Mississippi Division of Medicaid

Managed Care Provider Webinar

2021

Behavioral Health| Rural Health Clinic| Federal Qualified Health Centers | 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 18, 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.	UnitedHealthcare
10:35 a.m.	10:50 a.m.	Molina Health
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

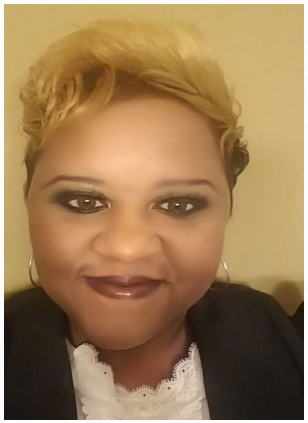
Lucretia Causey

Patricia Collier

April Burns

Magnolia Health

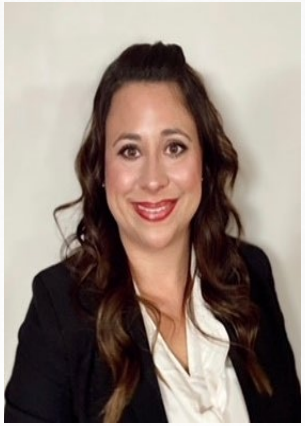
Brittany Cole



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

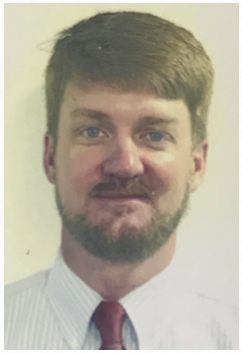
Kristi Plotner

Teresa Morris

Rhona Waldrep

Ty Klingelhofer

Molina Healthcare



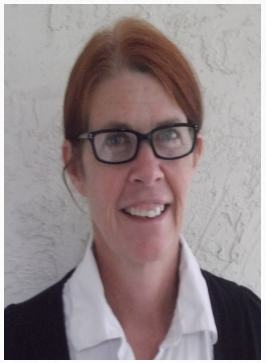
Bert Emrick

Earl Robinson

Chinwe Nichols

Chris Cauthen

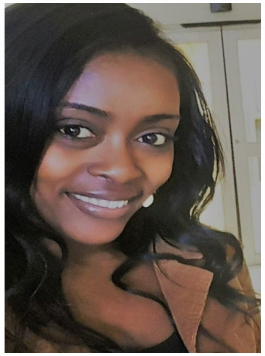
Daniel Bradshaw



Pam Canavan

Lakeida Ward

Ellie Coley

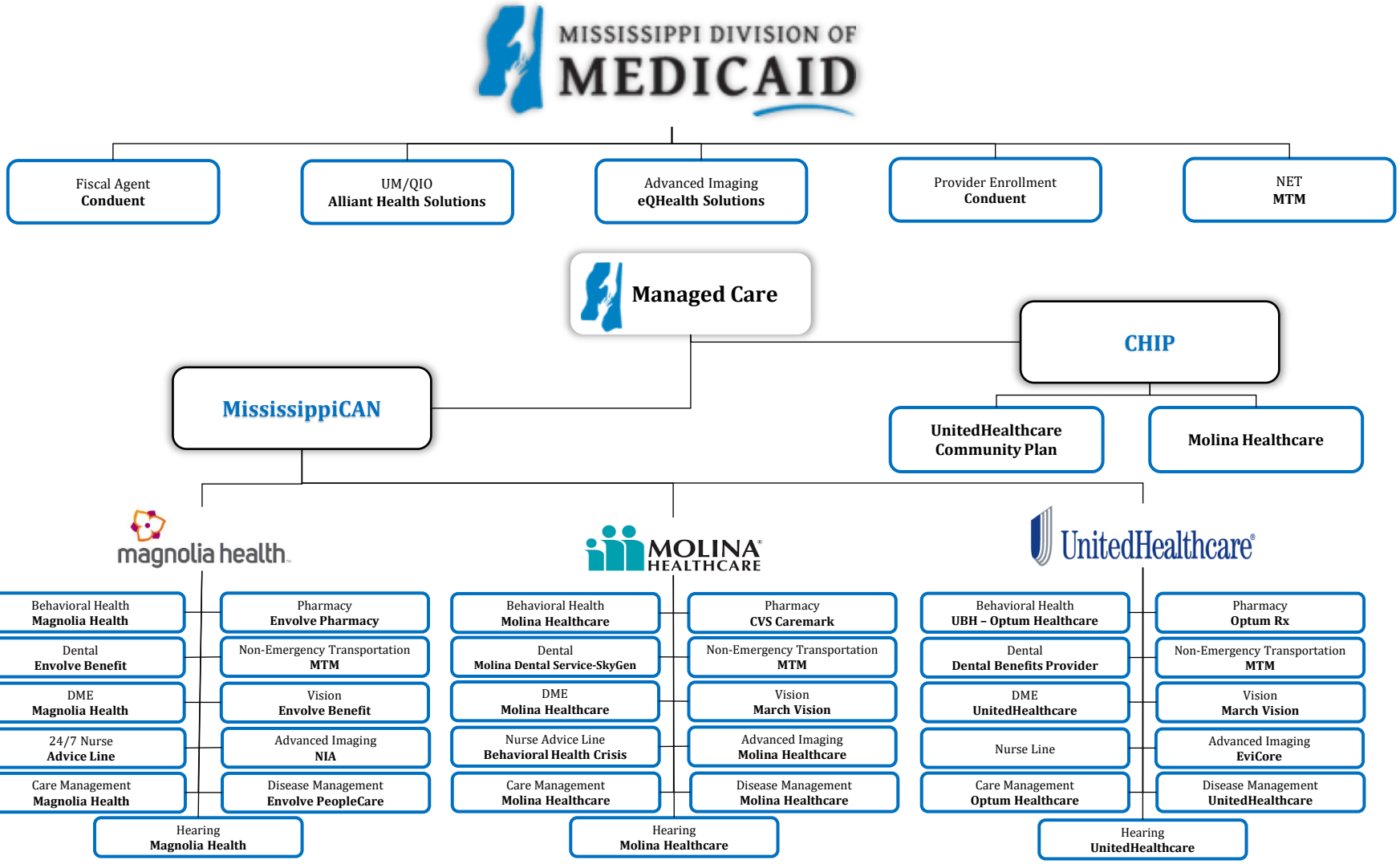


Laterria Lacy

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

2021 Managed Care Provider Webinars

November 18, 2021

United Healthcare

Behavioral Health

Policy Changes

- **11/1/20** – ICORT, Partial Hospital at Hospitals, moved services from Mental Health to Expanded EPSDT
- **5/1/21** – Facility fee added for IOP and PH @ outpatient hospital
- **7/1/21** – Freeze on rate changes
- **8/1/21** – MYPAC changes

Prior Authorizations

- **Behavioral Health**
- **Phone: 877-743-8734**
- **Online: https://www.ms-medicaid.com/msenvision/downloadenrollPackage.do**

Community Mental Health Center (CMHC)

- **Training was conducted in October for Prior Authorization.**

Mississippi Youth Programs Around the Clock (MYPAC)

- Targeted case management/Wraparound facilitation- get authorization now and file those claims.
- Waiting for code for clinical bundle- will provide instructions once received.

