login
				
				Fax: (844) 808-2409
				
				Mail:
				Molina Healthcare of Mississippi, Inc.
				Attention: Provider Grievance & Appeals
				188 E. Capitol Street, Suite 700
				Jackson, MS 39201
				
				Please visit our website to review this information:
				https://www.molinahealthcare.com/providers/ms/medicaid/home.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Behavioral Health***	**Administrative Code Title 23: Medicaid, Part 206, Mental Health Services** https://medicaid.ms.gov/wp-content/uploads/2020/11/Title-23-Part-206-Mental-Health-Services-effective-11.1.20.pdf **Autism Spectrum Disorder (ASD) Services** Autism-Spectrum-Disorder-ASD-FEE-SCHEDULE-Print-Date-11-03-2020zp.pdf **Community Mental Health Services** https://medicaid.ms.gov/wp-content/uploads/2020/11/NT-CMH-Services-Fee-Schedule-Print-Date-11032020-002.pdf **Intellectual/Developmental Disabilities 1915(i) Community Support Program** https://medicaid.ms.gov/wp-content/uploads/2019/02/IDDD-CSP.pdf **Mississippi Youth Programs Around the Clock (MYPAC)** https://medicaid.ms.gov/wp-content/uploads/2017/05/MYPAC_Fee-Schedule.pdf Providers must submit authorization documentation to DOM for all MYPAC members. Providers must also submit authorization documentation to CCOs for MississippiCAN members. **Opioid Treatment Program fee schedule** https://medicaid.ms.gov/wp-content/uploads/2020/11/Opioid-Treatment-Program-Fee-Schedule-Print-Date-11032020.pdf **Psychiatry and Psychiatric Nurse Practitioners for Mental Health/Psychiatry Services** https://medicaid.ms.gov/wp-content/uploads/2020/11/Psychiatry-and-	**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 • Acute services members are approved for 5-7 days if medical necessity is met. Then the UM will request discharge planning information every three days until discharge to identify any barriers and to assist with members having appropriate follow up services. This will also allow us to involve Care Management services earlier in the members admission. • 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. After the first 60 days of admission, the UM will request discharge planning information monthly to identify any barriers to	**General Information** **Online:** www.UHCprovider.com/Link **Provider Services:** 877-743-8734 **Prior Authorization** **Online:** www.providerexpress.com/Behavioral Health PA **Phone:** 877-743-8734 **Claim Submission** **Online:** www.UHCprovider.com/Link **Mailing:** UnitedHealthcare P.O. Box 5032 Kingston, NY 12402-5032 Link Training On Line: www.uhcprovider.com/Link Training Education for Electronic Transactions **phone:** 800-842-1109 **Grievances** **Online:** www.UHCprovider.com/Link **Phone:** 877-743-8734 **Fax:** 801-994-1082 **Appeals** **Online:** www.UHCprovider.com/Link **Fax:** 801-994-1082 **Mailing:** UnitedHealthcare Community Plan Attn: Appeals P O Box 5032 Kingston, NY 12402-5032	**LaKeida Ward** Sr. Rep, Provider Services (Behavioral Health) (601) 317-4313 LaKeida.Ward@molinahealthcare.com MSBHProviderServices@MolinaHealthCare.Com Molina follows the Division of Medicaid guidance and Fee Schedules for reimbursement for the following Behavioral and Mental Health services: ▪ 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/# Please review our Prior Authorization Guidelines for a list of Behavioral and Mental Health Services that require authorization. The Behavioral and Mental Health PA Form is also listed at the https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx https://www.molinahealthcare.com/providers/ms/medicaid/resource/utilized_mgt.aspx Please reference our Provider Enrollment, Credentialing, Claims, and Appeals and Grievance slides for information and instructions for Behavioral Mental and Health providers.

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
	Psychiatric-Nurse-Practitioners-MHS-Fee-Sch-Print-Date-11032020.pdf **Therapeutic and Evaluative Mental Health Services for Expanded EPSDT (T&E)** https://medicaid.ms.gov/wp-content/uploads/2020/11/Therapeutic-and-Evaluative-Mental-Health-Services-Fee-Schedule-Print-Date-11032020.pdf **Psychiatric Residential Treatment Facilities (PRTF) 2020** https://medicaid.ms.gov/wp-content/uploads/2020/07/PRTF-2020-Rates.pdf	discharge, and to allow involvement from care Management. • 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 Clinical Appeals & Quality Review Pre-Service appeals are requests to have prior authorization denials reviewed. **If services have been rendered, the claim dispute process should be followed.**		

