Mississippi Division of Medicaid

Managed Care Provider Webinar

2021

New Providers | Credentialing/Contracting | Authorizations | Claims Processing

MISSISSIPPI DIVISION OF MEDICAID

Purpose of the 2021 Provider Webinar

The purpose of today's provider workshop is to provide clarity and understanding for Mississippi Division of Medicaid Managed Care programs MississippiCAN and CHIP processes; to resolve provider and office managers' issues and concerns.

The Division of Medicaid in collaboration with the coordinated care organizations (CCOs) are ready to assist and help resolve issues and concerns.

Mission: The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

Agenda

Wednesday, November 3, 2021
1:00 p.m. – 3:00p.m.

1:00 p.m.	1:20 p.m.	Welcome & Introductions
1:20 p.m.	1:35 p.m.	Magnolia Health
1:35 p.m.	1:50 p.m.	Molina Healthcare
1:50 p.m.	2:05 p.m.	UnitedHealthcare
2:05 p.m.	2:40 p.m.	Question and Answer Session
2:40 p.m.	3:00 p.m.	Closing Remarks How to Access Presentation & Material Provider Evaluation

Welcome & Introductions

Division of Medicaid Managed Care

Sharon Jones

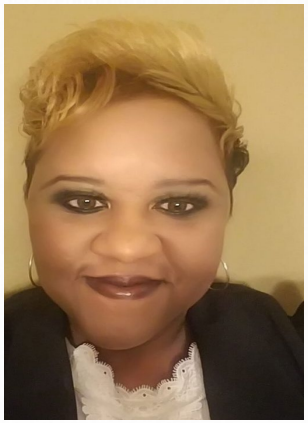
Lucretia Causey

Patricia Collier

April Burns

Magnolia Health

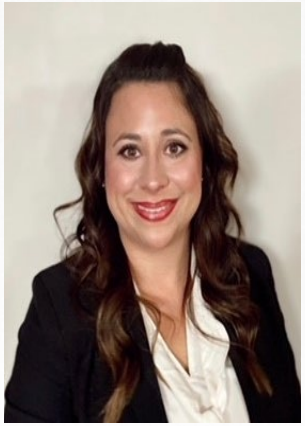
Brittany Cole



Heather Samuel

Jasmine Shaw

Katherine St Paul



Kiri Patterson

Leslie Cain

Melinda Clesca

Matt Harris

Precious Griffith

Tracy Miller

UnitedHealthcare Community Plan

Adrian Hagan

Dawn Teeter

Jamille Bernard

Kimberly Bollman

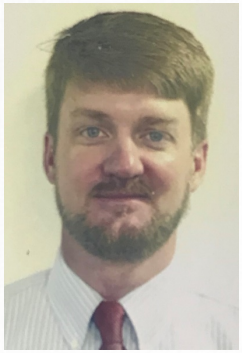
Kristi Plotner

Teresa Morris

Rhona Waldrep

Ty Klingelhofer

Molina Healthcare



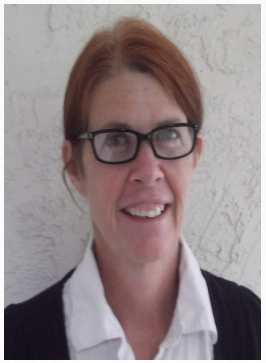
Bert Emrick

Earl Robinson

Chinwe Nichols

Chris Cauthen

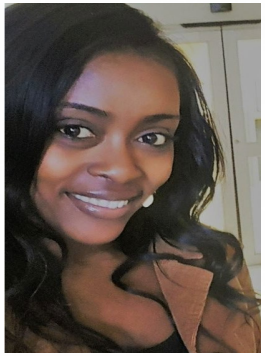
Daniel Bradshaw



Pam Canavan

Lakeida Ward

Ellie Coley

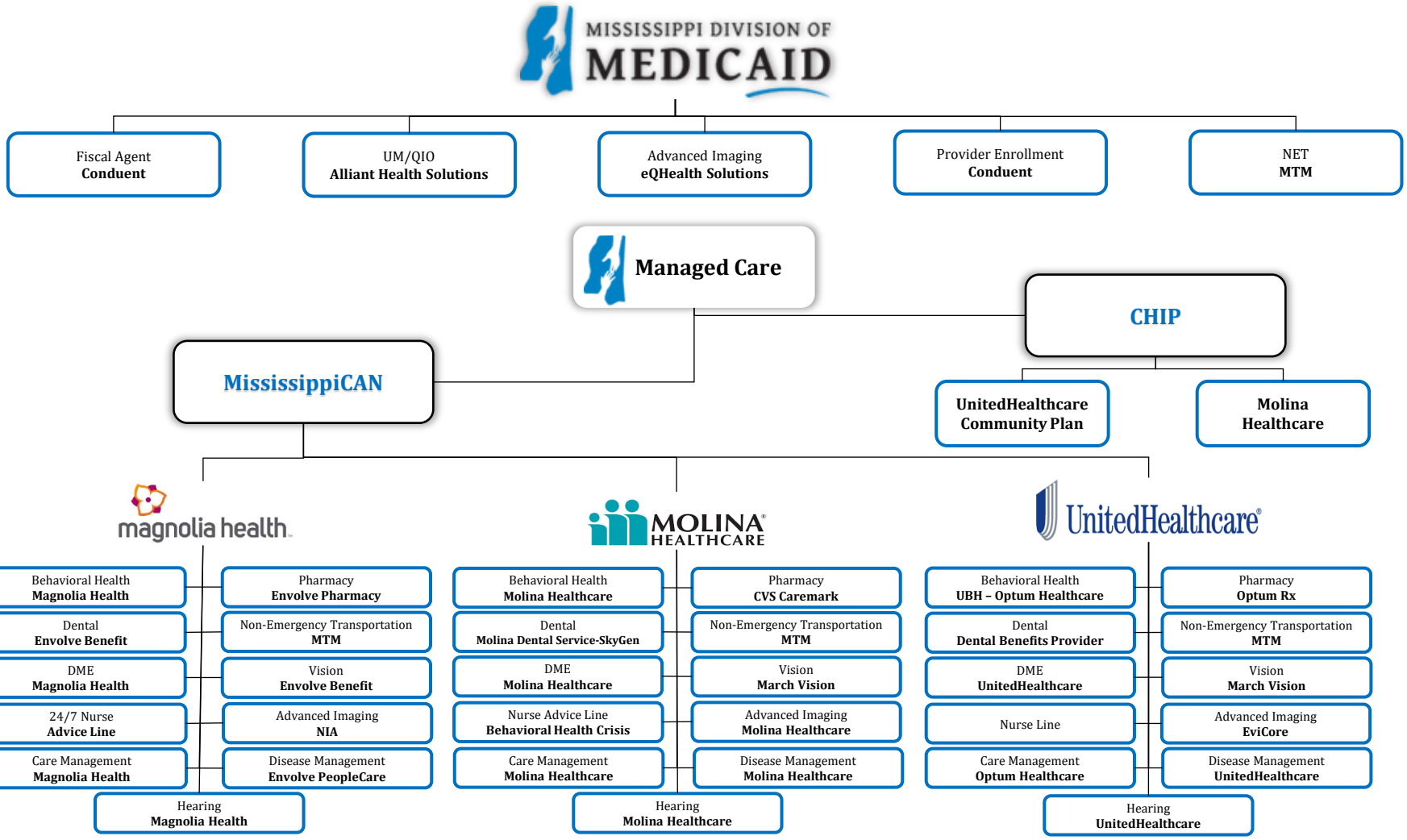


Laterria Lacy

Tamala Harris

Trina Stewart

Tuwanda Williams


MISSISSIPPI DIVISION OF MEDICAID
Fiscal Agent
Conduent
UM/QIO
Alliant Health Solutions
Advanced Imaging
eQHealth Solutions
Provider Enrollment
Conduent
NET
MTM
Managed Care
CHIP
MississippiCAN
UnitedHealthcare Community Plan
Molina Healthcare
magnolia health
Behavioral Health
Magnolia Health
Pharmacy
Envolve Pharmacy
Dental
Envolve Benefit
Non-Emergency Transportation
MTM
DME
Magnolia Health
Vision
Envolve Benefit
24/7 Nurse
Advice Line
Advanced Imaging
NIA
Care Management
Magnolia Health
Disease Management
Envolve PeopleCare
Hearing
Magnolia Health
MOLINA HEALTHCARE
Behavioral Health
Molina Healthcare
Pharmacy
CVS Caremark
Dental
Molina Dental Service-SkyGen
Non-Emergency Transportation
MTM
DME
Molina Healthcare
Vision
March Vision
Nurse Advice Line
Behavioral Health Crisis
Advanced Imaging
Molina Healthcare
Care Management
Molina Healthcare
Disease Management
Molina Healthcare
Hearing
Molina Healthcare
UnitedHealthcare
Behavioral Health
UBH – Optum Healthcare
Pharmacy
Optum Rx
Dental
Dental Benefits Provider