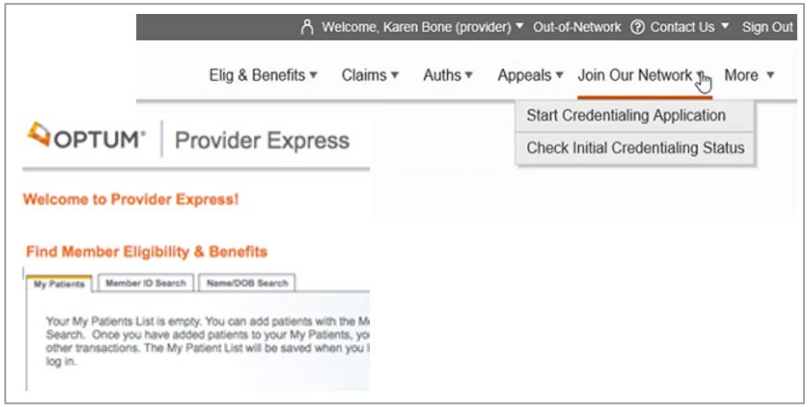
Psychiatric Residential Treatment Facilities (PRTF)

- **Eligibility changes and letters needed- Reach out to your provider rep.**

Join our Network – Start Credentialing Application

- **Apply for provider Medicaid ID with MS Division of Medicaid: ms-medicaid.com/msenvision/downloadenrollPackage.do**
  Not currently required for CHIP participation

- **Two options will display when the user clicks 'Join our Network'**
  - 'Start Credentialing Application' will transfer the user to the NPRF
  - 'Check Initial Credentialing Status' will transfer the user to the status bar



- **Integration with CAQH –** The user clicks the 'Start Credentialing Application' link, Provider Force connects to OHBS Facets and found a CAQH ID loaded on the OON record for this provider. Using the CAQH ID, Provider Force retrieves the provider's data from the CAQH application.
- **Pre-populated NPRF –** If the CAQH application is complete, active on Optum roster, and the provider has given Optum authorization to access the application data, we will pre-populate as many of the NPRF fields as possible. Note the updated messaging at the top of the form; any changes to data that came from CAQH must be updated on the CAQH website.

Contact Information

Provider Advocates

- **Dawn Teeter – Central to Southern MS**
  - **Email:** Dawn.Teeter@optum.com
  - **Phone**: 952-687-4121
- **Rusty Palmer - Central to Northern MS**
  - **Email:** James.Palmer@optum.com
  - **Phone:** 651-495-5298

- **Call Center Contact Information**
  - **Online:** www.UHCprovider.com
  - **Provider Services:** 877-743-8734
  - **Members:** 877-743-8731

Rural Health Clinics & Federal Qualified Health

Provider Enrollment/New Contract Process

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**.