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		Appeals/Retro Overview Communication about Appeals are received by the coordinators: ❑ Via mail ❑ Via email ❑ Via fax ❑ Telephone **Appeal Coordinators Process: Standard Prior Authorization *Requests:*** ❑ *Pre-service* appeal ❑ Expedited appeal ❑ Retroactive Authorization ❑ Peer to Peer request Appeal Mailing Address: 12515-8 Research Blvd Austin, TX 78759 Appeal Email: appeals@cenpatico.com Appeal Fax: 866-714-7991 Provider Services: 866-912-6285		

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Federally Qualified Health Center (FQHC)*	**Administrative Code Title 23: Medicaid Part 211, Federally Qualified Health Centers (FQHC)** https://medicaid.ms.gov/wp-content/uploads/2013/12/Admin-Code-Part-211.pdf **Federally Qualified Health Center (FQHC) 2020** https://medicaid.ms.gov/wp-content/uploads/2020/01/2020FQHC.pdf **Federally Qualified Health Center (FQHC) Enrollment and Provider Updates** • Submit clinic enrollment or change of ownership (CHOW) documentation to both Medicaid FFS and Medicaid managed care organizations simultaneously. • Submit servicing provider documentation also. • Update servicing provider information immediately when providers are added to the clinic roster and when they are removed from the clinic roster.	FQHC Enrollment: New Group Contract Process To begin the contracting process, complete the Join Our Network **Form** in its entirety and submit online**.** This information 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 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.*** 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	FQHC/RHC: The following items are contracting requirements for FQHC/RHC. UHC Community Plan must have these items when completing a contract with a FQHC/RHC. Individual provider must complete CAQH application to complete the credentialing process Facility Credentialing Application Provider Roster (This is a specific Roster Template for FQHC/RHCs) W9 General and professional liability insurances Rate Letters for Medicaid Rate Letters for Medicare Clean Disclosure To request the facility credentialing application: **MS-FQHC-RHC@uhc.com** To request the FQHC/RHC Provider Roster Template: **MS-FQHC-RHC@uhc.com** or your Network Account Manager To submit updates/changes/additions to your roster: **MS-FQHC-RHC@uhc.com**	The Division of Medicaid limits reimbursement to FQHCs 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: • A physician, physician assistant, nurse practitioner, or nurse midwife • A dentist • An optometrist • A clinical psychologist or clinical social worker. FQHCs are reimbursed an encounter rate. Please view the rates on the Division of Medicaid Fee Schedule: https://medicaid.ms.gov/providers/fee-schedules-and-rates/# • FQHCs must file POS 50 • Failure to file the correct POS will result in a claim denial. 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. **Earl Robinson** Manager, Provider Services and FQHC Representative 601-760-2433 Earl.Robinson@molinahealthcare.com

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		• Collaborative practice agreement (Nurse Practitioners and Physician Assistants) • W-9 • Locations page **Rates:** • FQHCs can obtain their current "per visit rate" by reviewing www.ms-medicaid.com/msenvision/ProviderRates. Please make sure to submit updated rate letter or changes timely to ensure proper claims reimbursement. • 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, unless otherwise stated in your contract • 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. For information on EPSDT services, please click here. For additional questions, please contact Provider Services at 1-866-912-6285		Please reference our Provider Enrollment, Credentialing, Claims, Appeals and Grievance, and Prior Authorization slides for information and instructions for FQHCs.