Non-Emergency Transportation
MTM
DME
UnitedHealthcare
Vision
March Vision
Nurse Line
Advanced Imaging
EviCore
Care Management
Optum Healthcare
Disease Management
UnitedHealthcare
Hearing
UnitedHealthcare

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Welcome New Providers

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11/3/2021

About Magnolia Health

Magnolia Health is a health insurance provider that has been proudly serving Mississippi citizens for 10 years.

- Medicaid Coordinated Care Organization (CCO)
- Experienced MississippiCAN health plan since 2011
- Locally-based, locally led *Mississippians serving Mississippians*
- NCQA Accredited
- Nationally supported through parent company Centene Corporation

Magnolia's Products

Products

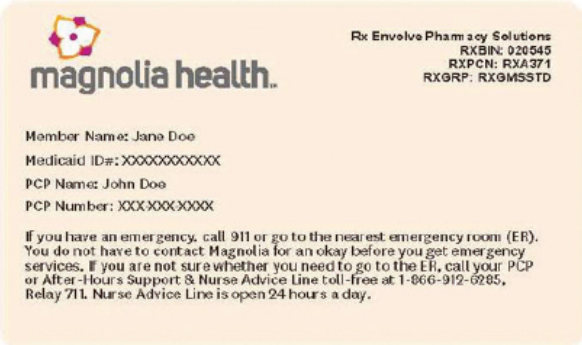
Medicaid	Marketplace	Medicare Advantage
MississippiCan	Ambetter	wellcare By allwell wellcare

Magnolia Member ID Cards

How to Identify a Magnolia Health's MSCAN Member

FRONT:

- Name
- Medicaid ID number
- PCP name/number
- Pharmacy vendor information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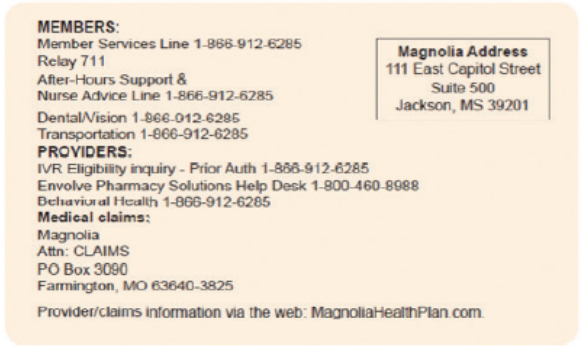
Rx Envolve Pharmacy Solutions
RXBIN: 020545
RXPCN: RXA371
RXGRP: RXGMSSTD

Member Name: Jane Doe
Medicaid ID#: XXXXXXXXXX
PCP Name: John Doe
PCP Number: XXXXXXXXX

If you have an emergency, call 911 or go to the nearest emergency room (ER). You do not have to contact Magnolia for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or After-Hours Support & Nurse Advice Line toll-free at 1-866-912-6285, Relay 711. Nurse Advice Line is open 24 hours a day.

BACK:

- Important member & provider phone numbers
- Medical claims address
- Website address


MEMBERS:
Member Services Line 1-866-912-6285
Relay 711
After-Hours Support &
Nurse Advice Line 1-866-912-6285
Dental/Vision 1-866-912-6285
Transportation 1-866-912-6285

Magnolia Address
111 East Capitol Street
Suite 500
Jackson, MS 39201

PROVIDERS:
IVR Eligibility inquiry - Prior Auth 1-866-912-6285
Envolve Pharmacy Solutions Help Desk 1-800-460-8988
Behavioral Health 1-866-912-6285
Medical claims:
Magnolia
Attn: CLAIMS
PO Box 3090
Farmington, MO 63640-3825

Provider/claims information via the web: MagnoliaHealthPlan.com

Don't Forget!!!

- ✓ **Always check eligibility before and on the Date of Service. Here's how:**
  - ✓ **Medicaid Envision website at: www.ms-Medicaid.com/msenvision/**
  - ✓ **Magnolia's Secure Provider Portal at www.MagnoliaHealthPlan.com**
  - ✓ **Call 1-866-912-6285 to reach health plan**

  Remember! Member ID cards are not a guarantee of coverage or payment.

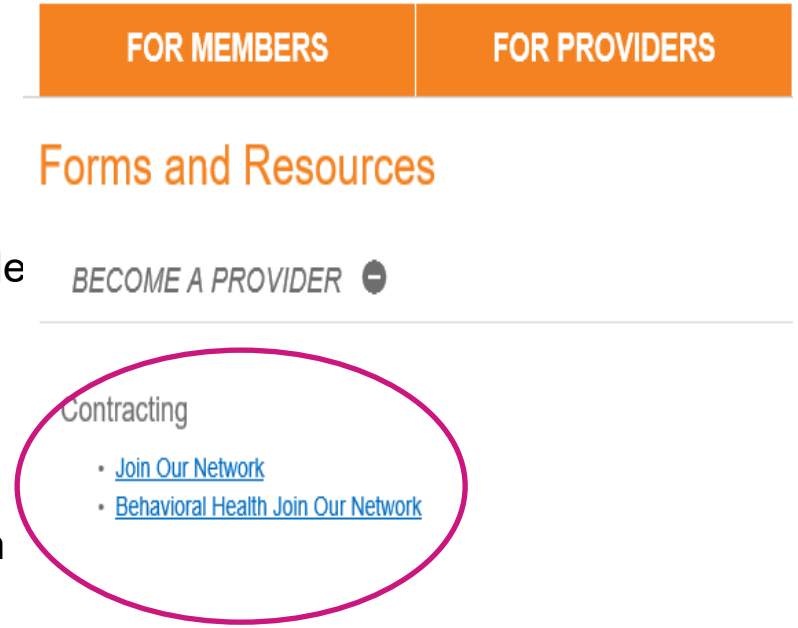
- ✓ **Make front and back copies of the member's card for vendor information, claim information, and contact numbers.**

New Provider Contracting Process

Step 1: To begin the contracting process, complete the Join Our Network form in its entirety found on our website www.MagnoliaHealthPlan.com.