Get Contracted – 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

If you are a joining a FQHC that already has a participation agreement with UnitedHealthcare, providers listed on the Provider Roster Template will be added to the existing agreement.

- **Provider Roster Template can be requested & sent to:** ms-fqhc-rhc@uhc.com or your Network Account Representative
- **Get Connected –** Set up online tools, paperless options, & complete training.
  - **Join Our Network | UHCprovider.com**

Contact Information

- **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)

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**

Top Three Issues

Top Provider Claims Processing Issues
Invalid Place of Service
3rd Party COB
Duplicate Claim

Reimbursement

- FQHC/RHC providers are reimbursed at a prospective payment system (PPS) rate per encounter.
- Rates are determined by CMS, and we are required to reimburse in accordance with those rates.
- Payment rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

EPSDT

- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services are available to members up to age 21 who are eligible for Medicaid.
- **EPSDT services include:**
  - A comprehensive unclothed physical exam
  - Comprehensive family/medical/developmental history
  - Immunization status, any shots that are needed
  - Lead assessment and testing
  - Necessary blood and urine screening
  - TB skin test
  - Developmental assessment
  - Nutritional assessment/counseling
  - Adolescent counseling
  - Vision testing/screening
  - Hearing testing/screening
  - Dental referral services

- **The EPSDT screening CPT codes for initial or periodic examinations must have the EP modifier listed in block 24D of the CMS–1500 claim form. The vision, hearing, developmental, autism, depression, and maternal depression screening CPT codes must have the EP modifier listed in block 24D of the CMS–1500 claim form which must be billed in conjunction with the comprehensive age-appropriate screening. EP is a required modifier for all EPSDT claims**

Claims Filing

All claims must be submitted with the correct POS.

- **FQHC: POS 50**
- **RHC: POS 72**
- **Individual providers** information should be listed in **Box 24J** and **35a/35b**.

The NPI for the RHC/FQHC where the services were rendered should be listed in Box 33a to ensure claims are reimbursed correctly.

Contact Information

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Provider Advocate

- **Name:** Adrian Hagan
- **Email:** adrian_d_hagan@uhc.com

Call Center Contact Information

- **Provider Services: Community & State: 877–743–8734**

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.

MOLINA HEALTHCARE

Behavioral Health Policy Changes

MYPAC Transition

The Mississippi Youth Programs Around the Clock (MYPAC) program was revised to be compliant with the Centers for Medicare and Medicaid Services (CMS) regulations regarding Targeted Case Management. Effective July 1, 2021, MYPAC, as a bundled all-inclusive mental health service that includes Wraparound, transitioned to a targeted case-management model using Wraparound. All other medically necessary ancillary mental health services will be billed separately.

Medicaid 5% Reimbursement Reduction

During the 2021 Mississippi Legislative Session, Senate Bill 2799 was passed. One of the changes to Mississippi Code 43-13-117 Medicaid – Types of care and services for which financial assistance furnished. Effective July 1, 2021, Section 43-13-117(B) was deleted, which mandated a 5% reimbursement reduction from the allowed Medicaid amount for certain services. Managed care entities applying the 5% rate reduction should eliminate this policy from reimbursement payments. While the normal reimbursement rate establishing the mandatory minimum was previously the reduced amount, the fee-for-service allowed amount will now be considered the “normal reimbursement rate” for purposes of assuring compliance with Section 43-13-117(H) (d).

For reference, this legislation is located at the following website:
http://billstatus.ls.state.ms.us/documents/2021/dt/SB/2700-2799/SB2799SG.pdf

Crisis Response Services

The Division of Medicaid, Office of Mental Health, revised Administrative Code, Title 23: Medicaid Part 206 Mental Health Services effective September 1, 2020. Please access this link to view the revisions:
https://medicaid.ms.gov/wp-content/uploads/2021/07/Title-23-Part-206-Mental-Health-Services-eff.-07.01.21.pdf

Molina healthcare will follow the guidance of the Division of Medicaid and comply with all changes previously referenced.

Psychiatric Residential Treatment Facilities (PRTF)

Psychiatric Residential Treatment Facilities provide residential services for individuals under age twenty-one (21).

The goal of PRTF treatment is to help the individual reach a level of functioning where less restrictive treatment will be possible.

❑ Inpatient psychiatric services for individuals under age twenty-one (21) must be provided before the individual reaches age twenty-one (21) or, if the individual was receiving the services immediately before reaching age twenty-one (21), before the earlier of the following: the date the individual no longer requires the services or the date the individual reaches age twenty-two (22)

❑ Prior authorization is required

❑ Services are billed using Revenue code 1001

The need for PRTF admission must be supported by documentation that:

❑ The individual has a psychiatric disorder or suspected mental illness that is documented by the assignment of an appropriate diagnosis, as per the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

❑ The individual can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.

❑ The individual's psychiatric symptoms are severe enough to warrant residential treatment under the direction of a psychiatrist.

❑ The referring psychiatrist or psychologist advises that residential treatment is needed.

At least one (1) of the following:

1) The individual has failed to respond to less restrictive treatment in the last three (3) months.
2) Adequate less restrictive options are not available in the individual's community.
3) The individual is currently in an acute care facility whose professional staff advise that residential treatment is needed.