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Rural Health Clinic (RHC)*	**Administrative Code Title 23: Medicaid, Part 212, Rural Health Clinics** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-212.pdf **Rural Health Clinics (RHC) 2020** https://medicaid.ms.gov/wp-content/uploads/2020/01/2020RHC.pdf **Rural Health Clinics (RHC) Updates** Mississippi Envision (ms-medicaid.com) **Rural Health Clinics (RHC) Updates** MS SPA 20-0007 Rural Health Center (RHC) Services submitted to CMS | Mississippi Division of Medicaid Reeves Administration announces temporary Medicaid changes in response to coronavirus outbreak | Mississippi Division of Medicaid (ms.gov) SPA 18-0013 RHC Physician Administered Drugs (PAD) approved by CMS | Mississippi Division of Medicaid **Rural Health Clinics (RHC) Enrollment and Provider Updates** • Submit clinic enrollment, or change of ownership (CHOW) documentation to both Medicaid FFS and Medicaid managed care organizations simultaneously. • Submit servicing provider documentation also. • Update servicing provider information immediately	RHC Enrollment: New Group Contract Process To begin the contracting process, complete the Join Our Network **Form** in its entirety and submit online **via** www.MagnoliaHealthPlan.com website. **NOTE: This form CANNOT be used to start the Credentialing process for individual physicians.* **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.*** 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	FQHC/RHC: The following items are contracting requirements for FQHC/RHC. UHC Community Plan must have these items when completing a contract with a FQHC/RHC. Individual provider must complete CAQH application to complete the credentialing process Facility Credentialing Application Provider Roster (This is a specific Roster Template for FQHC/RHCs) W9 General and professional liability insurances Rate Letters for Medicaid Rate Letters for Medicare Clean Disclosure To request the facility credentialing application: **MS-FQHC-RHC@uhc.com** To request the FQHC/RHC Provider Roster Template: **MS-FQHC-RHC@uhc.com** or your Network Account Manager To submit updates/changes/additions to your roster: **MS-FQHC-RHC@uhc.com**	The Division of Medicaid limits reimbursement to RHCs 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: • A physician, physician assistant, nurse practitioner, or nurse midwife • A dentist • An optometrist • A clinical psychologist or clinical social worker. RHCs are reimbursed an encounter rate. Please view the rates on the Division of Medicaid Fee Schedule: https://medicaid.ms.gov/providers/fee-schedules-and-rates/# • RHCs must file POS 72 • Failure to file the correct POS will result in a claim denial. Please reference our Provider Enrollment, Credentialing, Claims, Appeals and Grievance, and Prior Authorization slides for information and instructions for RHCs.

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
	when providers are added to the clinic roster and when they are removed from the clinic roster.	**Rates:** 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 For information on EPSDT services, click here. For additional questions, please contact Provider Services at 1-866-912-6285		