Step 2: Register with CAQH or review your CAQH profile and ensure each item on the checklist are uploaded to CAQH website.

Step 3: A team member from Magnolia's contracting team will be in touch or you will receive a contract within 30-45 days.



Credentialing and Contracting

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Add a New Prac, Location, or Update

To Add a New Practitioner:

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)
- W-9
- Locations page

To Add a New Location:

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

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

To Update Information:

To update provider information the form can be found on Magnolia's website under For Provider > Contracting Section > Provider Update Form for Contracted Providers.

Recredentialing

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

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

Rejects & Denials- Taxonomy

What is a taxonomy code?

A taxonomy code is a unique 10-character code that designates your classification and specialization. You will use this code when applying for a National Provider Identifier, commonly referred to as an NPI.

As a provider, do I need to know my taxonomy code?

Yes. To become a Magnolia participating provider and file MSCAN claims, you must first enroll as a MS Medicaid provider. To enroll, you must have an NPI . And to get and NPI you will need to include the taxonomy code that reflects your classification and specialization. **Note:** Applications for NPIs are processed through the National Plan & Provider Enumeration System, or NPPES.

Where do I find my taxonomy code?

To find the taxonomy code that most closely describes your provider type, classification, or specialization, use the National Uniform Claim Committee (NUCC) code set list.

Note: You may select more than one code or code description when applying for an NPI, but you must indicate one of them as the primary code..

Note: You may select more than one code or code description when applying for an NPI, but you must indicate one of them as the primary code

Rejects & Denials- Taxonomy

What happens if there is an issue with my taxonomy or NPI?

Your claim may reject or deny for missing/incomplete/invalid taxonomy or taxonomy/NPI mismatch. **STEP 1: CHECK** the NPI and Taxonomy billed on the claim against NPPES to confirm they match and/or correct. **STEP 2: CONSULT** with the health plan to determine if your taxonomy, NPI, and specialty are correct in the system. **STEP 3**: If your claim has been **rejected**, correct the error and refile clean claim within 180 days from DOS. If the claim is **denied**, make the appropriate correction and resubmit a corrected claim.

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Prior Authorizations

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MSCAN PA Request & Contact Info

Prior Authorization Form(s) can be located on our website at:
http://www.magnoliahealthplan.com/for-providers/provider-resources/

Secure Web Magnoliahealthplan.com/login/	**Email** Magnoliaauths@centene.com
Phone 1.866.912.6285 **Fax** 1.877.650.6943	**Mail** Magnolia Health Attn: Utilization Management 111 E. Capital Street, Suite 500 Jackson, MS 39201

Authorization initiation should occur at least five (5) calendar days in advance for non-emergent services.

MSCAN PA Denials and Recourse

- ✓ **Peer to Peer**
  - If the treating practitioner does not agree with an adverse determination, the practitioner may discuss the decision with the Medical Director who rendered the decision.
  - Conducted by the Medical Director
  - To begin the process, call 1-866-912-6285 and ask to speak the UM Department

- ✓ **Appeal**
  - All appeal documents will be fully investigated
  - Prior authorization appeals should only be mailed to the address below if services have not been rendered.

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

- ✓ **DOM State Fair Hearing**
  - A member or authorized representative may request a hearing if he or she is dissatisfied with the Adverse Benefit Determination

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Claims

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How to Submit Claims

Paper Claim Submission

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

Handwriting on a claim form or handwritten claims will not be accepted.

EDI Claim Submission

Full list of EDI partners, visit our website at:
https://www.magnoliahealthplan.com/providers/resources/electronic-transactions.html

EDI assistance:

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

Electronic Payor ID: 68069
Behavioral Health: 68068

Web Portal Submission

Link to log in:
https://www.magnoliahealthplan.com/login.html

Provider Portal

- **Contracted** providers can register now.
- **Non-contracted** providers will be able to register after submission of first claim.

After creating an account you will be able to:

1. Verify member eligibility
2. Check & submit claims
3. Submit & confirm authorizations
4. View detailed patient list

MSCAN Claims Timeframes

- **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. Can be completed through the portal or mailed to: **Magnolia Health Plan PO BOX 3090 Farmington, MO 63640**

  ***Please specify if this is a corrected claim or reconsideration**

- **Claim Appeals** – must submit within thirty days (30 days) of the notice of adverse benefit determination. Please include the appeal form found on Magnolia's website. Can be mailed only: **Magnolia Health Plan Attn: Claim Appeal PO. Box 3090 Farmington, MO 63640**

Remittance Advice Review

Once a claim has been processed, a Remittance Advice (RA) is issued in either Explanation of Payment (EOP) or Electronic Remittance Advice (ERA). An RA provides finalized claim details and contains explanatory claim processing message codes.

Where can provider's obtain their ERAs or EOPs?
Providers can obtain through Provider Portal, Payspan, or Electronic Clearinghouse.

Explanation of Payments have 3 sections:

1st: **Basic claim information Section** includes four (4) categories: Member, Provider, Claim, and Most Recent Payment Information

2nd: **Service Lines Section** includes information specific to each individual service line such as: Procedure Code, DX, Modifiers, POS, Charged, Paid Amount, Pay Date, Check/EFT number, Status (Paid or Denied), and Payment Code

3rd: **Payment Description Section** includes Payment codes from the Service line area with a description

Rejected vs. Denied Claim

When required data elements are missing or are invalid, claims will be rejected or denied by Magnolia for correction and resubmission.

- **Rejections** happen prior to the claims being received in the claims adjudication system and will be sent to the provider with a letter detailing the reason for the rejection.
- **Denials** happen once the claim has been received into the claims adjudication system and will be sent to the provider via an Explanation of Payment (EOP).
- To avoid delays in processing of a CMS 1500, providers must bill:
  - NPI number in box 24Jb
  - Taxonomy code in box 24Ja
  - Group NPI in box 33a,
  - Taxonomy code in box 33b.
- To avoid delays in processing of a UB-04, providers must include:
  - Appropriate bill type in box 4,
  - Tax identification number in box 5,
  - Admission date in box 12, and the group NPI in box 56.