❑ The admission has been certified by the UM/QIO as medically and psychologically necessary.

Note : Services require Prior Authorization and are subject to Concurrent Review

A listing of PRTF facilities is located on the Division of Medicaid's website at the link below:
https://medicaid.ms.gov/wp-content/uploads/2021/09/PRTF-Rates-Calendar-Year-Rates-2021-June-30-2024.pdf

Billing for PRTF is on a per diem basis

❑ The standard facility rates are determined by DOM from facility cost report data

❑ Rates are effective on January 1st of each year

MOLINA HEALTHCARE

Mississippi Youth Programs Around the Clock (MYPAC)

Targeted Case Management/Wraparound Services for PRTF Level of Care:

- ❑Providers must be certified by the Department of Mental Health to provide Wraparound or any other community mental health services, such as Day Treatment or Intensive Community Outreach and Recovery Teams (ICORT).
- ❑Children/Youth must meet the clinical criteria for PRTF and prior authorized by DOM or its designee.
- ❑Children/Youth must be Early, and Periodic Screening, Diagnostic, and Treatment (EPSDT) eligible.

MYPAC Providers:

- ❑MYPAC providers who are also enrolled as a Community Mental Health Center (CMHC)/Private Mental Health Center (PMHC) must transition MYPAC enrollees to their CMHC/PMHC provider number effective July 1, 2021, as their MYPAC provider number will be closed by the Division of Medicaid effective June 30, 2021.
- ❑MYPAC providers who do not already have a CMHC/PMHC provider number will keep their current provider number and the Division of Medicaid will transition those providers to a PMHC (X01) provider type.

Wraparound for PRFT Level of Care Prior Authorization and Claims Requirements

- ❑Prior authorization will be required for Targeted Case Management/Wraparound o
  - ➢Procedure Code: T2023 Targeted Case Management, Per Month for Wraparound
  - ➢Required Modifiers: HW, HT
  - ➢Allowed Provider Types: X00 and X01
  - ➢Reimbursed as a monthly rate of $1,200.00.

Mississippi Youth Programs Around the Clock (MYPAC)

- The PA for beneficiaries enrolled in MYPAC (H2022) will end June 30,2021 and will be transitioned by the CCO's and Alliant to each providers' CMHC (X00) or PMHC (X01) provider number with the new wraparound code (T2023) beginning July 1, 2021, to the end of the month of the current MYPAC (H2022) PA.
- New prior authorization requests for Wraparound (T2023) will be approved for a 12- month timeframe. Beneficiaries will be locked-in to T2023 for this timeframe.
- Prior Authorization will not be required for ancillary mental health services unless the individual service currently requires a prior authorization. Example: Day Treatment
- All claims for services provided to beneficiaries locked-in to T2023 should also include the HT modifier to indicate these services are for this level of care. This applies to any ancillary services provided by the Targeted Case Management/Wraparound agency or any other agency/individual providing services to the beneficiary.

Wraparound Services while in a PRTF or Acute Facility: Based on the proposed State Plan Amendments 21-0039, wraparound is allowed and reimbursable for 30 days prior to discharge from a mental health facility with prior authorization.

Lock-Ins: The SED Lock-in process will remain the same with the exception that the lock-in will be based on the prior authorization for new code T2023 and the SED lock-in will transition from the X04 to the X00/X01 provider number.

Additional information: Procedure code H2021 – Community-based Wrap-around Services, per 15-minute unit was discontinued effective June 30, 2021. Providers who are currently billing H2021 for beneficiaries who do not meet the PRTF level of care will now bill T1017 – Targeted Case Management, each 15 minutes.

Independent providers, outside of the Wraparound Facilitation agency, who participate in the Child and Family Team meeting may bill H0032 for Treatment Plan Development and Review and must utilize the HT modifier. This will not require a prior authorization unless the beneficiary has exhausted their allowed units.

The Division of Medicaid is also submitting a new State Plan Amendment for Mississippi Youth Programs Around the Clock (MYPAC) by July 1, 2021. This bundled service will cover: treatment plan development and review, medication management, individual, group and family therapy, day treatment, peer support, crisis response and skill building groups.

Community Mental Health Centers (CMHCs)

Molina Healthcare of MS complies with DOM guidance regarding CMHCs as outlined in the Medicaid Administrative Code:
https://medicaid.ms.gov/wp-content/uploads/2021/07/Title-23-Part-206-Mental-Health-Services-eff.-07.01.21.pdf

Molina Healthcare of MS also complies with DOM guidance regarding the reimbursement of covered services for CMHCs. The current CMHC Fee Schedule is located at:
https://medicaid.ms.gov/wp-content/uploads/2021/10/COMMUNITY-MENTAL-HEALTH-Services-CMHS-Fee-Schedule-Print-Date-10-05-2021.pdf

Behavioral Health Prior Authorization Submissions

We require that all PA submissions to Molina include:

- ❑ Member demographic information,
- ❑ Facility information,
- ❑ Date of admission or Date Span of Services
- ❑ Clinical information sufficient to document the Medical Necessity of the admission or procedure.