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Pharmacy*	DOM Pharmacy Preferred Drug List (PDL) is the same for Medicaid fee-for-service, MississippiCAN, and CHIP. **Pharmacy Services, Part 214** https://medicaid.ms.gov/wp-content/uploads/2014/01/Admin-Code-Part-214.pdf **DOM Pharmacy website** https://medicaid.ms.gov/providers/pharmacy/	**Magnolia's Pharmacy Benefit Manager (PBM) is Envolve Pharmacy, a subsidiary of Centene Corporation.** Envolve Pharmacy follows the Medicaid Preferred Drug List (PDL) found here: https://medicaid.ms.gov/providers/pharmacy/preferred-drug-list/ **For Pharmacy PA request through Envolve, follow the steps below:** • Complete the Magnolia/Envolve Pharmacy Solutions Medication Prior Authorization Request form, which can be found on the Magnolia Health's website at www.magnoliahealthplan.com. Choose "For Providers" → "Pharmacy" → and then select MISSISSIPPICAN (MEDICAID). • Fax completed forms to Envolve Pharmacy Solutions at 1-877-386-4695. • Once approved, Envolve Pharmacy Solutions notifies the prescriber by fax. • If the clinical information provided does not explain the reason for the requested prior authorization medication, Envolve Pharmacy Solutions responds to the prescriber by fax, offering DOM PDL alternatives. • For urgent or after-hours requests, a pharmacy can provide up to a seventy-two (72) hour supply of most medications by calling the Envolve Pharmacy Solutions Pharmacy Help Desk at: 1-800-460-8988. **Envolve Pharmacy Solutions Contacts:** **Prior Authorization Fax:** 1-877-386-4695 **Prior Authorization Phone:** 1-866-399-0928 **Pharmacy Help Desk Phone:** 1-800-460-8988 **Clinical Hours**: Monday through Friday, 7:30a.m. - 6:00 p.m. (CST) **Mailing Address:** Envolve Pharmacy Solutions, 2425 W Shaw Ave, Fresno, CA 93711	DOM Pharmacy Preferred Drug List (PDL) is the same for Medicaid fee-for-service, MississippiCAN, and CHIP. Benefit is administered by OptumRX **General Information** **RX Provider Services:** 877-305-8952 **Prior Authorization Online:** www.UHCprovider.com/Link > Prior Authorization and Notification **Phone:** 877-743-8734 **Fax:** 866-940-7328 For non-preferred medications or for those requiring prior authorization (turnaround time is typically < 24 hours) ***Emergency 3-Day Supply is available*** **Claim Submission** **Online:** www.UHCprovider.com/Link **Grievances** **Online:** www.UHCprovider.com/Link **Phone:** 877-743-8734 **Fax:** 801-994-1082 **Appeals** **Online:** www.UHCprovider.com/Link **Fax:** 801-994-1082 **Mailing:** UnitedHealthcare Community Plan Attn: Appeals P O Box 5032 Kingston, NY 12402-5032	Molina adheres to the criteria in DOM Pharmacy Preferred Drug List (PDL) for both the MississippiCAN, and CHIP Programs. **MSCAN Provider Manual page 25 Pharmacy Program:** https://www.molinahealthcare.com/providers/ms/medicaid/manual/~/media/Molina/PublicWebsite/PDF/providers/ms/medicaid/MS-Medicaid-Provider-Manual.pdf Emergency 72-hour prescription overrides available when prior authorization is required. **Pharmacy PA Forms** https://www.molinahealthcare.com/providers/ms/medicaid/drug/Pharmacy-Prior-Authorization-Forms.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
		When calling, please have member information, including Magnolia ID number, complete diagnosis, medication history, and current medications readily available.		
Clinical Policies		Clinical policies are one set of guidelines used to assist in administering health plan benefits, either by prior authorization or payment rules. They include but are not limited to policies relating to evolving medical technologies and procedures, as well as pharmacy policies. Clinical policies help identify whether services are medically necessary based on information found in generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by the policy; and other available clinical information. Clinical policies can be found on Magnolia Health's website at: https://www.magnoliahealthplan.com/providers/resources/clinical-payment-policies.html	**Medical & Drug Policies and Clinical Guidelines:** www.uhcprovider.com/policies and clinical guidelines **Behavioral Health Policies and Clinical Guidelines:** www.providerexpress.com/clinical-resources **Dental Policies and Clinical Guidelines:** www.uhcprovider.com Dental policies-protocols	**Guidelines are listed at this link:** https://www.molinahealthcare.com/providers/ms/medicaid/resource/guide_standards.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Administrative and Claims Policies	**MS Medicaid Administrative Code** Administrative Code | Mississippi Division of Medicaid (ms.gov) **MS Medicaid Billing Manual** Billing Handbook | Mississippi Division of Medicaid (ms.gov) **CHIP State Plan** Children's Health Insurance Program (CHIP) State Plan | Mississippi Division of Medicaid (ms.gov)	Health care claims payment policies are guidelines used to assist in administering payment rules based on generally accepted principles of correct coding. They are used to help identify whether health care services are correctly coded for reimbursement. Each payment rule is sourced by a generally accepted coding principle. They include, but are not limited to claims processing guidelines referenced by the Centers for Medicare and Medicaid Services (CMS), Publication 100-04, Claims Processing Manual for physicians/non-physician practitioners, the CMS National Correct Coding Initiative policy manual (procedure-to-procedure coding combination edits and medically unlikely edits), Current Procedural Technology guidance published by the American Medical Association (AMA) for reporting medical procedures and services, health plan clinical policies based on the appropriateness of health care and medical necessity, and at times state-specific claims reimbursement guidance. Payment policies can be found on Magnolia Health's website at: https://www.magnoliahealthplan.com/providers/resources/clinical-payment-policies.html	**Community Plan Reimbursement Policies of MS:** www.uhcprovider.com/mississippi-health-plans/reimbursement-policies	**Please access our Provider Website:** https://www.molinahealthcare.com/providers/ms/medicaid/comm/training.aspx https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Provider Directory	**MS Medicaid Provider Search** Mississippi Envision (ms-medicaid.com)	Magnolia's providers directory is an important source for members to locate Magnolia's participating providers. As a Magnolia participating provider, we ask that providers review their information located within the directory for accuracy regularly. Magnolia request that providers notify the health plan immediately regarding demographic changes or updates such as: address change, location adds, office hour changes, office closures, etc. **Demographic changes can be submitted by using the form found here:** https://www.magnoliahealthplan.com/content/dam/centene/Magnolia/medicaid/pdfs/ProvUpdateFormForContrcPro.pdf **Please note that a W9 may be required to process your request for change.* Magnolia Health has partnered with VerifyHCP®, a quick and easy clinician directory verification portal developed by LexisNexis® Risk Solutions. To make attestation more efficient for you and your staff, VerifyHCP enables practices to validate or update pre-populated directory information in one place across all participating health plans. Outreach is done periodically and providers should be prepared to update their directory information from the instruction provided by this vendor.	**Provider Directory:** www.uhcprovider.com/directory	**Find a Provider** https://providersearch.molinahealthcare.com/Provider/ProviderSearch?RedirectFrom=MolinaStaticWeb&memstate=ms&State=ms&Coverage=NA