Claims missing required information will be rejected and returned with a notice sent to the provider, thus creating payment delays. Such claims are not considered “clean” and therefore cannot be accepted into our system. **Note: Rejections are not considered clean claims and the timely filing timeframe does not reset. Timely filing is 180 days from the DOS to the submission of a clean claim.**

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Top Issues

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11/3/2021

Top Issues

Issue	Resolution
Claim Denials Due to Authorization	✓ Obtain Authorization for services prior to rendering services. To determine if a service requires prior authorization, please visit https://www.magnoliahealthplan.com/providers/preauth-check.html ✓ The authorization and claim information must match: member's information, procedure code, date(s) of service, and the rendering provider's information must all match to prevent claim denial ✓ If the procedure code submitted at the time of the authorization differs from the services performed, contact provider services immediately to update the authorization; otherwise this may result in claim denials
Administrative Denials such as: Timely Filing and Eligibility	✓ Please ensure you are adhering to the product specific timely filing guidelines for first time claim submission, corrected claims, reconsideration, and claim appeals ✓ Make sure you are checking eligibility each visit
Coding edit denials (see examples) • Unbundled • Place of service Mismatch • Incorrect CPT/HCPCS/Rev/Mod or unlisted code • Procedure code conflicts/ inconsistent with member's age or gender	✓ Magnolia administers edits based on CMS and NCCI for professional and outpatient facility claims. ✓ Review claim and ensure you are billing appropriately. If not, submit corrected claim. ✓ Providers should reference the most up-to-date sources for professional coding guidance prior to the submission of claims for reimbursement of covered services ✓ Review payment policies found on Magnolia Health Plan website: https://www.magnoliahealthplan.com/providers/resources/clinical-payment-policies.html

Top Issues

Issue	Resolution
Upfront Rejections: Invalid member name or ID number Missing or invalid Missing member date of birth Missing provider name, TIN, or NPI number The date of service on the claim is not prior to receipt date of the claim Dates are missing from required fields Missing or invalid type of bill Missing, invalid, or incomplete diagnosis code(s) Missing service line detail Member not eligible on the date of service Missing admission type Missing patient status Missing or invalid occurrence code or date Missing or invalid revenue code Missing or invalid Current Procedural Terminology (CPT)/procedure	✓ If submitting claims electronically, complete a daily review your acceptance and claim status report for rejected claims. Timely filing is determined by the date Magnolia receives a clean claim. Rejected claims are not considered clean claims. ✓ Ensure all necessary claim form fields (loops or segments) are completed and no numbers are transposed. ✓ Check claims to ensure there are no missing elements ✓ Check eligibility on and before DOS

Top Issues

Issue	Resolution
Credentialing/ Enrollment	✓ Notify Magnolia Health Plan of changes with enrollment, such as: additions, changes, deletions of practitioners 90 days in advance. ✓ Submit clean Enrollment and Credentialing packets to MagnoliaCredentialing@Centene.com ✓ BH and Medical Enrollment are done separately remember to enroll in both if your is dual. Check enrollment
Provider TIN and NPI do not match what is on file with Magnolia or DOM provider files	✓ Ensure Referring, Originating, Ordering, Billing, Rendering, or Attending Provider is registered with DOM on the DOS ✓ Refer to the MS Medicaid Provider Billing Handbook, Section: General Billing Information, 1.7 National Provider Identifier (NPI), for information regarding registering your NPI. https://medicaid.ms.gov/wp-content/uploads/2016/07/1.7-NPI-Provider-Enrollment.pdf

Contact Information

- **Magnolia Provider Services Line**
  Call: (866) 912-6285
  Fax: (877) 811-5980

- **Medical Prior Authorizations**
  Call: (866) 912-6285
  Email: Magnoliaauths@centene.com
  Fax: (877) 650-6943
  Web Portal: provider.magnoliahealthplan.com
- **BH Prior Authorizations**
  Call: (866) 912-6285
  Email: AUGMississippiUM@cenpatico.com
  Fax number is 1-866-535-6974
  Web Portal: provider.magnoliahealthplan.com
- **EDI Department**
  Call: (800) 225-2573, ext. 25525
  Email: EDIBA@centene.com
- **PaySpan**
  Call: (877) 331-7154

- **Magnolia Contracting**
  Call: (866) 912-6285
  Email: MagnoliaContracting@Centene.com

- **Magnolia Credentialing**
  Call: (866) 912-6285
  Email: MagnoliaCredentailing@Centene.com

- **Magnolia Provider Claims**
  Call: (866) 912-6285
  Fax: (877) 811-5980

MOLINA HEALTHCARE

New Providers/Joining Our Network

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

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

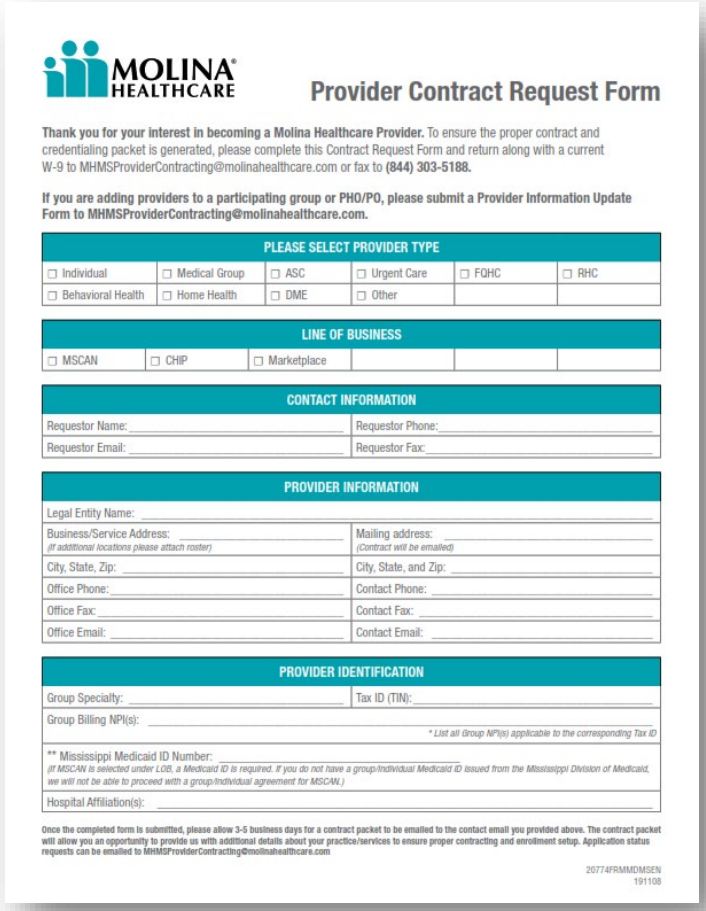
After completing, a representative from our Provider Contracting Department will reach out to you regarding the enrollment and credentialing process.

For additional information, email MHMSProviderContracting@MolinaHealthCare.Com

Mailing Address:
188 East Capitol Street, Suite 700
Jackson, MS 39201

Phone Number:
1-844-826-4335

Fax Number:
1-844-303-5188



MOLINA HEALTHCARE

Provider Contract Request Form

Thank you for your interest in becoming a Molina Healthcare Provider. To ensure the proper contract and credentialing packet is generated, please complete this Contract Request Form and return along with a current W-9 to MHMSProviderContracting@molinahealthcare.com or fax to **(844) 303-5188.**

If you are adding providers to a participating group or PHO/PO, please submit a Provider Information Update Form to MHMSProviderContracting@molinahealthcare.com.