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.

Molina performs concurrent inpatient review in order to ensure patient safety, Medical Necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Molina will request updated original clinical records from inpatient facilities at regular intervals during a Member's inpatient admission. This information is due from the inpatient facility within twenty-four (24) hours of the request.

- ❑ 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) 206-4006

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

Mail:
188 East 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**

FQHC & RHC Provider Enrollment

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.

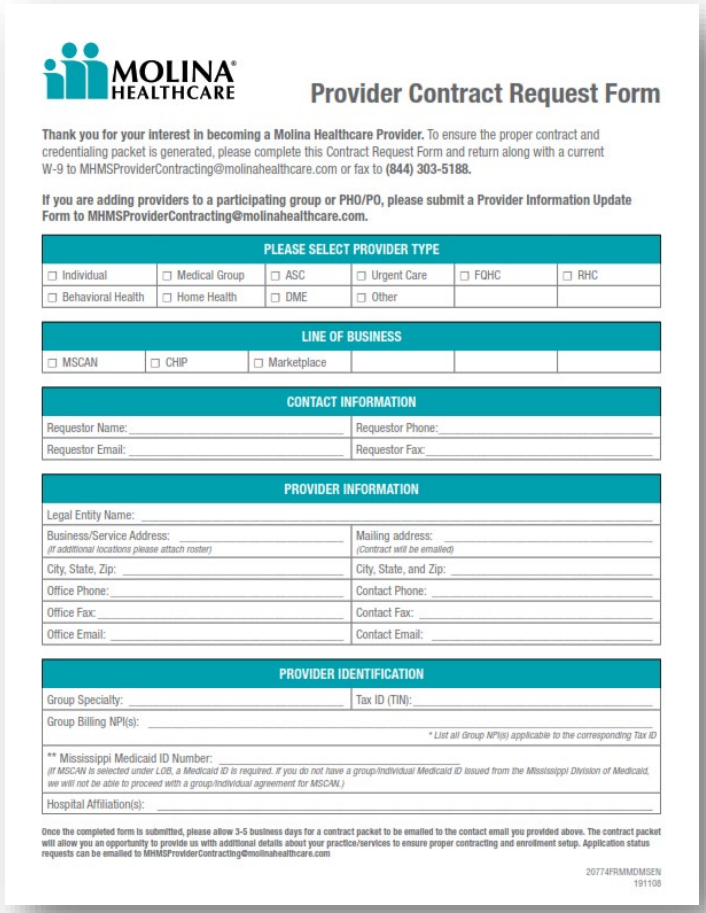
After completing, a representative from our Provider Contracting Department will reach out to you regarding the enrollment and credentialing process.

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

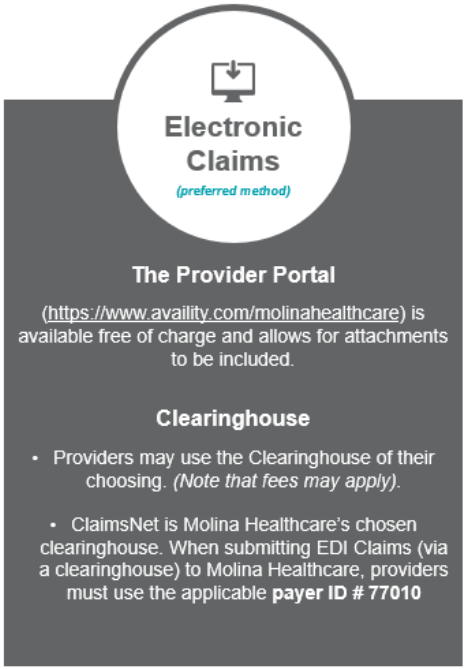
FQHC & RHC Review/Credentialing

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.

MOLINA HEALTHCARE

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**

FQHC & RHC Services and Rates

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

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

Services are reimbursed based on the Division of Medicaid Fee Schedule
https://medicaid.ms.gov/providers/fee-schedules-and-rates/

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

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

EPSDT

EPSDT stands for **Early and Periodic Screening, Diagnosis and Treatment.** EPSDT is a program that provides comprehensive and preventative health care services for children under the age of 21. EPSDT visits are free for all children who are Molina Healthcare members.

