Mississippi Division of Medicaid

Managed Care Provider Webinar

2021

Hospital Services | Inpatient & Outpatient Services | Newborn Services | Credentialing/Contracting

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

Thursday, November 4, 2021
10:00 a.m. – 12:00p.m.

10:00 a.m.	10:20 a.m.	Welcome & Introductions
10:20 a.m.	10:35 a.m.	Molina Healthcare
10:35 a.m.	10:50 a.m.	UnitedHealthcare
10:50 a.m.	11:05 a.m.	Magnolia Health
11:05 a.m.	11:40 a.m.	Question and Answer Session
11:40 a.m.	12:00 p.m.	Closing Remarks How to Access Presentation & Material Provider Evaluation

Welcome & Introductions

Division of Medicaid Managed Care

Sharon Jones

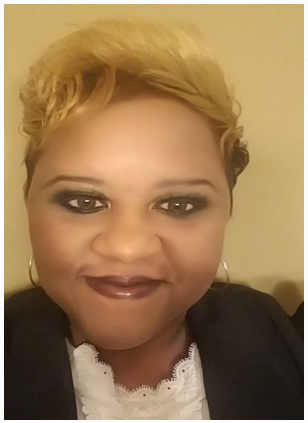
Lucretia Causey

Patricia Collier

April Burns

Magnolia Health

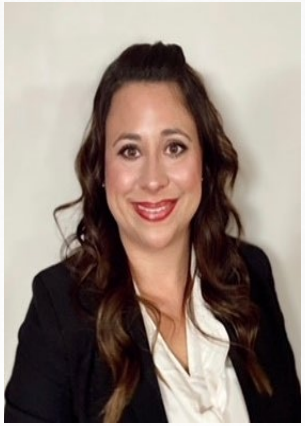
Brittany Cole



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

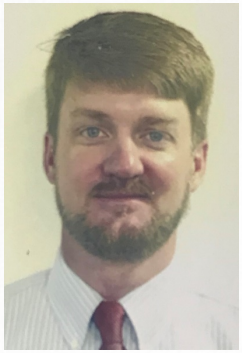
Kristi Plotner

Teresa Morris

Rhona Waldrep

Ty Klingelhofer

Molina Healthcare



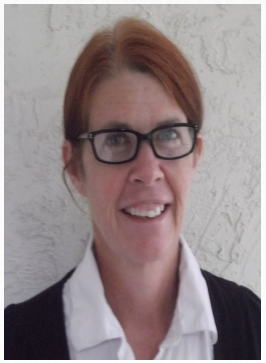
Bert Emrick

Earl Robinson

Chinwe Nichols

Chris Cauthen

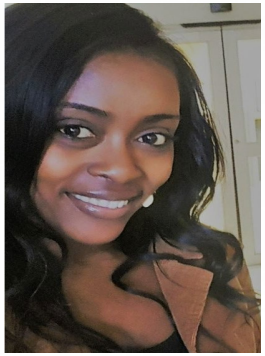
Daniel Bradshaw



Pam Canavan

Lakeida Ward

Ellie Coley

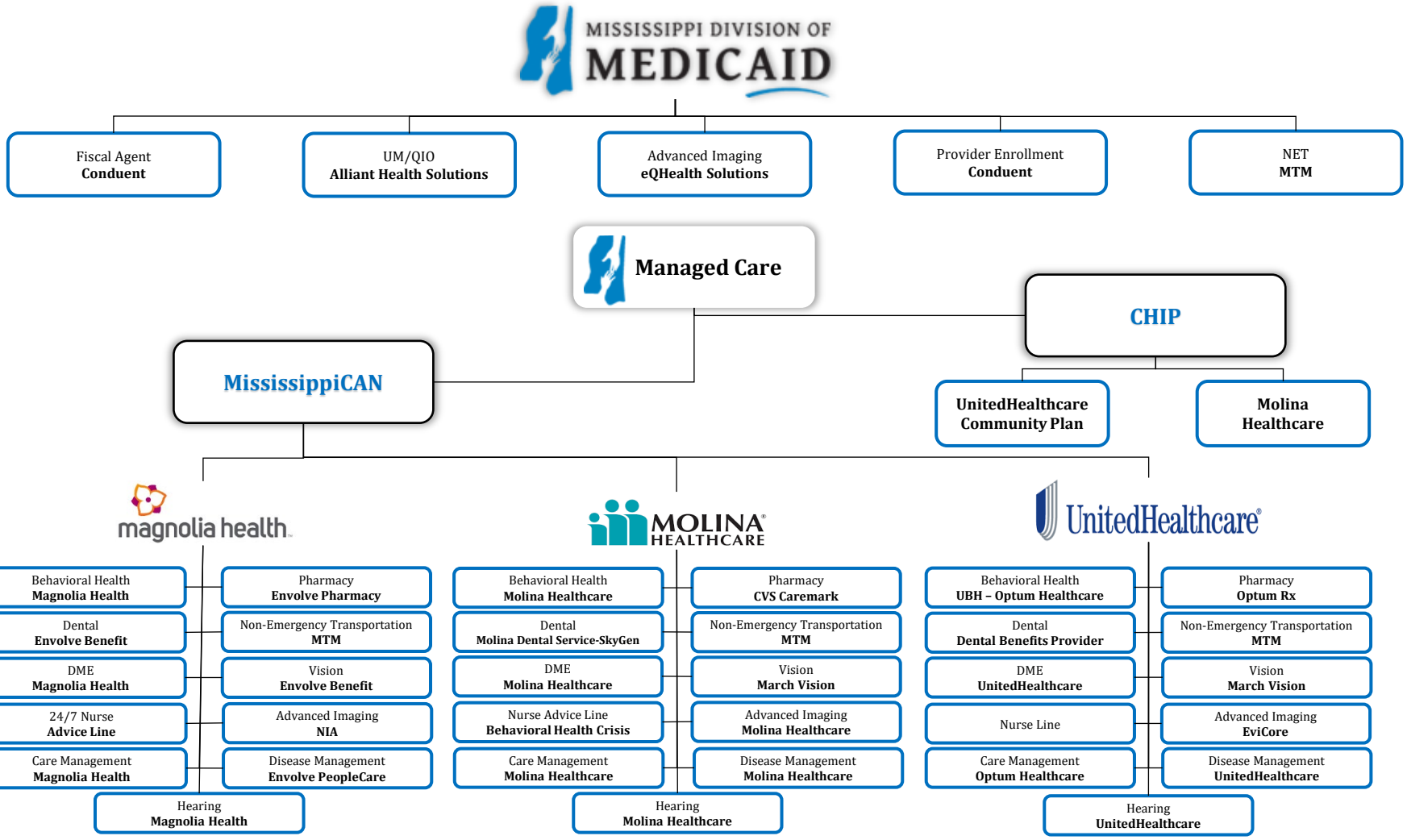


Laterria Lacy

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

MOLINA HEALTHCARE

Inpatient Services – Management and Admissions

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

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

- 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.

Inpatient Services – Review and Status Determinations

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

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

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

Emergency Services

- Emergency services encompass covered inpatient and outpatient services, inclusive of dialysis services, that are furnished by a Medicaid qualified provider and needed to evaluate or stabilize an Emergency Medical Condition.

- Emergency services do not require a prior authorization and will be reimbursed no less than the amount Medicaid reimburses Fee For Service Providers, regardless of the provider's network participation.

- Molina's goal is to ensure our members are accessing care in the appropriate setting. Our Care Management team will be actively involved with our members to assist them with how and where to seek treatment that best meets their needs.