PLEASE SELECT PROVIDER TYPE					
☐ Individual	☐ Medical Group	☐ ASC	☐ Urgent Care	☐ FQHC	☐ RHC
☐ Behavioral Health	☐ Home Health	☐ DME	☐ Other		

LINE OF BUSINESS					
☐ MSCAN	☐ CHIP	☐ Marketplace			

CONTACT INFORMATION	
Requestor Name:	Requestor Phone:
Requestor Email:	Requestor Fax:

PROVIDER INFORMATION	
Legal Entity Name:	
Business/Service Address: *(If additional locations please attach roster)*	Mailing address: *(Contract will be emailed)*
City, State, Zip:	City, State, and Zip:
Office Phone:	Contact Phone:
Office Fax:	Contact Fax:
Office Email:	Contact Email:

PROVIDER IDENTIFICATION	
Group Specialty:	Tax ID (TIN):
Group Billing NPI(s): ** List all Group NPI(s) applicable to the corresponding Tax ID*	
** Mississippi Medicaid ID Number: *(If MSCAN is selected under LOB, a Medicaid ID is required. If you do not have a group/individual Medicaid ID issued from the Mississippi Division of Medicaid, we will not be able to proceed with a group/individual agreement for MSCAN.)*	
Hospital Affiliation(s):	

Once the completed form is submitted, please allow 3-5 business days for a contract packet to be emailed to the contact email you provided above. The contract packet will allow you an opportunity to provide us with additional details about your practice/services to ensure proper contracting and enrollment setup. Application status requests can be emailed to MHMSProviderContracting@molinahealthcare.com

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MOLINA HEALTHCARE

New Providers/Joining Our Network

All providers interested in joining our network for MSCAN must have an **active Mississippi Medicaid ID number** issued from the **Mississippi Division of Medicaid (DOM)** upon submission of the contract Request Form. We will not be able to proceed with a group or individual agreement for MSCAN until an **active Mississippi Medicaid ID number** is obtained.

Non-Participating Provider Reimbursement

All Out-of-Network Providers (Physicians, Nurse Practitioners, Facilities, and Ancillary Providers) must obtain a Prior Authorization (PA) prior to rendering services. All Non-Participating Providers require authorization regardless of services or codes.

The Prior Authorization Guide and forms are located on our website at:
https://www.molinahealthcare.com/providers/ms/medicaid/forms/Pages/fuf.aspx

Non-Participating Providers are reimbursed at **50% of the current Mississippi Medicaid Fee-For-Service Fee Schedule** for covered Non-Emergent services, if accompanied by a valid prior authorization number.

Non-Participating Providers are reimbursed at 100% of the current Mississippi Medicaid Fee-For-Service Fee Schedule for covered Emergency Services. Prior authorization is not required for covered Emergency Services.

******For any claim denials received for out-of-network status, please follow the process for submitting a reconsideration as outlined in that section of the presentation.******

Review/Credentialing

Once the complete packet has been submitted, the following actions will occur:

- ✓ A Contracting Specialist will conduct an initial review of the submitted documents. In the event additional information/action is needed or we receive incomplete forms, the group will be notified.
- ✓ Upon review of the complete packet, the Contract Specialist will route the entire packet to the Molina Credentialing team to begin credentialing.
- ✓ The DOM standard by which the Coordinated Care Organizations (CCOs) are required to comply with is that within **90 days of receipt of a complete packet** (to include having updated CAQH profiles) that credentialing of the group should be approved or denied.

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Post-Credentialing and Recredentialing

Post-Credentialing

- Upon completion of credentialing, a credentialing letter will be generated by the Credentialing team and sent to the mailing address listed on the contract.
- A member of the Provider Contracting team will work with our Configuration Team to ensure the group and rendering providers are loaded into our claims system.
- Upon successful completion of the configuration, the group will be assigned a Provider ID number.
- The Senior Provider Services Representative for the county where the group is located will make outreach to schedule a New Provider Orientation.

If a provider or group receives the credentialing complete letter and have not received outreach from Provider Services, please email MHMSProviderServices@MolinaHealthCare.Com.

Recredentialing

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

Taxonomy and NPI Numbers

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

Provider Services – Call Center

- The Provider Service Contact Center is the first line of communication for providers.
- Provider Services Contact Center can verify eligibility, answer claims related questions, check Prior Authorizations status, etc.
- Located in Mississippi
- Phone: (844) 826-4335
- Hours of operations
  7:30 am – 6:00 pm CST

Provider Services – External Representatives

Chinwe Nichols, *Director, Provider Services*
Chinwe.Nichols@molinahealthcare.com
601-317-2442

LaKeida Ward, *Manager, Provider Services*
Behavioral and Mental Health Providers
LaKeida.Ward@molinahealthcare.com
601-317-4313

Earl Robinson, *Manager, Provider Services*
Earl.Robinson@molinahealthcare.com
601-760-2433

Ricky Bailey, *Senior Rep, Provider Services*
North MS and TN
Ricky.Bailey@molinahealthcare.com
901-515-6703

Jade McGowan, *Senior Rep, Provider Services*
MS Delta and AR
Jade.McGowan@molinahealthcare.com
601-760-8779

Tuwanda Williams, *Senior Rep, Provider Services*
Southwest MS and LA
Tuwanda.Williams@molinahealthcare.com
601-760-8758

Laterria Lacy, *Senior Rep, Provider Services*
Central and Southeast MS
Laterria.Lacy@molinahealthcare.com
601-559-3142

Tamalia Williams, *Senior Rep, Provider Services*
FQHCs
Tamalia.Williams@molinahealthcare.com
601-862-6468

Kwiinta Anderson, *Senior Rep, Provider Services*
South MS, AL and LA
Kwiinta.Anderson@MolinaHealthcare.com
601-658-7408

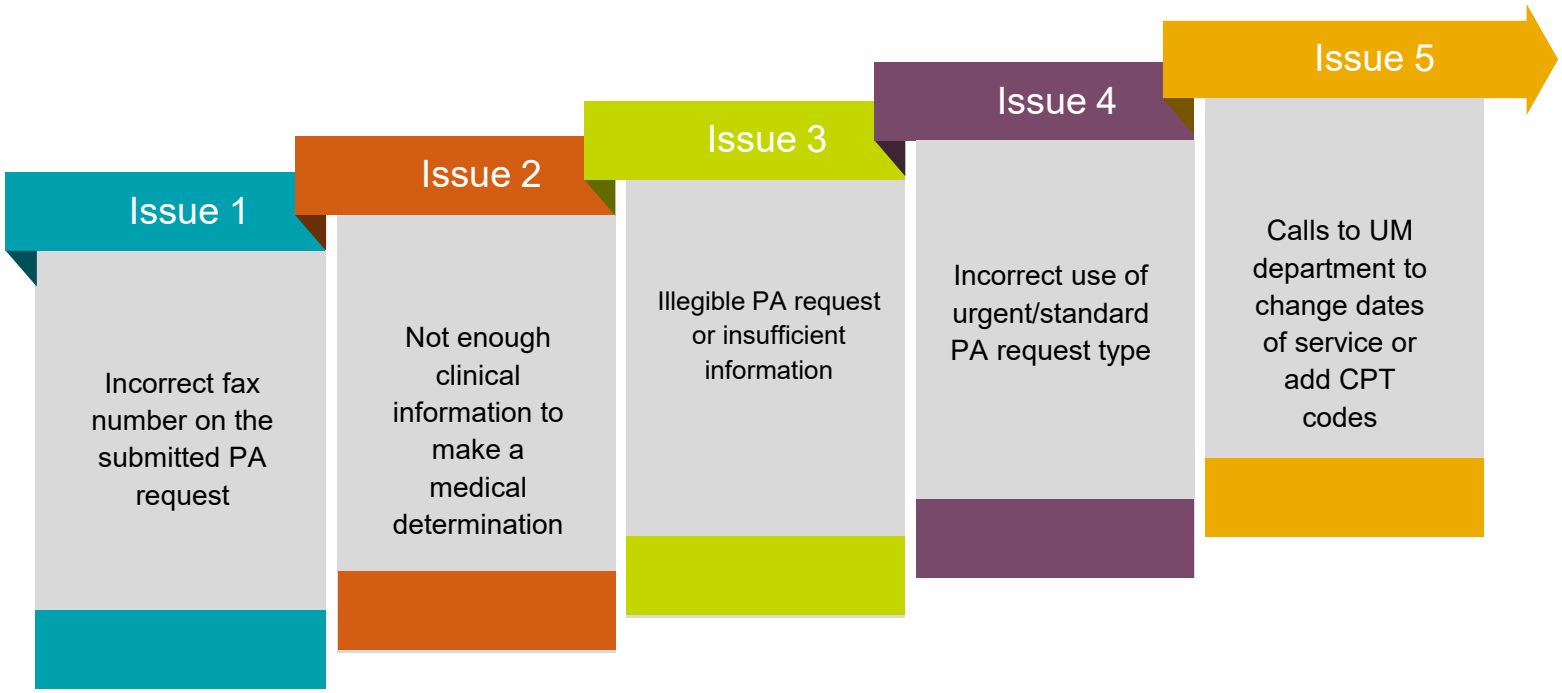
MHMSProviderServices@molinahealthcare.com
(General Provider Services Inquiries)