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

School Encounter Rates

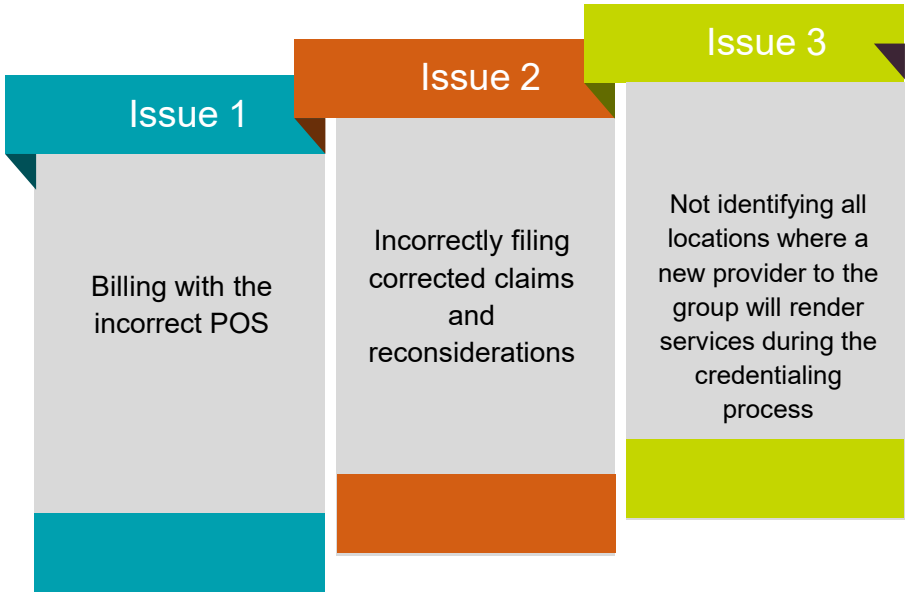
School Based Administrative Claiming is an administrative function of DOM FFS. The CCOs are required to enroll and reimburse School-based providers, which are school districts with nurses providing EPSDT screenings.

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

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

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

FQHC & RHC Top 3 Issues



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*
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

Contact Information

Contact Information

Molina Healthcare of Mississippi, Inc.
188 E. Capitol Street, Suite 700
Jackson, MS 39201

Phone Numbers

Main Line Toll Free	(844) 826-4333
Member Eligibility Verification	(844) 809-8438
Member Services	(844) 809-8438
Provider Services	(844) 826-4335
Behavioral Health Authorizations	(844) 826-4335
Pharmacy Authorizations	(844) 826-4335
Radiology/Transplant/NICU Authorizations	(855) 714-2415

Fax Numbers

Main Fax	(844) 303-5188
Prior Auth – Inpatient Fax	(844) 207-1622
Prior Auth – All Non-Inpatient Fax	(844) 207-1620
Behavioral Health - Inpatient Fax	(844) 207-1622
Behavioral Health - All Non-Inpatient Fax	(844) 206-4006
Pharmacy Authorizations Fax	(844) 312-6371
Physician Administered Drugs	(844) 312-6371
Radiology Authorizations Fax	(877) 731-7218
Transplant Authorizations Fax	(877) 813-1206
NICU Authorizations Fax	(833) 734-1509

Vendors

- **MTM (Non Emergent Transportation)**
  Toll Free: (888) 597-1206
  Toll Free: (844) 826-4335
  https://memberportal.net/?planCode=MOL
- **CVS Caremark (Pharmacy)**
  Toll Free: (844) 826-4335
  PA submissions Fax: (844) 312-6371
- **March Vision (Vision)**
  Toll Free: (844) 606-2724
  Toll Free: (844) 826-4335
  www.marchvisioncare.com

MOLINA HEALTHCARE

Behavioral Health

Policy Changes & Updates

Effective July 1, 2021, MYPAC, as a bundled all –inclusive mental health service that includes wraparound, transitioned to case-management model with wraparound and any medically necessary ancillary mental health services being billed separately.

BH Clinical Guidelines

11/18/2021

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 & Outpatient

Inpatient (continued)

- Partial Hospitalization Program (PHP)- request are typically made within 24 hours of admit as this is an outpatient service
  - Members are approved for 5 days if medical necessity is met
- Electroconvulsive Therapy (ECT) request should be made prior to the start of treatment.
- Inpatient Utilization managers can be reached at AUGMississippium@cenpatico.com
- Fax number is 1-866-535-6974

Outpatient

- Some behavioral health services require prior authorization. To check to see if pre-authorization is necessary, use our online tool. Standard prior authorization requests should be submitted for medical necessity as soon as the need for service is identified.

- Initial requests may be backdated one business day; requests for days beyond the one back day may be submitted to the retro appeals department at fax number: 1-866-714-7991. Concurrent requests for continued services may be submitted up to 21 days prior to the start of the new authorization.

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

Inpatient Prior Authorization

Authorizing the following LOCs:

- **Acute (IP) and Crisis Stabilization Unit (CSU)-** requires authorization to be made within 48 hours of member admit

For acute services members are approved for 5-7 days if medical necessity is met. Magnolia 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.

For CSU services members are approved for 5 days upon initial review pending medical necessity

- **Psychiatric Residential Treatment Program (PRTF)-** authorization can be completed up to 7 days prior to the date of admission.

Members are initially authorized for 30 days if medical necessity is met. After the first 60 days of admission, the Magnolia will request discharge planning information monthly to identify any barriers to discharge, and to allow involvement from care Management.

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.