Discharge Planning

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

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:

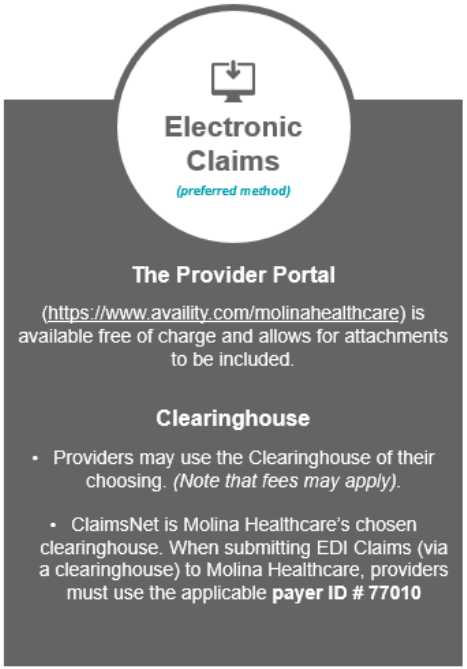
- Assist in benefit determination
- Prevent unanticipated denials of coverage
- Create a collaborative approach to determining the appropriate level of care for Members receiving services
- Identify Case Management and Disease Management opportunities
- Improve coordination of care

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**

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.

Provider Services

PROVIDER CONTACT 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 FIELD SERVICES

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*
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901-515-6703

Jade McGowan, *Senior Rep, Provider Services*
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601-760-8758

Laterria Lacy, *Senior Rep, Provider Services*
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Tamalia Williams, *Senior Rep, Provider Services*
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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

Newborn Enrollment

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

Effective 5/1/21, no Prior Authorization is needed on file before claims submission for routine deliveries that are not complicated and do not exceed the routine timeframes (three days for vaginal or five days for C-Section) for the claim to pay.

Molina will continue to require authorizations to determine medical necessity on OB delivery stays that are non-routine or complicated.

Providers should wait to file a claim for the below stays until receiving a determination letter.

- **scheduled deliveries before 39 weeks gestation**
- **Delivery stays that are none-routine or complicated (e.g. O10-O16, O20-O29, O30-O48, O60-O77, O85-O92, O94 -O9A, O09, O00-O08)**
- **delivery stays that exceed routine time frames (notification to be filed no later than day 4 for vaginal/ day 6 for C-Section)**
- **sick newborns (Sick Baby revenue codes that required an auth <u>regardless</u> the length of stay, e.g. 172, 173, 174)**
- **newborns who require services other than normal newborn care (stay beyond 5 days)**

Note: ***The Division of Medicaid (DOM) will continue to require providers to submit newborn enrollment forms. Molina will continue to generate an authorization from the form.***

If you have any questions or concerns, please contact our Utilization Management department at (844) 826-4335.

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 and Service Agreement

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.

There are two Service Agreements:

- ❑ Hospital Services Agreement – ***For hospitals only***
- ❑ Provider Services Agreement – ***For all non-hospital providers***

The Agreements contain the following active Lines of Business (LOB):

- ❑ **MEDICAID (MSCAN)** – Molina entered this LOB on 10/1/2018
- ❑ **CHIP** – Molina entered this LOB on 11/1/2019

- ✓ Only the first page on the agreements has a place for provider demographics and signatures.
- ✓ Please ensure that all CAQH data is attested and that Molina has been granted access to view the profile.

If a group has 10 or more providers, we can provide an Excel spreadsheet to accompany this form for your roster

Please do not document an effective date on the agreement. This is determined by the credentialing approval date

Please review your current agreement to ensure it includes all LOB's in the event the group is already contracted

MOLINA HEALTHCARE

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

2021 Managed Care Provider Webinars

November 4, 2021

United Healthcare

Hospital Services

Inpatient Services

All inpatient hospital admissions require notification within one (1) business day.