MSBHProviderServices@molinahealthcare.com
(Behavioral and Mental Health Providers)

Access the complete list of county assignments at:
https://www.molinahealthcare.com/providers/ms/medicaid/comm/Provider-Representatives-Map.aspx

MOLINA HEALTHCARE

Top Prior Authorization Issues



MOLINA HEALTHCARE

Prior Authorizations Submissions

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

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

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

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

Methods of Submission

Web Portal: https://www.availity.com/molinahealthcare

Phone: (844) 826-4335. Please follow the prompts for prior authorization.
Note: *For telephonically submitted requests, it may be necessary to submit additional documentation before the authorization can be processed.*

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

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

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 Capitol Street
Suite 700
Jackson, MS 39201

Prior Authorizations and Referrals

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

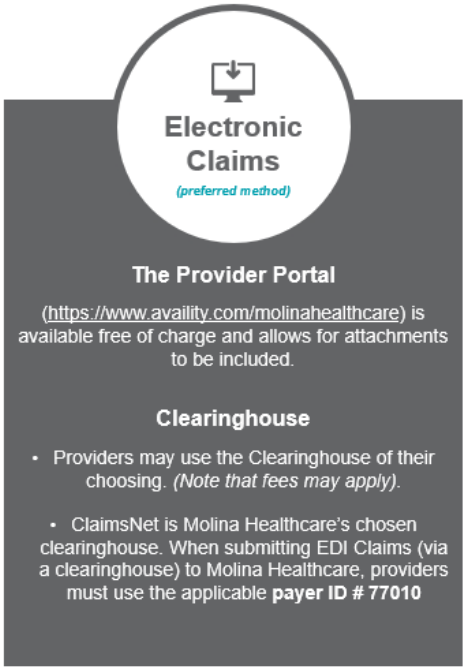
- Assist in benefit determination
- Prevent unanticipated denials of coverage
- Create a collaborative approach to determining the appropriate level of care for Members receiving services
- Identify Case Management and Disease Management opportunities
- Improve coordination of care

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

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

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

Claim Submission Methods and Timely filing



Claims mailed to our Jackson, MS office will be returned unprocessed

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

MOLINA HEALTHCARE

Rejected vs Denied Claim

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

Rejected Claim

Claim does not meet basic claims processing requirements.

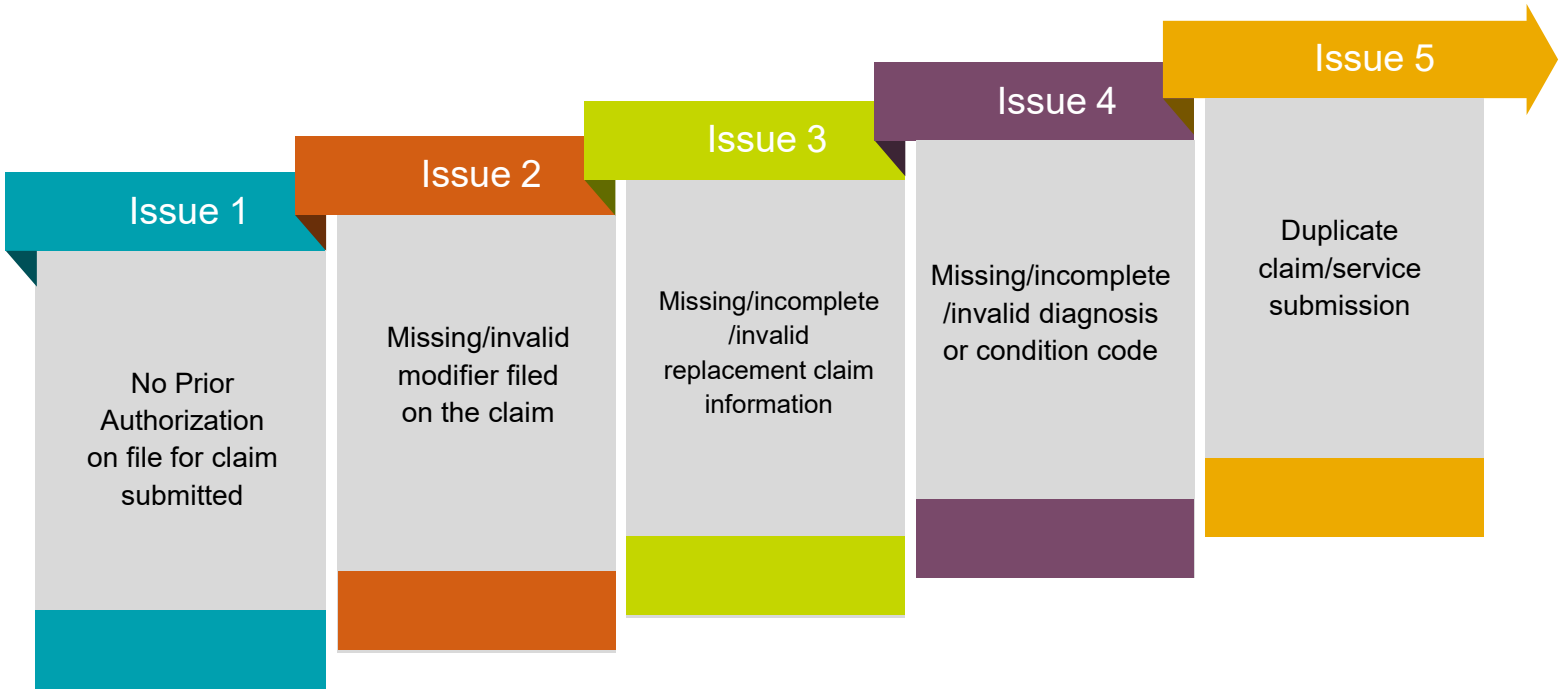
A few examples of rejected claims include the use of an incorrect claim form, required fields are left blank or required information is printed outside the appropriate fields.

Denied Claim

The claim has been reviewed and was determined not to meet payment requirements.

A few examples of reasons for denied claims include an invalid modifier, a missing: provider address, date of service or NPI and corrected claims indicator or original claim number.