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

Clinical Contact Information

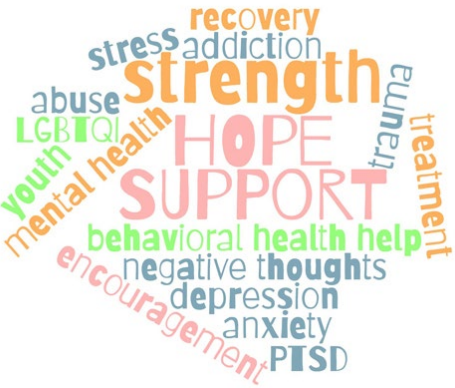
- Appeal Mailing Address – 12515-8 Research Blvd Austin, TX 78759
- Appeal Email address – appeals@cenpatico.com
- Appeal Fax Number - 866-714-7991
- Provider Services – 866-912-6285

***Claim reconsiderations should be mailed to P.O.Box 7600 Farmington, MO 63640**
***Claim appeals should be mailed to P.O.Box 6000 Farmington, MO 63640**

CMHC – Top Tips

Things to Remember:

- All claims should be submitted with HW modifier in the first position
- Prior authorization is required for some services – utilize pre-auth check tool
  https://www.magnoliahealthplan.com/providers/preauth-check.html
- Contracting and Credentialing Provider Type is Facility



MYPAC changes 2021

Revisions were made effective July 1. 2021 to the Mississippi Youth Programs Around the Clock (MYPAC) program to be compliant with the Centers for Medicare and Medicaid Services (CMS) regulations regarding Targeted Case Management.

MYPAC Provider:

- MYPAC providers who are also enrolled as a Community Mental Health Center (CMHC)/Private Mental Health Center (PMHC) should transition those MYPAC enrollees to their CMHC/PMHC provider number effective July 1, 2021, as their MYPAC provider number will be closed effective June 30, 2021.
- Those who do not already have a CMHC/PMHC provider number will keep their current provider number but be transitioned to a PMHC (X01) provider type.
- Future providers interested in providing Wraparound services should enroll as a PMHC (X01) through the Department of Mental Health.

PRTF- Updates

Targeted Case Management/Wraparound Services for PRTF Level of Care:

- Providers must be certified by the Department of Mental Health to provide Wraparound.
- Children/Youth must meet the clinical criteria for PRTF and prior authorized by DOM or its designee.
- Children/Youth must be Early, and Periodic Screening, Diagnostic, and Treatment (EPSDT) eligible.

Wraparound for PRFT Level of Care Prior Authorization and Claims Requirements

- Prior authorization will be required for Targeted Case Management/Wraparound
- New prior authorization requests for wraparound (T2023) should be approved for a 12-month timeframe. Beneficiaries will be locked-in for this timeframe.
- Prior Authorization will not be required for ancillary mental health services unless the individual service currently requires a prior authorization. Example: Day Treatment

Wraparound Services while in a PRTF or Acute Facility:

- Wraparound is allowed and reimbursable for 30 days prior to discharge from a mental health facility with prior authorization.
- Procedure code H2021 – Community-based Wrap-around Services, per 15-minute unit will be discontinued effective June 30, 2021. Providers who are currently billing H2021 for beneficiaries who do not meet the PRTF level of care will now bill T1017 – Targeted Case Management, each 15 minutes.

Contact Information

Important Numbers & Links

Provider Services: (866)-912-6285

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

Send secure emails:
AUGMississippiUM@cenpatico.com

Magnolia Website:
www.magnoliahealthplan.com

Magnolia Health's Secure Portal:
Provider.magnoliahealthplan.com

Federally Qualified Health Center & Rural Health Clinic

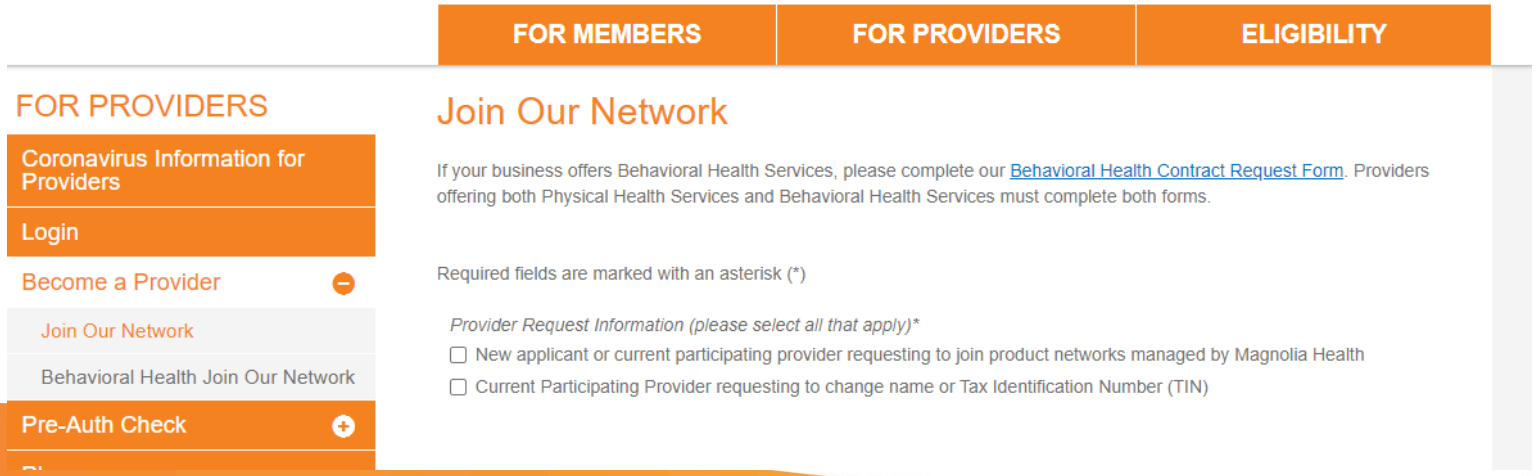
11/18/2021

FQHC/RHC Enrollment: New Group Contract Process

- To begin the contracting process, complete the Join Our Network **Form** in its entirety and submit online**.**