- 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/Prior Auth & Notification

Outpatient Services

- Prior Authorization may be required on specific Outpatient Hospital Services.
- 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.
  - **Online:** www.UHCprovider.com/Prior Auth & Notification

Discharge Planning

- Starts with the hospital admission, **UHC Inpatient Care Managers (ICM)** and **Discharge Care Managers (DCM)** work with the facility to assist and monitor with hospital to home patient needs. They help facilitate appropriate health care services are provided with members upon discharge.
- UHC also has a Complex and disease Care Management Program- This Care Management programs goal is to focus interventions on members with complex medical, behavioral, social, pharmacy and specialty needs, which result in a better quality of life for members, and improved access to health care.

Prior Authorization

- The service authorization process begins at intake, which is the point at which we receive prior authorization request from providers or become aware of inpatient admissions. The intake process supports varied administrative internal processes, including referral into care coordination and disease management programs.
  - **Vaginal Deliveries: IP stay 3> days requires an auth**
  - **Cesarean Deliveries: IP stay 5> days requires an auth**

Submitting Claims – based upon facility procedure of claims submission

Newborn Processes

- 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.**
- Newborn **Notification** is required within one **(1) business day for NICU admissions**, if mother is covered by UHC MSCAN

Newborn Prior Authorization

- 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/wp-content/uploads/2014/01/Admin-Code-Part-222.pdf
    - **Vaginal Deliveries: IP stay 3> days requires an auth**
    - **Cesarean Deliveries: IP stay 5> days requires an auth**

- **The Medicaid birth notification form, along with any additional information can be used if there is insufficient member information to submit all elements.**
    - **Online:** www.UHCprovider.com/Prior Authorization & Notifications
    - **Phone:** 866-604-3267
    - **Fax:** 888-310-6858

Integrated Clinical Care Team

- **Healthy First Steps (HFS) Neonatal Intensive Care Unit (NICU) Team** can address the pediatric and maternal needs of our members. They assess inpatient utilization and neonatal intensive care unit admissions.
- **The newborn and maternal processes are supported by our Integrated Clinical Care Team.**

Timeframe of Submissions

- The submissions are to notify us within **24 hours of the NICU admission.**
- UHC Inpatient Case Management- (ICM) follows and monitors the newborn in the NICU.
- UHC Neonatal Care Management Team (NICU) will get notification of newborn as well, this team will follow newborn and mother for longitudinal care management needs. Ensuring mother and newborn have needs met from hospital to home.

Claims Processing

- Claims are processed once member goes home. They are processed under the newborn's ID

Credentialing | Contracting Hospitals

UnitedHealthcare does not distinguish hospital owned clinics from the hospital.

- **Hospital Credentialing**
  - There is a hospital specific credentialing form.
  - UnitedHealthcare recredentials facilities **every 3 years.**
  - Facility will receive an application from our **CVO, Aperture/Verysis**.
  - Facility is to complete and return the form for processing; ensuring all required attachments are provided with the recredentialing form
  - To check credentialing status, email the Network Management Resource Team at: networkhelp@uhc.com.

  Have the following data elements available:

    - ***Place TIN & nature of request in subject line***
    - Facility Name
    - Tax ID Number
    - National Provider Identifier (NPI)

- **Updated Rosters with Current Providers**
  - Physician would submit their hospital privileges to be loaded.
  - **Contact Us:** networkhelp@uhc.com

- **What to do when a provider gets an out-of-network denial:**
  - **Verify you are contracted for the product you received the denial.**
  - **Contact the Provider services Line at: 877-842-3210**
    - **Have the following data elements available:**
      - Facility Name
      - Tax ID Number
      - National Provider Identifier (NPI)
      - Date of Service
      - Member ID Number
  - **Contact Claim Escalation Team**
    - **Mississippi Claims Escalation Team** – southeastprteam@uhc.com
      - Complete the claim template form with all required information including comments on the disagreement of how the claim was processed.
      - Include any additional documentation
      - You will receive an automated message acknowledging receipt.
  - **Contact your Provider Advocate**
    - The claim template form can also be utilized to communicate with your Provider Advocate.