Top Provider Claims Processing Issues



MOLINA HEALTHCARE

How to File a Claim Reconsideration, Dispute or Appeal

Preferred Method – online via Molina's Provider Portal: https://www.availity.com/molinahealthcare

Fax: (844) 808-2409

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

Documentation needed for submission of Reconsiderations, Disputes, or Appeals

- ❑ All Claim Reconsiderations, Disputes or Appeals must be submitted on the Molina Claims Request for Reconsideration Form (CRRF) found on Molina's Provider website and the Provider Portal.
- ❑ The form must be filled out completely in order to be processed.
- ❑ Any documentation to support the reconsideration, dispute or appeal must be included, ex. include Medical Records, copy of Explanation of Payment, copy of Authorization Form.
- ❑ If submitting voluminous Medical Records, please indicate where Molina can find pertinent information to support the medical necessity for the service.
- ❑ Please review our Provider Manuals for additional instructions: https://www.molinahealthcare.com/providers/ms/medicaid/manual/medical.aspx

Appeals Quick Reference

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

Pre-Service Appeals

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

Post-Service Appeals

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

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

2021 Managed Care Provider Webinars

November 3, 2021

United Healthcare

New Providers

Contract Process – There are 4 Steps to Join our Network.

Get Started – Submit your request for participation.
Get Credentialed – Verify your experience and expertise.
Get Contracted – Review and sign your participation agreement.
Get Connected – Set up online tools, paperless options, & complete training

Contact Information – Join Our Network | UHCprovider.com

Hospitals & Healthcare Facilities – Send us an email request at networkhelp@uhc.com

Include the following information:

- Care Provider Full Name
- Tax ID Number
- Service Address Location(s)
- National Provider Identifier (NPI)

Care Providers – Submit your request through our RFP Portal https://ncc-optum.secure.force.com/rfp

Provider Relations Advocates

Territory	Advocate	Email	Phone
Manager – MS Provider Relations	Stephanie Bullock	stephanie_bullock@uhc.com	763-361-0974
Northern – MS	Jamille Bernard	jamille_Bernard@uhc.com	763-361-0734
West Central – MS	Tonya Daves	tonya_Daves@uhc.com	952-202-4447
East Central – MS	Adrian Hagan	adrian_d_hagan@uhc.com	763- 361-1143
Southwest – MS	Tanya Stevens	tanya_m_stevens@uhc.com	763- 361-0926
Southeast & Gulf Coast – MS	Tina Price	tina_Price@uhc.com	952-406-6057

Claim Issues – The Mississippi Provider Relations Team would like to remind you of a process that's available to you for faster claims resolution.

Step One: Claim Reconsideration – Whether you prefer online, telephone or mail, UnitedHealthcare has resources available to you to submit a claim reconsideration request.

Online – Submit a claim reconsideration request online via the **Claims Tool** on the **UnitedHealthcare Provider Portal**. To access the portal, please sign in to **UHCprovider.com**

Please note that you will receive a reference number with your online submission.

Telephone – For **Community & State** claims related issues, please call Provider Services at **877-743-8734**.

Please be sure to ask for a call reference number!

For all claim reconsideration options, please allow up to 30 days for processing!

Step Two: Claim Escalation – If you do not agree with the outcome of your claim reconsideration request, then you may submit your claim concern to the **Mississippi Claims Escalation Team** for further review.

Mississippi has a dedicated team of experienced claims analysts who will review the claim reconsideration request, before you submit a claim appeal. **Please note that a reference number must be provided from the initial attempt(s) to resolve.**

- Provide details about your disagreement with how the claim is processed and include any relevant documents.
- Please include the required claim information on the claim escalation template.
- Please note that if the required information is not provided, your request will be returned for the additional details and may delay your resolution.
- Submit your claim escalation request to **southeastprteam@uhc.com.**
- You will receive an automated message acknowledging receipt and will be contacted via email once the review is completed.

Provider Services

Community & State: 877–743–8734

Network Management Resource Team:
Networkhelp@uhc.com

The Network Management Resource Team can help with questions about:

- Credentialing & Effective Dates
- Product Participation
- Contract/Fee Schedule
- Demographic Updates
- Basic Network Questions

Credentialing | Contracting

Verify & Update Your Demographic Data – Each quarter, all health care professionals who are contracted with UnitedHealthcare must verify and/or attest that their information is accurate and meets regulatory guidelines.

- **Use the following methods below to verify and/or submit any new demographic information.**
  - **CAQH ProView –** A multi-payer solution that allows you to update your profile in real time and instant access to directory services and more.
  - **Roster Management Program –** f you're a participating health care professional in the Roster Management program, please work directly with your assigned roster manager to review and verify the accuracy of your practice's data.
  - **My Practice Profile –** My Practice Profile lets you verify and attest to the accuracy of practice's data. UnitedHealthcare shares this information with members to locate your organization.
  - **Alternative Options –** If you don't have access to the other methods, you can verify your practice data using the UnitedHealthcare demographic change request form.

Get Credentialed – During the credentialing process, we'll work with you to verify your qualifications, practice history, certifications and registration to practice in a health care field.

- Completing a CAQH ProView application is a fast and easy way to securely submit credentialing information. You enter information just once and it's available to multiple health insurers at no cost to you.
- You can start the process at CAQH.org.

Re-Credentialing Process – After you have been in the network for 3 years you will receive notification for recredentialing to ensure professional qualifications remain valid and current. The notification will include instructions specific to your specialty.

  - If your application is on CAQH ProView™ and up to date, you may not need to take any action at the time of recredentialing.
  - You can submit updates on your services or service area at any time through CAQH ProView

Contact Information

- **If you have any questions on accessing CAQH ProView, call the CAQH Help Desk: 888-599-1771**
- **Verify & Update Your Demographic Data:** Verify and update your demographic data | UHCprovider.com
- **Recredentialing**: Recredentialing | UHCprovider.com

Network Management Resource Team

The Network Management Resource Team can help with questions about:

- Credentialing & Effective Dates
- Product Participation
- Contract/Fee Schedule
- Demographic Updates
- Basic Network Questions

Please email us & include:

- ✓ NPI
- ✓ Tax ID
- ✓ Nature of Request

Networkhelp@uhc.com

Prior Authorization | Appeals

Providers Top Prior Authorization Issues

- Prior Authorization and Notification Process
- Administrative burden
- Physician Loading

Submitting Admission Notification, Prior Authorization Requests

- In 2019, we retired certain fax numbers used for medical prior authorization requests to migrate to more efficient electronic processes.
- Your primary UnitedHealthcare prior authorization resource is **Prior Authorization and Notification** tool on the Provider Portal.
- Use the Prior Authorization and Notification tool to check prior authorization requirements, submit new medical prior authorizations and inpatient admission notifications, check the status of a request, and submit case updates such as uploading required clinical documentation.

Contact Information

- **Prior Authorization & Notification**
  - UHCprovider.com/paan
  - You may also contact **UnitedHealthcare Web Support** at providertechsupport@uhc.com or call **866-842-3278**, **option 1**, from 7 a.m. to 9 p.m. CT, Monday through Friday.