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Member Handbook	**MS Medicaid Member Services** Member Services | Mississippi Division of Medicaid (ms.gov)	The member handbook is a detailed guide to Magnolia and your healthcare benefits. It is our contract with you. The member handbook explains your rights, your benefits, and your responsibilities as a member of Magnolia's health plan. Please read this booklet carefully. This booklet tells you how to access Magnolia's healthcare services. It also gives you information on your Magnolia benefits and services such as: • What is covered by Magnolia • What is not covered by Magnolia • How to get the care you need • How to get your prescriptions filled • What to do if you are not satisfied with your health plan or coverage • Eligibility requirements • Magnolia's geographic service area • Materials you will receive from Magnolia The practices, policies, benefits, and services described herein may be modified or discontinued from time to time. Every attempt will be made to inform you within thirty (30) days of any changes as they occur. Please visit www.MagnoliaHealthPlan.com, or call 1-866-912-6285, for the most up-to-date information. Call Member Services at 1-866-912-6285 to receive an additional copy of the member handbook at no charge. You may also visit our website at www.MagnoliaHealthPlan.com to view the member handbook.	**Member Handbook** MSCHIP Site: www.uhccommunityplan.com/MSCHIP MSCHIP Member Handbook: www.uhccommunityplan.com/Chip Handbook.pdf MSCAN Site: www.uhccommunityplan.com/MSCAN MSCAN Member Handbook: www.uhccommunityplan.com/CAN Handbook.pdf Member benefits: 877-743-8731	**MSCAN** https://www.molinahealthcare.com/members/ms/en-us/mem/medicaid/overvw/handbook.aspx **CHIP** https://www.molinahealthcare.com/members/ms/en-us/mem/chip/overvw/handbook.aspx

Managed Care | MississippiCAN & CHIP 2020 Provider Desk Reference

Updated on 11/30/2020

	Medicaid Fee-for-Service	Magnolia Health	UnitedHealthcare	Molina Healthcare
Provider Manuals (CCO and Vendors)	**MS Medicaid Administrative Code** Administrative Code | Mississippi Division of Medicaid (ms.gov) **MS Medicaid Billing Manual** Billing Handbook | Mississippi Division of Medicaid (ms.gov) **CHIP State Plan** Children's Health Insurance Program (CHIP) State Plan | Mississippi Division of Medicaid (ms.gov)	Magnolia Health's along with our vendors Provider Manuals can be located on Magnolia Health's website at: www.MagnoliaHealthPlan.com Magnolia Health Provider Manual Magnolia Health MississippiCAN Provider Manual (PDF) Envolve Dental Provider Manual Envolve Dental Provider Manual (PDF) Envolve Vision Provider Manual Envolve Vision Provider Manual (PDF)	**Medical, Behavioral Health, Pharmacy and Therapy Services** www.uhcprovider.com/admin-guides **Dental** www.uhcproviders.com **Vision** www.marchvisioncare.com/MS_ProviderReferenceGuide	**MSCAN and CHIP** https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx **March Vision** https://www.marchvisioncare.com/providerresources.aspx **Avesis Dental and Hearing** https://www.avesis.com/commercial3/providers/index.aspx **MTM** https://www.mtm-inc.net/providers/training/
CCO Provider Forms	**Provider Resources:** Provider Resources | Mississippi Division of Medicaid (ms.gov) **Managed Care** Managed Care | Mississippi Division of Medicaid (ms.gov)	**Provider Resources:** Magnolia Health provides the tools and support you need to deliver the best quality of care. Helpful Provider forms and resources can be found here: https://www.magnoliahealthplan.com/providers/resources.html	**Provider Forms:** www.uhcprovider.com/forms	**MSCAN and CHIP** https://www.molinahealthcare.com/providers/ms/medicaid/forms/fuf.aspx **Pharmacy PA Forms** https://www.molinahealthcare.com/providers/ms/medicaid/drug/Pharmacy-Prior-Authorization-Forms.aspx
Communication Bulletin & Newsletters	**MS Medicaid Provider Bulletin** Provider Bulletins | Mississippi Division of Medicaid (ms.gov)	**Magnolia Provider News:** https://www.magnoliahealthplan.com/providers/provider-news.html **For Provider updates and information related to Covid-19, please visit:** https://www.magnoliahealthplan.com/providers/coronavirus-information.html	**Quarterly Provider Newsletters:** www.uhcprovider.com/Newsletter **Monthly Provider Bulletins:** www.uhcprovider.com/Provider Bulletins **News for Members:** MSCHIP: www.uhccommunityplan.com/MSCHIP MSCAN: www.uhccommunityplan.com/MSCAN	**Provider Newsletter** https://www.molinahealthcare.com/providers/ms/medicaid/comm/newsletters.aspx **Provider Training and Resources** https://www.molinahealthcare.com/providers/ms/medicaid/comm/training.aspx **Provider News** https://www.molinahealthcare.com/providers/ms/medicaid/comm/news.aspx