Credentialing & Contracting Hospitals

Contact Information

- **Point of Contact at the UnitedHealthcare Community Plan-Mississippi**
  - **Name:** Rhona Waldrep
  - **Email:** Rhona_L_waldrep@uhc.com
  - **Contact Number:** (205) 672-3227
- **Point of Contact for Network Management**
  - Network Management team members are assigned to specific hospitals and not a geographic area.
  - If you do not know your specific contract management team member; please connect with me at the number above.

Hospital Network Management Team	Network Management Contact - email	Network Management Contact - Phone
Maria Gookin	maria_a_gookin@uhc.com	(763) 361-3598
Chris Wilson	chris_wilson@uhc.com	(225) 237-2049
Tamara Keene	t_keene@uhc.com	(601) 992-9918
Margie Stevens	margie_stevens@uhc.com	(952) 202-9505
Melanie Bishop	melanie_bishop@uhc.com	(662) 329-6129

- **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
South West – MS	Tanya Stevens	tanya_m_stevens@uhc.com	763- 361-0926
Southeast & Gulf Coast – MS	Tina Price	Tina_Price@uhc.com	952-406-6057

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

magnolia health™

Hospital Services

11/3/2021

Inpatient & Outpatient

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.

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.

Discharge Planning

- Concurrent review staff will work closely with hospital staff to ensure a comprehensive discharge plan is developed and in place prior to discharge.

- For members in Care Management, the Concurrent Review Nurse or designated staff will engage the member's Care Manager to ensure appropriate discharge planning and follow-up.

Authorization Submission

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

Authorizations can be submitted:

- Inpatient Fax: 1-877-291-8059
- Outpatient Fax: 1-877-650-6943
- Web: magnoliahealthplan.com/login
- Phone: 1-866-912-6285

Emergency Services PA

- 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 il: magnoliaauths@centene.com

Timeframes and Delays

- **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.
- **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.

Example of Issue which may cause delay:

All necessary clinical information with authorization requests are not submitted and/or providers doesn't respond to the Health Plans attempts to contact them for the necessary clinical information in order to make a determination on their authorization request.

To prevent this issue:

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.

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

Inpatient Claims

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

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

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

Newborns

11/3/2021

Newborn Enrollment Form

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.

- The information from the Newborn Enrollment Form is used to create the birth event for the newborn.
- If the Newborn Enrollment Form indicates that the newborn is a sick baby (non well-baby DRG, NICU admission, needs additional days outside of the delivery type), Magnolia will create an authorization and reach out for additional clinical information if an authorization has not already been submitted.

Prior Authorization

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- Web: www.provider.magnoliahealthplan.com
- Phone: 1-866-912-6285
- Email: magnoliaauths@centene.com

Inpatient and NICU Admission and Authorizations

If complications develop with the newborn that necessitate a non well-baby DRG, a NICU admission, or additional hospital days outside of the delivery type, an authorization request should be submitted along with clinical information to support the stay **within two** business days.

How to Submit Claims

Paper Claim Submission

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

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Credentialing/Contracting

11/3/2021

Hospital Credentialing Specifics

Distinguishing between hospital-owned and hospitals by NPI, taxonomy, etc.

- Hospital-owned clinics refers to medical services rendered in an on-site hospital clinic or other hospital affiliated clinic location.
- Providers should credential with Magnolia using the NPI and taxonomy code that most closely describes their provider type, classification, or specialization.
- For billing and identification purposes, Magnolia recommends hospital-owned clinics to have a separate NPI from the hospital.

Updating Rosters to Add, Delete, or Change Practitioners and Locations

- Delegated Groups are required to submit rosters timely upon adding or terming a practitioner with their organization.
- Rosters should be submitted **no less than once per month**.
- Submissions for Medical and Behavioral Health should be submitted to the magnoliacredentialing@cetene.com mailbox.
- Roster must indicate whether the practitioner should be enrolled as a Behavioral Health or Medical Practitioner.
- Add, Delete, or Change must be indicated on the roster for Magnolia's Credentialing Specialist to take the appropriate action.

Hospital Credentialing Specifics

What to do if you receive a denial related to a non-participating status?