- **If you don't have access to the Prior Authorization and Notification Tool, you can call: 877-743-8734**
  - **Available Monday – Friday 8 a.m. – 5 p.m. (CT), 24 hours for emergency.**

For a complete and current list of prior authorizations, go to UHCprovider.com/priorauth

Party	Action	Time Frame	Extensions Available
Appeal: A request for review to of an adverse benefit determination related to a member. In the case of a member, UnitedHealthcare Community Plan's adverse benefit determination may include determinations on the health care services a member believes they are entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the member's health).			
Member, care provider on behalf of a member, or authorized representative	File an appeal	Members, an authorized representative or you may file an appeal within 30 calendar days from the date of receipt of the adverse benefit determination notice.	
UnitedHealthcare Community Plan	Confirm receipt of the appeal and expected date of resolution	Within 10 calendar days of receipt of the appeal	
UnitedHealthcare Community Plan	Resolve an appeal	Within 30 calendar days of UnitedHealthcare Community Plan's receipt of the appeal or as expeditiously as the member's health condition requires Within 72 hours after UnitedHealthcare Community Plan receives the request for an expedited resolution of an appeal	Health plan may extend time frames by up to 14 calendar days in accordance with 42 C.F.R. § 438.408(c)

Appeals

Upon receipt of notice of an appeal denial, you may request an Administrative State Hearing through the Division of Medicaid.

Contact Information

- **You should submit an Appeal using the File Appeal button in Claims tool on the Provider Portal, when available.**
- **Need a paper form because you are unable to submit your appeal online? UHCprovider.com/claims**
- **Completed appeal forms should be submitted to the following address:**
  - **UnitedHealthcare Community Plan**
    P.O. Box 5032
    Kingston, NY 12402-5032

Claims Processing

Claims Processing

Claims, Billing & Payments

- **UnitedHealthcare Provider Portal Claim Submission Tool**
  - **With the Claim Submission Tool, You Can:**
    - Submit professional claims, including National Drug Code (NDC) claims, for all UnitedHealthcare members
    - Easily see which fields are required. The highlighted fields will update based on the information you enter
    - View on-screen messages that allow you to correct certain errors before you hit submit
    - Eliminate paper, postage and mail time
- **Submit claims electronically using a clearinghouse to reduce costs, help ensure faster processing and reduce claim entry errors.**
  - **Use electronic payer ID 87726 to submit claims.**
  - **Contact your vendor or our EDI unit at 800-210-8315.**
- **Mail completed paper claims to:**
  - **UnitedHealthcare Community Plan**
    P.O. Box 5032
    Kingston, NY 12402-5032

Contact Information

- To learn about claim submission methods and connections using Electronic Data Interchange (EDI), visit the EDI 837: Electronic Claims, for information.

Top Provider Claims Processing Issues
Member Terminated
3rd Party COB
Duplicate Claim
Timely Filing
Eligibility

Submit a Corrected Claim/Claim Reconsideration

- You can use the Claims tool to submit a corrected claim or claim reconsideration and track claim reconsideration requests.
- Most corrected claims can be sent electronically. Use frequency code 7 on the 837 transaction to indicate that it's a replacement of a previous claim.
- If you can't submit corrected claims using EDI, submit a claim reconsideration request using Claims.

When Should You Submit a Claims Reconsideration?

- Amount is different than what provider expected
- Claim was filed in a timely manner, when provider has proof
- Claim was denied for no authorization when provider has an authorization number
- Difference in Coordination of Benefits (COB) information

Need a paper form because you are unable to submit your reconsideration online?

- Use our Single Paper Claim Reconsideration Request Form instead.

The Claim Reconsideration Form can be mailed to the following address:

- **UnitedHealthcare Community Plan**
  P.O. Box 5032
  Kingston, NY 12402-5032

Contact Information

For more information about Claims, including training and quick reference guides, go to UHCprovider.com/portal.

Timely Filing

- Timely filing limit is **180 days** from **Date of Service**.
- Timely filing limit to submit a reconsideration is **90 days**, from **Date of EOB**.

Remittance Advice Review

- A PRA is generated for every processed claim and includes relevant details about how the claim was processed.
- The Electronic Remittance Advice (ERA), or 835, is the electronic transaction that provides claim payment information.
- You can receive your 835 files through your clearinghouse, direct connection, or download them from the EPS/Optum Pay app on the Provider Portal.

Contact Information/Resources

- **For more information on UnitedHealthcare's 835 transactions, refer to the EDI Companion Guides | UHCprovider.com**
- **Additional 835 Solution Guides are located at EDI 835: Electronic Remittance Advice (ERA) | UHCprovider.com**
- **UnitedHealthcare Community Plan EDI Support**
  - **EDI Transaction Support Form**
  - **Email: ac_edi__ops@uhc.com**
  - **Phone: 800-210-8315**

Rejected Claims vs. Denied Claims

- **Rejected Claims –** Maintain timely filing limits.
- **Denied Claims –** Subject to timely filing limits

How Providers Can Access Webinar Presentation

2021 Managed Care Provider Workshop Presentation

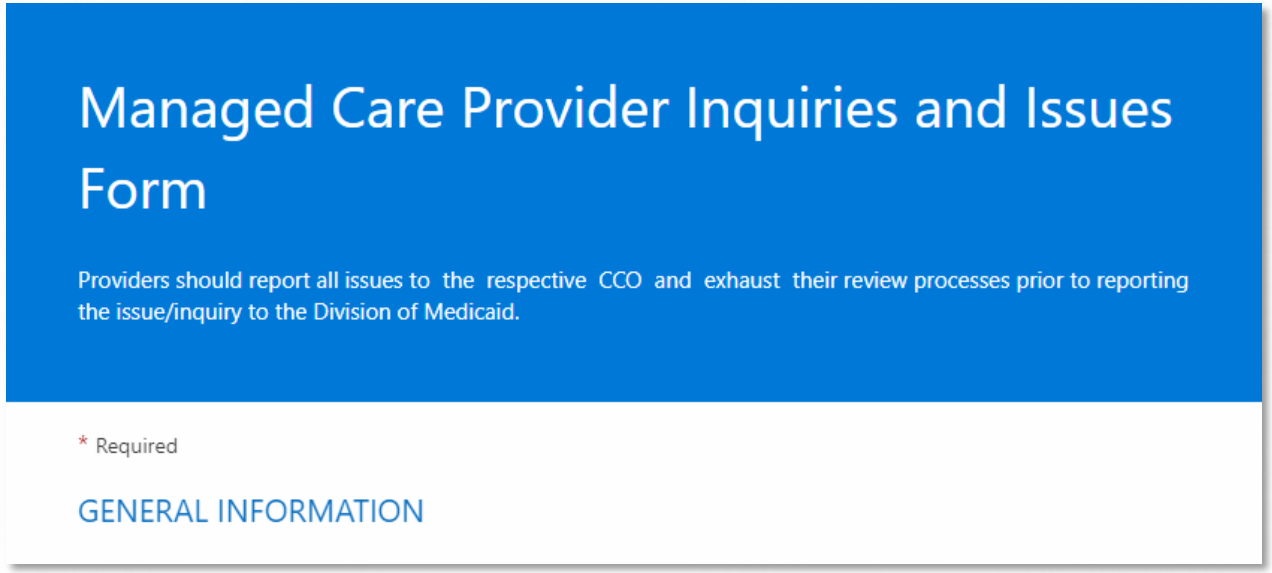
Managed Care | Mississippi Division of Medicaid (ms.gov)

Managed Care Inquiries and Complaints

HELP US, HELP YOU

Please forward all issues and complaints to:

https://forms.office.com/g/WXj92sN1MH



Providers:
Please complete the following

2021 Managed Care Provider Evaluation

We would appreciate your feedback following today's webinar.

https://forms.office.com/g/f7BDqpDCce

2021 Managed Care Provider Satisfaction Survey

Don't forget to complete the 2021 Provider Satisfaction Survey

https://forms.office.com/g/HZ47znpRVy

Questions & Answers

Division of Medicaid
Sharon Jones