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

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



New Group Contract Process

Magnolia requires a contract be accompanied by:

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

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

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

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.**

FQHC/RHC Rates and Reimbursement

- FQHC and RHCs can obtain their current PPS Encounter Rate by reviewing the appropriate fees schedule at https://medicaid.ms.gov/providers/fee-schedules-and-rates/#.
- 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 PPS 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.
- Service Limits
  - Reimbursement to an FQHC or RHC is limited to no more than four (4) encounters 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

Early and Periodic Screening, Diagnosis and Treatment

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

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

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

magnolia health

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

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

Billing Requirements for EPSDT Services

All EPSDT visit codes should be filed with an EP modifier.

Covered codes for EPSDT services are found in the Division of Medicaid Administrative Code, Title 23, Part 223

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

Magnolia Follows the Bright Futures Periodicity Schedule for Screenings and Immunizations

Claims Filing

"Transforming the health of the community one person at a time"

11/18/2021

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**

TOP 3 Issues

1. Non-covered denials
    - Prior to performing a service, please verify that the service is covered. You can verify by going to https://www.ms-medicaid.com/msenvision/
2. CMS Medicaid NCCI Unbundling
    - Magnolia uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting, and to aid in meeting HIPAA compliance regulations. The software will detect correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes against rules that have been established by the American Medical Association (AMA), the Center for Medicare and Medicaid Services (CMS), the State of Mississippi, public domain specialty society guidance, and clinical consultants who research, document, and provide edit recommendations based on the most common clinical scenario. Claims which are not billed in a manner that does not adhere to these standard coding conventions.
3. Provider Medicaid ID Required
    - The rendering provider must have an active Mississippi Medicaid ID.
    - Services should not be rendered until you have received an approval letter from Medicaid.

Contact Information

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

- **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

How Providers Can Access Webinar Presentation

2021 Managed Care Provider Workshop Presentation

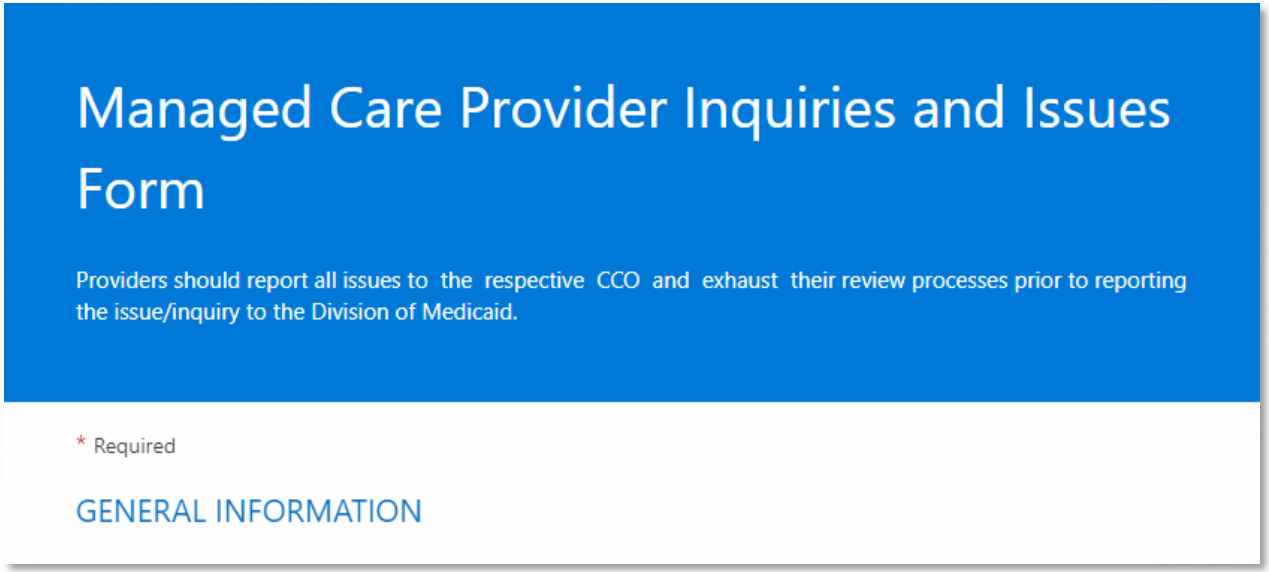
Managed Care | Mississippi Division of Medicaid (ms.gov)

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