- Non-participating or Out of Network Denials will most often display a denial reason of EXA1: Authorization Not on file.
- MSCAN members have no out of network benefits and all Non-Participating providers must obtain a pre-service authorization.

What to do if you believe an EXA1 denial for non-participation status is an error.

1. File a claim dispute with all supporting documentation to show practitioner completed credentialing process (submission confirmation, emails, etc.)
2. If you have recently submitted an update or new enrollment please ensure you have allowed 30 days for processing to complete
3. If Magnolia has an incorrect practitioner status in the system, please contact provider services at 1.866.912.6285

Contact Information

Provider inquires can be submitted the following ways:

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

- **Medical Prior Authorizations**
  Call: (866) 912-6285
  Email: Magnoliaauths@centene.com
  Fax: (877) 650-6943
- **Magnolia Credentialing**
  Call: (866) 912-6285
  Email: MagnoliaCredentailing@Centene.com

How Providers Can Access Webinar Presentation

2021 Managed Care Provider Workshop Presentation

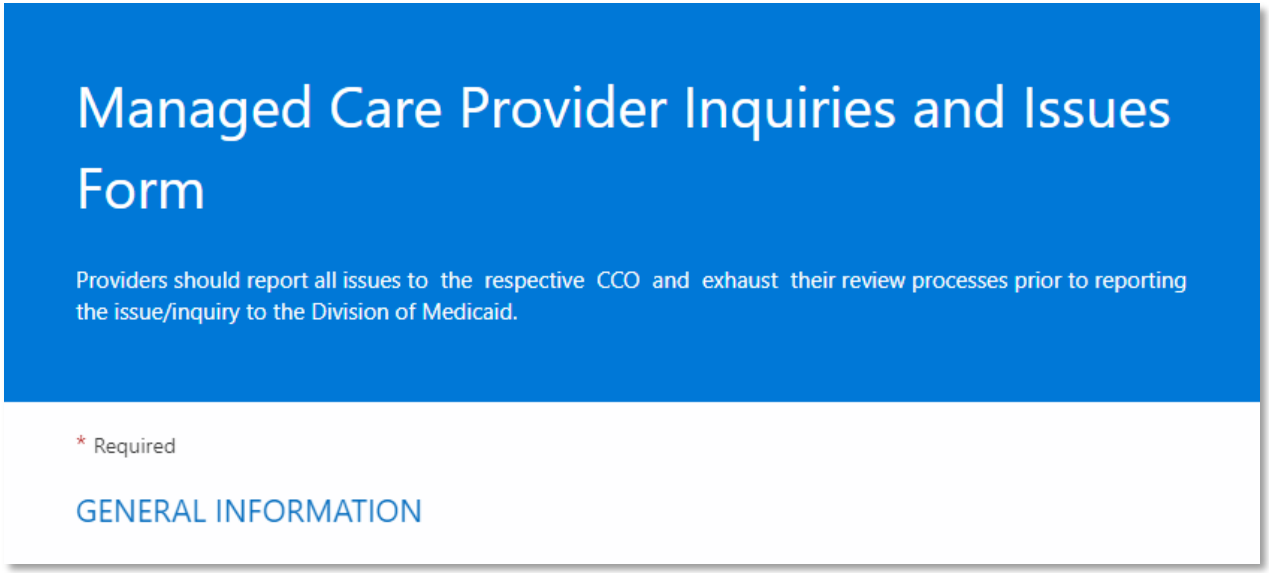
Managed Care | Mississippi Division of Medicaid (ms.gov)

MISSISSIPPI DIVISION OF MEDICAID

Managed Care Inquiries and Complaints

HELP US, HELP YOU

Please forward all issues and complaints to:
https://forms.office.com/g/WXj92sN1MH



MISSISSIPPI DIVISION OF MEDICAID

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

MISSISSIPPI DIVISION OF MEDICAID

Questions & Answers

Division of Medicaid
Sharon Jones

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